Focus On...

Mental Health

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Focus On...
Mental Health

Occupational therapy can play pivotal role in serving the mental health needs of people of all ages and conditions and within all settings—in the home, at school and nursing facilities, and throughout the community. This edition of AOTA’s “Focus On” series, on mental health, includes profiles of successful programs and projects helping a range of populations; official documents outlining best practices; and overviews of the evidence supporting occupational therapy interventions for mental health.

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Statements
- Cognition, Cognitive Rehabilitation, and Occupational Performance (available through AJOT) http://dx.doi.org/10.5014/ajot.2013.64579
- Occupational Therapy Services for Individuals Who Have Experienced Domestic Violence
- Occupational Therapy Services in the Promotion of Psychological and Social Aspects of Mental Health http://dx.doi.org/10.5014/ajot.2010.64578
- AOTA’s Societal Statement on Combat-Related Posttraumatic Stress
- AOTA’s Societal Statement on Stress and Stress Disorders
- AOTA’s Societal Statement on Youth Violence

Sample Letters to Congress on OT’s Role in Mental Health

Note: At the time individual items were published, prices and products were up to date. Please check http://store.aota.org or www.aota.org for current information.
Learning to create and lead occupational therapy groups requires an understanding not only of group leadership and dynamics, but also of the neurobiology of group therapy and client diagnoses. Occupational therapists have a rich history of group work beginning with the mental health arena and now within all specialty areas. How occupational therapists are trained in group work has evolved with the expansion of knowledge of group theory, neuroscience, research methods, and the adoption of the Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (Framework-II; American Occupational Therapy Association [AOTA], 2008). Using a case example of a student group in a graduate occupational therapy program, this article will describe the basic knowledge and skill set students must acquire and the implications this type of teaching of group dynamics has for the profession.

Occupational therapy combines the teaching of group skills and process and its implicit emphasis on self-awareness with occupation-based task analysis and neuroscience. Few other health professions have linked learning theory and practice as seamlessly as ours, but many academic programs delay the practicing of group skills until fieldwork in mental health. The authors urge occupational therapy educators not to separate the academic learning of skills until fieldwork in mental health. The authors urge occupational therapy educators not to separate the academic learning of skills and the experiential process of practicing these skills in the clinic. Unfortunately, with more academic programs discontinuing mental health Level II fieldwork, many students are missing opportunities to develop sophisticated group skills. The loss of this skill set could translate into further erosion of our role within physical and psychiatric rehabilitation.

Six Columbia University first year occupational therapy students created a Bucket Drumming group as part of a task group and leadership assignment for a local homeless shelter in New York City for men with severe mental illness, including schizophrenia, and for an outpatient center for clients with multiple sclerosis (MS). Student reflections on this group experience, presented as qualitative data, attest to the effectiveness of this teaching strategy. The neurobiology of drumming is discussed to understand the powerful effect this modality had on the students and clients as well as its differential impact on psychiatric and physical diagnoses. To assess the effectiveness of the group, the students created and administered a Bucket Drumming survey to measure the satisfaction of group members; the results were analyzed using the Statistical Package for the Social Sciences (SPSS). The conclusion summarizes the authors’ guidelines for robustly teaching group dynamics to adult learners so that graduate students can continue the rich tradition of occupational therapy group work in all settings.

The Neuroscience Underlying Group Therapy

From an evolutionary perspective, group formation is an adaptation that increased chances for survival. Individuals belonging to a group are more likely to collaborate on tasks, receive warning of danger, and get assistance from others in time of need, and therefore have higher chances of survival than isolated individuals. O’Gorman, Sheldon, and Wilson (2008) proposed an evolutionary theory of selectivity of group-level traits, where desirable altruistic behaviors are facilitated by group inclusion, while group-harmful behaviors such as selfishness are eliminated through punishment or alienation. Because group inclusion involves the acquisition of social roles, the natural selection process may have favored individuals with genetic traits for prosocial behavior as well as psychological mechanisms that facilitate the identification, avoidance, and ostracism of non-reciprocators.

Noted group theorist Kurt Lewin (1944) stated that the capacity for change is much greater in a group setting than when change is attempted individually. Recent studies on the brain’s ability to empathize provide insight into the neurological benefits of therapeutic groups. The social neurology of the human brain is localized predominantly in the cerebral cortex and is correlated with the structural enlargement of this area compared to other species. The ability to empathize is a fundamental factor guiding social relationships among human beings living within a society. Our brains are biologically wired for social networking skills such as predicting the behaviors of others, understanding when to trust people, and forming relationships varying in levels of intensity (Dunbar, 2008).

Empathy enables us to share emotional experiences and states with others and is activated in the frontal, temporal, and somatosensory cortex, and amygdala. The emotion is recognized as belonging to the other person rather than to one’s self in the heteromodal association area of the brain. Suppression of one’s own point of view occurs to enable us to perceive the views of the other

person (Rankin et al., 2006). Numerous studies have attributed loss of social behavior to localized areas of the brain using case studies of traumatic brain injuries, strokes, psychiatric disorders, and localized brain lesions in laboratory animals. The mirror neuron system allows an observer to relate to the feelings, expressions, and behaviors of a social partner by representing those behaviors through activation of similar areas of the observer’s brain (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003). Mirror neurons have been described in empathic behavior, social cognitive skills, and goal-setting abilities in collaborative groups.

The Neuroscience Underlying Bucket Drumming

The neuroscience that underlies music and bucket drumming helps explain its efficacy. The Bucket Drumming group challenges its participants to follow a drum line demonstrated by the leader, to remember this drum line, to play back the drum line together with other group members, and then combine their drum line with the other half of the group, which learned a different drum line. In such a group, timing, memory, and coordination are practiced to achieve synchrony. Motor output regulated by the frontal cortex is coordinated with aspects of vision, auditory feedback, and proprioception in the other areas of the brain stimulating neuronal collaboration. The hippocampal role in memory formation is exercised through trying to remember the correct beat. When two separate drum lines join to create one piece toward the end of the group, concentration and selective attention are exercised to play the learned drum line, despite hearing a different beat from the other half of the group.

Studies investigating the neurology of music show links between music and cognitive function. In a meta-analysis, music has been found to play a catalytic role in hippocampal-dependent temporal order learning, spatiotemporal reasoning, memory, recall, focus modulation, attention span, attention range in left neglect, sensory-motor learning, auditory verbal learning, emotional adjustment, motor/executive function, and psychosocial function (Thaut et al., 2009). With vast neuronal associations in the brain, the use of music in therapy can be individualized to facilitate cognitive remediation using the brain’s natural neuroplastic tendency. The hippocampal role in memory formation is exercised through trying to remember the correct beat. When two separate drum lines join to create one piece toward the end of the group, concentration and selective attention are exercised to play the learned drum line, despite hearing a different beat from the other half of the group.

Brain studies of clients with schizophrenia, a diagnosis prevalent at the shelter, identify it as an inability to effectively process information due to a deficit in communication between the various lobes of the brain (Sigurdsson, Stark, Karayiorgou, Goros, & Gordon, 2010). The perceptual processing of individuals with schizophrenia has been described as perceiving sensory stimuli such as conversations as separate or isolated components that need to be consciously pieced together (Uhlhaas & Mishara, 2007). Cognitive training with participants with schizophrenia has resulted in significant improvements in task performance, with fMRI data showing increased neuronal connectivity in the prefrontal cortex (Edwards, Barch, & Braver, 2010). Areas of the brain responsible for working memory, perceptual organization, spatial memory, and coordination (such as the prefrontal cortex and hippocampus) are stimulated in cognitive training exercises (Edwards et al., 2010).

Individuals with schizophrenia experiencing auditory hallucinations have coped by using methods such as listening to cassette players, subvocal counting, and earplugs (Nelson, Thrasher, & Barnes, 1991). The beat learned in bucket drumming can be concentrated on to achieve similar means of symptom management. Musical training also habituates a person to concentrate on a specific task, ignore multisensory distractions, and filter out disruptive stimuli that may otherwise affect the ability to focus attention.

Effective interventions to address the physical and cognitive symptoms of MS include planned movement or stimulation of motor neurons firing to the muscles. This therapeutic movement simultaneously sends sensory information back to the central nervous system where the brain receives sensory and proprioceptive updates and integrates information. This fine tunes the inhibitory and excitatory action potentials, coordinates the movements, and plans the next movement via motor neurons to the muscles. In MS, where this mechanism is disrupted due to poor signal conduction, neuroplasticity or myelin regeneration needs to occur to compensate for the damage (Gold et al., 2003). By practicing coordinated rhythmic movements, such as in bucket drumming, a person with MS stimulates the feedback loop in a pleasurable and reinforcing activity while activating the pathways, which need to be stimulated for neuronal repair (“use it or lose it”). By targeting specific motor, sequencing, memory, and coordination pathways during drumming, a patient engages in a pleasurable and therapeutic activity that battles the physical and cognitive effects of MS. By participating in a drumming beat played in unison by the group, patients share a rhythm with others going through similar struggles, decreasing their feelings of isolation.

Action-Based Resources for Teaching Group Dynamics

Membership in the task group assignment at Columbia University is randomly assigned and entails a semester-long assignment where students experience and examine group dynamics while resolving a purposefully ambiguous community-based occupational problem. The vagueness of the assignment arouses strong emotions, inter-group competition, and object cathexis. Panic ensues when members realize the leader and group are inevitably imperfect and not all-powerful.

Lewin (1944) coined the term action research to denote the importance of experimental methods as a way to revolutionize the study of group dynamics. He advocated that the learning of group skills be a hands-on experience and that active participation in groups and reflection on this mutual experience was the best way to understand the principles of how groups work. Various techniques popularized by Lewin to teach about group process are invaluable to occupational therapy students, including keeping personal journals, signing learning contracts, and vowing to facilitate the learning of others within the group context. Lewin’s work on participant observation, experiential work, and motivation within groups links smoothly with the client-centered approach central to the occupational therapy paradigm.
The therapeutic factors of Yalom and Leszcz (2005) provide an essential starting place for occupational therapy students' acquisition of clinical reasoning skills within the group format. Understanding and consciously applying the factors of universality, altruism, and cohesiveness first within their own task groups and then within the Bucket Drumming group helped the students quickly learn to appreciate forces responsible for therapeutic change within their groups. A neurological basis for therapeutic factors such as universality and altruism has been suggested (Carr et al., 2003; O’Gorman et al., 2008).

Cole’s (2005) seven-step format of group leadership is an effective method for teaching critical aspects of this role. Before leading the drumming group, students practiced using Cole’s seven steps within their task group. The daunting role of leadership was made less overwhelming by shared responsibility and co-leadership. An equal distribution of steps ensured that introductions were made, the activity was carefully planned and presented, and a framework existed for generalizing the learning that occurred in the group to the lives of clients in the community.

A key element of what enables a group to be uniquely occupational therapy is its focus on activity and the adoption of the formal procedure of activity analysis. This step has been made easier by the publication of the Framework-II (AOTA, 2008), particularly the activity demands domain. Other professionals who lead groups in any setting are neither trained to analyze nor titrate the dosage and quality of group interventions with the same breadth or rigor as occupational therapists.

Student Research and the Bucket Drumming Group

A heuristic device to potentiate the students’ group leadership skills was the assignment of a group leadership reflection paper that focused on their task group’s use of theory presented in class. The students’ reflections on the Bucket Drumming group provided qualitative evidence of their learning about group dynamics. Common themes that emerged in the student reflections include the following: a focus on Yalom and Leszcz’s (2005) here-and-now and self-reflective feedback loop; drumming as a cool, age, gender, and traditional African-American occupation; basing a group on a leader’s passion; importance of activity analysis and client assessment; differences and similarities between shelter and MS clinic clients but addressing depression in both groups; the reality of power, control, and hidden agendas; handling conflicts skillfully; rhythmic activity as a combination of physical, cognitive, and spiritual factors; bucket drumming as play and stress relief; synchronous drumming as a vehicle for achieving group cohesiveness; buckets as recycling found objects; and bucket drumming as rehearsal for return to church, family, and home.

The students designed a survey to research the effectiveness of their groups in the clinics. Using a Likert scale of 1 (agree) to 3 (disagree), the survey addressed client mood, confidence level, isolation, view of music as an enjoyable occupation, and socialization. Their results, which are summarized in Table 1, demonstrated that at least 70% of all participants valued all aspects of group participation and found it enjoyable.

In summary, this article has emphasized the neurobiological basis of group therapy and occupation as well as Lewin’s (1944) core belief that hands-on experiences provide a proven method of learning group skills. The written reflections of the students as qualitative data and a quantitative analysis of the participant satisfaction surveys illustrate the importance of laboratory and small group student experiences as well as the case for outcomes research within combined classroom and clinic activities. From the literature of social science, psychology, and education, principles have been culled for instructing adult learners to lead groups. Johnson and Johnson (2008) succinctly summarized these guidelines for experiential learning procedures: active learning is more effective than passive; the combination of theory and practice generates true knowledge; and it is easier to change cognition, attitudes, and behaviors in groups than individually. Combining this approach with the teaching of task analysis and the neuroscience of therapeutic change culminates in a sophisticated occupational therapist who provides a unique form of group therapy and ensures our place at the rehabilitation table in the future.

Note. Copies of the Bucket Drumming Group Protocol are available by e-mailing Dr. Raphael-Greenfield, eir12@columbia.edu.

Acknowledgments

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References


Table 1. Client Satisfaction Survey

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made me feel less alone</td>
<td>1.29</td>
<td>.470</td>
<td>70.6%</td>
</tr>
<tr>
<td>Want music to be part of my life</td>
<td>1.12</td>
<td>.332</td>
<td>88.2%</td>
</tr>
<tr>
<td>Try other enjoyable activities</td>
<td>1.18</td>
<td>.393</td>
<td>82.4%</td>
</tr>
<tr>
<td>More comfortable working with others</td>
<td>1.19</td>
<td>.544</td>
<td>87.5%</td>
</tr>
<tr>
<td>More confident</td>
<td>1.31</td>
<td>.602</td>
<td>75%</td>
</tr>
<tr>
<td>Improve my mood</td>
<td>1.06</td>
<td>.250</td>
<td>93.8%</td>
</tr>
<tr>
<td>Socialize with others outside group</td>
<td>1.27</td>
<td>.594</td>
<td>80%</td>
</tr>
</tbody>
</table>

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Michael R. Silva, Pamela G. Caine, Stephanie Soo, Elisa C. Rotonda, and Daiana O. Patrone are graduates of Columbia University’s Programs in Occupational Therapy.

At the Institute for Dynamic Living in Springfield, Massachusetts, the non-profit mental health organization where I work as the program director, it became increasingly evident given the large numbers of referrals received, that access to occupational therapy services (individual and group) was greatly needed. Following marketing efforts by the clinic, parents, caregivers, and a variety of primary care physicians and mental health services providers (psychiatrists; outpatient behavioral health clinicians; and staff from foster care programs, residential programs, schools, and the Department of Youth Services) began inquiring about access to occupational therapy services. The children and youth referred for community-based, mental health occupational therapy services presented with a wide range of needs due to having trauma, attachment, anxiety, mood, learning, sensory processing, and/or behavioral difficulties. These mental health-related symptoms led to occupational barriers and decreased occupational participation across a variety of contexts (e.g., home, school, community).

Clients of mental health services often experience occupational deprivation (limitations or circumstances that hinder one’s ability to acquire, enjoy, or participate in occupation) and/or alienation (lack of satisfaction in occupational participation) due to stigma, economic barriers, and/or not fully understanding their individual strengths and needs.¹ At our organization, children and youth had started to receive occupational therapy services via individual sessions; however, it became apparent within the first few months of operation that many children would also benefit from group programming. Some of the children referred had difficulty with anxiety, lack of impulse control, behavioral outbursts, and difficulty with social skills and boundaries that negatively influenced home, school, and community participation.

A number of goals can be targeted within a group context to facilitate physical, emotional, and social development to ultimately increase occupational performance, participation, and satisfaction. During the first series of groups offered at our clinic, most of the services were covered by third-party reimbursement; however, some participants’ residential programs covered the

Creating Occupational Therapy Groups for Children and Youth in Community-Based Mental Health Practice

TINA CHAMPAGNE

Using therapy groups to help to facilitate occupational performance, participation, and satisfaction.
cost of attendance. As an added, incidental benefit that helps to support the occupational therapy process and ability to provide additional services, group program development and implementation at our clinic also provides Level I and Level II occupational therapy fieldwork opportunities.

ORIGINS OF MENTAL HEALTH SYMPTOMS AND BEHAVIORS

Mental health symptoms and behaviors may stem from a variety of factors, including trauma. In the United States, child protective service agencies report receiving approximately 3 million referrals each year, which represents 5.5 million children. These figures are believed to represent only a portion of the child maltreatment that occurs (e.g., neglect; physical, sexual, emotional abuse), given that an estimated two thirds of maltreatment goes unreported. Other experiences estimated two thirds of maltreatment sexual, emotional abuse), given that an portion of the child maltreatment are believed to represent only a trauma. Terrorism, and refugee and war zone medical trauma, natural disasters, bullying), grief, sudden accidents, community and school violence (e.g., Smaller growth in the hippocampus, posttraumatic stress disorder Irritability of the limbic system, setting for depression rest; sleep (e.g., difficulty falling asleep, nightmares); and social, home, and school performance among children and youth. Further, attachment styles are often affected (e.g., secure, insecure-avoidant, insecure-ambivalent/anxious, disorganized), which in turn affects one’s relational capacity and social participation.

Trauma experiences, particularly when occurring during early childhood, often have a pervasive effect on human development and ultimately on occupational performance skills and participation. Physical (e.g., stomachaches, headaches) and emotional (e.g., fear, anxiety, anger, shame) symptoms often negatively affect the ability to engage in self-care; leisure; rest; sleep (e.g., difficulty falling asleep, nightmares); and social, home, and school performance among children and youth. Further, attachment styles are often affected (e.g., secure, insecure-avoidant, insecure-ambivalent/anxious, disorganized), which in turn affects one’s relational capacity and social participation.

SAFETY, STRENGTHS, AND RESILIENCY BUILDING

To help guide the focus of therapeutic intervention, a three-phase model is promoted in the field of trauma science for working with individuals with trauma histories that includes: (1) stabilization, (2) processing and grieving, and (3) integration/transcendence. This three-phase model is used at the Institute for Dynamic Living in group and individual sessions. The stabilization phase begins with helping the child feel safe and secure, developing trust, and facilitating the ability to self-regulate (e.g., recognize, identify, express, and modulate emotions). During this phase, interventions are often largely preparatory in nature. Once the child feels a sense of safety, stability, and support, the capacity for self-regulation typically increases and, in turn, positively affects occupational participation. It is important to note, however, that this three-phase model is not linear. The increased capacity for self-regulation and social engagement supports the ability to engage in self-reflective information processing interactions and occupations over time, and the ability to engage in other types and phases of therapy as part of the recovery process.

In addition to the three-phase model, the following six core components must be addressed when providing therapeutic interventions with child populations: (1) creating feelings of safety and security at home, in school, and in the community; (2) building the capacity for self-regulation; (3) self-reflective and cognitive processing capacity; (4) traumatic experience integration; (5) relational engagement; and (6) positive affective enhancement. Further, for some of the children and youth attending individual and group services at the clinic, the sources of trauma persist (e.g., multiple foster care placements, ongoing abuse), which affects intervention planning and implementation.

LEARNING AND SENSORY PROCESSING–RELATED BARRIERS

Having learning disabilities (e.g., ADHD), also may affect the ability to pay attention, concentrate, and listen attentively; demonstrate impulse control; organize one’s self; complete work in a timely manner; and maintain appropriate social boundaries. Similarly, sensory processing difficulties (e.g., sensory modulation, discrimination, motor, and/or praxis problems) often exist or co-exist among the children and youth referred to us at our program. Learning disabilities and/or sensory processing problems can influence the ability to understand social boundaries, coordinate one’s body
in space and time, self-organize, and functionally respond to environmental stimuli. These barriers often interfere with a child’s ability to form a coherent sense of self, and the ability to engage in meaningful roles, routines, and relationships at home, school, and within the community.

CREATING THE GROUP PROGRAMS

When creating group programs, occupational therapy practitioners apply the theories and frames of reference most appropriate for the client-centered needs and goals collaboratively identified. Many of the children and youth referred to us for services had occupational performance and participation barriers due in part to difficulties with some of the following:

- Emotion identification and regulation
- Hyperactivity, hypervigilance
- Sensory over- and/or under-responsivity
- Self-awareness (e.g., body awareness, body boundaries)
- Listening, sequencing, and organizational skills (e.g., auditory processing)
- Impulse control, behavioral outbursts
- Social awareness and participation skills

The program director and the occupational therapy staff determined that the Sensory Modulation Program (SMP), based on nonlinear dynamic systems theory, provided an integrative conceptual framework to support the occupational needs and goals of the clients, while providing general guidelines to help design and operationalize the group interventions. Further, the SMP promotes an integrated approach, which was necessary to meet the dynamic needs of each client.

Although it is important to collaboratively identify and understand both the strengths and barriers faced by clients when completing the occupational profile, intervention planning and implementation must be strengths based. While acknowledging that each child and family system has its own challenges, when integrating a strengths-based approach the emphasis must be on each child and family’s unique strengths, capacities, and inherent resiliency. Caldwell explained that a strengths-based model uses interventions that build upon these strengths and capacities, and requires the following characteristics:

- Is collaborative
- Rewards positive behaviors
- Teaches new skills and provides opportunities to practice these skills
- Emphasizes discussion and negotiation
- Provides the child/youth with choices
- Views the child/youth as resilient
- Views the child/youth’s parents or adult supports as caring and competent
- Is committed to understanding the child on multiple dimensions

Although there were interesting similarities across client goals and needs within our program, differences in age range required modifications to the group context, interaction styles, activities, and titles of each group. Modifications made to each group’s

<table>
<thead>
<tr>
<th>Table 1: Group Descriptions</th>
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<tbody>
<tr>
<td><strong>Movin’ &amp; Groovin’ (4 to 6 year olds)</strong></td>
</tr>
<tr>
<td>This group for young children incorporates developmentally appropriate play activities in the context of a group to target emotion identification, regulation, social skills, and sensorimotor skills to enhance occupational participation. Participants will increase developmental skills in the following areas:</td>
</tr>
<tr>
<td><strong>Emotion identification and regulation to:</strong></td>
</tr>
<tr>
<td>• Self-rate emotions.</td>
</tr>
<tr>
<td>• Recognize emotions of others.</td>
</tr>
<tr>
<td>• Use strategies to change how they feel.</td>
</tr>
<tr>
<td>• Create and learn how to use a sensory kit and complementary therapies.</td>
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| **Sensory Mod Squad (7 to 9 and 10 to 12 year olds)** |
| This group teaches emotion identification skills, awareness of sensory tendencies and preferences, and how to use strategies to change how one feels and function optimally. Increased skills support the capacity for increased occupational participation. Participants will learn how to: |
| • Identify and rate emotions and sensory processing patterns of self and others. |
| • Recognize the impact of personal tendencies and behaviors on relationships. |
| • Explore a combination of cognitive and sensorimotor strategies. |
| • Create and learn how to use a sensory kit and complementary therapies. |
| • Practice social skills (cooperation, conflict resolution). |

| **The Regulators (13 to 15 and 16 to 18 year olds)** |
| This group teaches teens how to identify and self-rate emotions and sensory processing patterns, and how to use specific strategies to help them feel more centered and regulated. Strategies learned can be used for health and wellness, prevention, and de-escalation purposes in order to increase occupational participation. Participants will learn to: |
| • Identify and self-rate emotions and sensory processing patterns and understand the impact on relationships, performance, and behaviors. |
| • Explore strategies to enhance existing self-regulating skills. |
| • Create a daily routine with health/wellness, prevention, and de-escalation strategies (sensory diet). |
| • Create and learn how to use a sensory kit and complementary therapies. |
| • Practice social skills (appropriate boundaries and conflict resolution). |
age and developmental needs reflected careful consideration of the titles and corresponding changes in group preparation, activities, and media used to ensure appropriateness to each age group. Based on this, for our first series of groups, we created three main titles covering different age ranges: Movin’ & Groovin’, for 4 to 6 year olds; Sensory Mod Squads, for 7 to 9 and 10 to 12 year olds; and The Regulators, for 13 to 15 and 16 to 18 year olds. Each group session allowed for up to eight participants, with one occupational therapist staff member and one occupational therapist or occupational therapy assistant student participating in each session. (As the clinic grows, we hope to add occupational therapy assistants to our staff to collaborate with occupational therapists in running the groups.) Table 1 on page 15 provides a brief overview of the first group series we created.

**JOINING THE GROUPS**

Upon gaining insurance approval for group services, the primary caregiver (parent, staff, foster parent, legal guardian) is called and an initial interview is scheduled and completed if the client is not already receiving individual services from the therapists at the clinic. As part of the intake process, the following questionnaires are completed by the primary caregiver(s): a developmental history, the Sensory Profile,16 and Behavior Rating Inventory of Executive Function.17 An occupational therapist completes an initial evaluation for each client prior to attending the first group if the child is not currently engaged in individual occupational therapy sessions at the clinic. The initial evaluation process is typically completed in one session, as is a review of the group’s behavioral objectives (e.g., full participation in group activities to the best of one’s ability, refraining from behaving inappropriately during groups and in the waiting room areas) and goals (e.g., understand the links between changes in emotions and behaviors; understanding the concepts of “calming,” “alerting,” and a combination; how strategies can be used to modulate how one feels and increase occupational participation).

Differences not only in the chronological but also developmental age ranges require the occupational therapist’s group process and analysis skills to ensure the appropriateness of group expectations and activities. Further, considerations regarding relational dynamics include recognizing attachment styles and defense mechanisms as they arise while developing trust in the occupational therapist, fieldwork student, other group participants, and the overall group process. Each group met once per week for 50 to 60 minutes for a total of 8 weeks. Again, although each of these groups used an integrative approach and had some common goal areas, differences in age ranges required modifications to the group context, interaction styles, and activities as necessary.

**MOVIN’ AND GROOVIN’**

Movin’ and Groovin’ was created for children between the ages of 4 and 6 years and met for once a week for 8 weeks. Parents participate in individual sessions but during groups they stay in the waiting room until the last (eighth session), where they are invited in for a review of all sessions by the occupational therapy staff, fieldwork student, and the children. The parents or caregivers are given a general review of each session after each group by the staff and children and updates are provided during the individual sessions as appropriate. Developmental needs of this first cohort of participants included increased social and perceptual motor integration (e.g., listening to others, picking up on social cues, learning manners, imitating, waiting for one’s turn) and body, spatial, and temporal awareness (e.g., body concept, sense of time, laterality, directionality, rhythm, coordination, balance). These abilities and behaviors contribute greatly to individuals’ ability to be successful learners, socialize appropriately, and self-regulate. Further, the opportunity to form relationships and have fun with children at similar developmental levels, and to trust in the therapists and students, helps those with trauma and attachment-based relational goals to increase their capacity for social participation. Activity examples woven into Movin’ & Groovin’ include the use of multisensory equipment and cues to increase awareness of personal and shared space; obstacle courses requiring teamwork and collaboration; social skills activities (e.g., social manners, social cues, boundaries); dance, movement (e.g., yoga poses), music, and rhythmic activities; and guessing and memory.
games (e.g., name games, emotion identification). Over the course of the 8 weeks, increased trust and socially appropriate interactions emerged to varying degrees within the participants (e.g., awareness of social cues, inter-personal effectiveness, boundaries).

 Sensory Mod Squad Group

Sensory Mod Squad is open to clients ages 7 to 12 years. They are split into two groups: 7 to 9 years and 10 to 12. These age ranges are split up into different groups to accommodate different developmental and learning needs and capabilities. The Sensory Mod Squad group meets once a week for 8 weeks, with the last 5 minutes of each meeting used to summarize each week’s group activities with parents and caregivers. Throughout the 8 weeks, children learn to self-rate their emotions and the emotions of others, trial and rate the influence of strategies from each of the sensory system, complete weekly handouts that are collated into workbooks by the eighth week, and each child creates an individualized sensory kit containing the sensory tools each has created each week. As part of the last session (week 8), parents and caregivers are invited to participate, and the children/youth and group leaders review and demonstrate the skills learned, and the purpose and contents of the sensory mod squad workbook and sensory kit each child creates and keeps upon discharge. After completing the 8-week group program, there is an individual discharge meeting and a discharge summary is provided with the assessment results and therapeutic recommendations. Additional resources provided include free informational handouts and monthly seminars for parents and caregivers.

OUTCOMES

Each of the three group types was well received by the participants, parents, caregivers, and referral sources. Feedback and suggestions for change about what was liked and disliked was collected through interviews with participants and parents/caregivers throughout the course of each group and also at the end of the 8 weeks. In addition, the occupational therapists and students who ran each group reflected weekly to identify perceived strengths of each session, ideas for change, and other potential intervention ideas for future activities. The overall success of the groups was most
evident during week 8, when the clients were able to independently demonstrate and explain the skills learned for parents and caregivers. Moreover, upon completing the 8-week groups, the clients, parents, and caregivers unanimously and successfully advocated for creating a “part two” (a second 8-week series of sessions) of each group to be offered in order to continue building upon skills learned.

Since this first round of groups, from year to year, the names of these particular groups at our clinic has stayed the same, and the age ranges generally remain the same, but the group content is modified based on the clients’ interests, needs, and goals. These groups continue to evolve over time based on client, caregiver, staff, and student feedback. In this way, we are able to ensure a client-centered approach to group program development, implementation and evolution while at the same time targeting the specific goals, interests, and needs of each participant.

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PERSPECTIVES
Launching the School Year
Continued from page 8

has goals that can be addressed by occupational therapy. Check the frequency for services.

Is the student receiving occupational therapy individually or in a group? Look for any specialized equipment provided by occupational therapy, such as an Alpha Smart or slant board. Jot down the student’s goals and other related services in a notebook or on index cards for quick reference. Knowing the IEP and checking it for accuracy will be your most valuable time-saving tip to prevent confusion and ensure accurate delivery of services.

Get a calendar and use it. My calendar is valuable and I am not sure what would happen if I lost it. I’m still keeping track of my dates with old fashioned pen and paper, but use what works best for you. The IDEA requires the initial evaluation to be completed 60 days after receiving the parental consent. Note that deadline in your agenda and then highlight it. Now create a self-imposed deadline at least 1 week in advance for completing your written report.

Become attached to your calendar. Look at it often throughout the day—in the morning, around lunch, and then in the afternoon before you go home. Never schedule anything without first consulting it. Write down all appointments, meeting times, and makeups so you don’t forget them. Otherwise—trust me on this—you will remember that you talked to the third grade teacher on your way to lunch last Tuesday about a last-minute Committee on Special Education meeting scheduled for Wednesday of the following week about 10 minutes after it’s too late. Besides, your tracking system can be another modeling behavior to teach your students efficient organizational skills.

Treating Students: The Fun Part!
Beginning sessions within the first few weeks of school may be determined by the IEP. I prefer to begin treatment as early as possible to get to know my students.

My treatment sessions are usually very structured. However, during those first few weeks, I use the treatment to determine each student’s skill level. If I have worked with the student previously, I can determine whether he or she has retained skills over the summer break. I can obtain a comparison writing sample for my students with written communication goals, or make other evaluations in consideration of interventions related to activities of daily living, behavior, and much more. Remember always to provide the student with some choices of activities. Be creative and have fun!

Reference

Veda Collmer, JD, OTR/L, has practiced occupational therapy in a variety of school settings across the United States. She is licensed to practice law in New York and specializes in family law.
he state of mental health among our nation’s adolescents is alarming. Violence, suicide, and substance abuse continue to impact millions of adolescent lives each year. The National Adolescent Health Information Center has identified the priorities of adolescent health to reduce death, homicide, substance abuse, weapons in school, teenage suicide, teenage pregnancy, and the incidence of HIV/AIDS. The mental health needs of adolescents are immense, but occupational therapy practitioners have the knowledge and skills to help address their needs. Ongoing research in occupational science supports occupational therapy practice in mental health, and the lives of adolescents can be transformed through occupational therapy intervention.3–14

This article presents an overview of the Occupational Therapy Training Program (OTTP), a community-based mental health agency built on the core philosophy and mission of occupational therapy and occupational science. OTTP serves as a model program striving to meet the critical needs of adolescents in urban Los Angeles.

DEFINING ADOLESCENCE
In 1960, Josselyn offered the following vivid and understandable definition of adolescence that is still applicable for practitioners today, as it offers a true sense of the adolescent experience:

An essential part of the psychological growth process from infancy to adulthood is adolescence; out of the chaotic state of that age group evolves the adult personality. Adolescence is the growth period in which all the earlier components are shaken up together to finally come to rest again in some type of cohesive pattern (p. 191).15

For the purpose of this article, adolescents are defined as youth ages 11 to 18 years, and transitional-age youth are defined as those between 16 and 25 years.

DEVELOPMENTAL HISTORY ROOTED IN OCCUPATIONAL THERAPY
The OTTP is one division of Special Service for Groups (SSG), a Los Angeles–based nonprofit agency. OTTP was officially established in 1975, developing out of an occupational therapy master’s project targeting adolescents involved in both the foster and probation systems who were soon to be transitioning into adulthood and reintegrating into the community. The project provided life skills training, work readiness training, and job placement and case management services to help them function independently and effectively as law-abiding, productive adult citizens.

The division continues to thrive on the principles of occupational therapy, which emphasize that by engaging in meaningful and purposeful activity individuals can develop the skills they need to function most optimally in day-to-day life and live life to its fullest.

TARGET POPULATION
OTTP serves at-risk, economically disadvantaged children, adolescents, and transitional-age youth ages 5 to 25 years, who may be at risk of or experiencing any of the following: poor academic performance, school suspensions or expulsions, prior or current gang involvement, juvenile justice involvement, foster care involvement, out-of-home placement, substance use or abuse, learning disabilities, mental illness, pregnancy, or parenting.

Los Angeles County has a population of 9.9 million and maintains the largest public mental health system in the nation,16 which is significantly affected by youth poverty and delinquency. The 2007 United Way of Greater Los Angeles Zip Code Data Book indicated that 275,250 families live in poverty,17 and approximately 31% of the adults do not possess a high school diploma.18 OTTP targets these high-need areas of Los Angeles County.

FUNDING AND STAFFING
OTTP maintains an approximately $8.5 million budget. Of that amount, roughly 65% or $5.5 million is devoted to mental health funding, contracted
with the County of Los Angeles Department of Mental Health. The additional 35% of the program targets workforce development among transitional-age youth, funded through the Los Angeles County Departments of Community & Senior Services, Children & Family Services, and Probation; the Pacific Gateway Workforce Investment Network; and the U.S. Department of Labor.

Of OTTP’s 100 staff members, 18 are occupational therapy practitioners (13 are occupational therapists, 3 of whom have an OTD), and 5 are occupational therapy assistants), 6 are licensed clinical social workers, 7 are licensed marriage and family therapists, 12 are registered social workers or marriage and family therapy interns working towards licensure, and 1 is a half-time psychiatrist. Additional key staff include employment specialists, case managers, job developers, parent partners, drivers, and administrative personnel.

Mental Health Services Offered by OTTP

School-Based Mental Health Services

These services are available in several alternative education settings; nonpublic schools for students who are receiving individualized education program services; and public elementary, middle, and high school settings. The term school-based mental health services can be a misnomer, as OTTP’s services are also delivered in the home with the entire family, after school hours, and in the community. Schools are considered to be the “gateway into OTTP,” serving as the primary service delivery sites, as well as the primary source for referrals. Often, the school setting is where behavioral issues are first documented, indicating the student’s struggles in learning and behavioral health issues. Likewise, it is often the student with demonstrated behavioral challenges who will be referred to OTTP for mental health services.

The occupational therapist typically collaborates with the social worker or marriage and family therapist in conjunction with the youth and family to create the care plan. After goals are established, the occupational therapy practitioner’s primary role is to facilitate groups on-site at the various schools. Within these groups, the occupational therapy practitioner works toward achieving each youth’s individual mental health goals. Sample curriculum topics include stress management and coping skills, work readiness, communication, anger management and conflict resolution, self-care, nutrition, cooking, banking, and budgeting. The occupational therapy practitioner may also provide individual sessions as indicated. Additionally, the occupational therapy practitioner provides case management services, linking the youth and family to resources such as housing, health care, employment documentation, after-school programs, vocational training programs, and educational supplies. Occupational therapy documentation identifies the goal, intervention, response, and subsequent plan for ongoing intervention.

Intensive Mental Health Services

OTTP also has the capacity to serve adolescents and transitional-age youth who have more intensive mental health needs. Targeted participants for these programs are referred directly from the Los Angeles County Departments of Mental Health, Children and Family Services, or Probation. These participants, labeled with mental illness, may frequently cycle in and out of the hospital due to psychotic breaks or suicidal or homicidal threats, are often prescribed medication, and may be at risk for out-of-home placement or school suspension or expulsion. On-call crisis intervention services are available 24 hours a day, 7 days a week for families enrolled into either of the following two intensive service programs.

Within the Full-Service Partnership (FSP), comprehensive mental health and case management services are provided to children, transitional-age youth, and families using a “whatever it takes” approach to help them move toward recovery and wellness. The occupational therapy practitioner on the team can work individually with the participant in the home, at school, or in the community. The occupational therapy practitioner also provides family-based intervention, focusing on the parent or caregiver’s ability to modify the home environment, establish behavioral expectations, and improve familial communication skills in order to improve the youth’s ability to function effectively and engage in daily occupations. Occupational therapy practitioners can also facilitate occupation-based groups specifically for the youth enrolled in FSP.

Wraparound is an evidence-based, family-centered, strength-based approach to helping youth and families achieve long-term self-sufficiency outside of the foster care system. An

<table>
<thead>
<tr>
<th>OTTP Outcomes Summary</th>
<th>Before OTTP</th>
<th>After OTTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was a troublemaker. I would pick fights with people.</td>
<td>They taught me how to control my anger…that helped a lot.</td>
<td></td>
</tr>
<tr>
<td>I would ditch school.</td>
<td>I go to school full time now. I finished my GE’s for the nursing program.</td>
<td></td>
</tr>
<tr>
<td>I would just stay at home in bed.</td>
<td>I attend a community college now.</td>
<td></td>
</tr>
</tbody>
</table>

Before OTTP

| Gang involvement. | No longer a member of a gang. |
| My self-esteem was very low. | I no longer tolerate mistreatment by men. |
| I used drugs daily. | I never use drugs. |
| I didn’t do any work. | I work part-time. |

Comments were solicited during follow-up telephone surveys with former OTTP participants who were at least 18 years of age and had been discharged from OTTP services for at least 1 year.
interdisciplinary team consisting of a facilitator, parent partner, and child and family specialist offers a variety of supports and structures to empower families to function at their optimal level within day-to-day life. The facilitator’s role is to ensure that the needed services and resources are provided to the family and help to ensure timely progress toward family goals. The child and family specialist functions as an advocate for the child and ensures that his or her needs are being met. The parent partner functions as the primary support person and advocate for the parent or caregiver. Occupational therapy practitioners function successfully in any of these key roles.

**OTTP Youth Center**
A variety of after-school services are provided at the OTTP Youth Center, where youth engage in various occupation-centered support and skill-building groups every school day, in the evenings, and on occasional weekends. Occupational therapy practitioners often co-facilitate these groups, and occupation remains central to OTTP’s targeted group interventions. The following are some of the specialty programs offered at the OTTP Youth Center.

Create My Space Mural Project: An occupational therapist and a social worker, in collaboration with a visiting artist, facilitated a 16-week group that culminated in the painting of a full-scale mural covering two walls within the OTTP Youth Center. The occupational therapist engaged the youth in the hands-on activity of drawing a “safe place.” The social worker helped the participants process through their various emotions related to safe spaces, while the visiting artist helped them to translate their ideas into large-scale images.

Food Fitness: Within a co-facilitated group, the marriage and family therapist examines the emotional influences on the individual’s diet and other lifestyle habits, such as why, how much, and when a person eats. The occupational therapy practitioner focuses on nutrition, how to select healthy foods within a budget, meal preparation, and time management for meal preparation and exercise. Together the occupational therapist and marriage and family therapist work toward the goal of improving the person’s self-confidence and self-image, and creating a healthier lifestyle.

“On a Good Note” Music Group: The occupational therapist works with group members on journaling activities that help them tell their life story. These journal entries evolve into music lyrics. The non-OT co-facilitator teaches the youth the technical skills to produce, record, and edit music. The occupational therapist uses group dynamics and behavior management strategies to help the youth attend better and control impulsivity during the session. At the culmination of the group process, participants have created their own CD, including writing the lyrics and music, and making a label.

**U.S. Department of Labor Young Parents Demonstration Grant:** Young parents (mothers, fathers, and expectant mothers), ages 16 to 24 years engage in life skills, work readiness, and educational training opportunities that lead to the skills needed to manage their home, academic, personal, and professional lives. This demonstration grant is measuring the effectiveness of a specific occupational therapy intervention, modeled after Lifestyle Redesign® in improving educational and employment-related outcomes in young parents.

OTTP Garden: To increase at-risk youths’ connection with nature, Mary Lawrence, COTA/L, pursued the donation of a plot of land that serves as a safe haven within which the youth can experience a nurturing, full-sensory activity. The garden provides a medium for them to let go of their personal challenges. It provides an opportunity to promote responsibility by taking care of the plants. This garden also represents opportunities for community activism through increased awareness of the cycles of nature and empowers participants to make changes to thrive in their own communities. They learn about composting, nutrition, and the importance of organic gardening versus using pesticides. They are also invited to participate in outings, such as to farmers markets and local ecosystem observatories. Ultimately, through engaging in the occupation of gardening, they improve their coping, social, and communication skills.

**NEXT STEPS**
OTTP is fortunate to have a broad, diverse funding base that can continue...
to support our breadth of services. But like most nonprofits, aggressive and ongoing pursuit of continued funding continues to be a necessity. Program evaluation demonstrating positive performance outcomes will continue to be key for OTTP and other nonprofits to ensure sustainability of funding. It is often difficult for nonprofits to implement sophisticated data collection processes, due to limited funding and staffing resources. One possible strategy is for community-based programs to partner with academic institutions for mentorship, guidance, and ongoing consultation. Programs such as OTTP can be excellent sources of data for future graduate level research studies, which are certainly needed to support the sustainability of programs like this one.

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OT and Community Mental Health

AOTA’s Societal Statement on Stress and Stress Disorders

Transitions for Children and Youth: How Occupational Therapy Can Help

FOR MORE INFORMATION

For more information about OTTP and other resources, please visit the OT Connections website at http://www.OTConnections.org.

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The History of Occupational Therapy in Adolescent Mental Health Practice

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This CE Article was developed in collaboration with the Mental Health Special Interest Section.

ABSTRACT
To more clearly understand how the profession of occupational therapy has historically defined, viewed, and interpreted clinical practice specific to adolescent mental health, the author of this article conducted an in-depth review and analysis of the topic in occupational therapy literature, including Occupational Therapy Archives (1917 to 1924), Occupational Therapy & Rehabilitation (1925 to 1950), the American Journal of Occupational Therapy (1960 to 2009); and 11 editions of Willard and Spackman’s Occupational Therapy textbooks (1947 to 2009). This article offers insight into how the profession of occupational therapy has historically conceptualized clinical practice settings, interdisciplinary collaboration, therapeutic approaches, and types of intervention specific to our role in adolescent mental health practice. The article also includes a timeline of key historical events that have helped shape occupational therapy practice in adolescent mental health.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize how occupational therapy’s role in adolescent mental health practice has evolved over time.
2. Identify practice settings where occupational therapy practitioners work with adolescents with mental health needs.
3. Identify the nature of interdisciplinary collaborations that have occurred in adolescent mental health practice.
4. Differentiate interventions that have been used by occupational therapy practitioners in adolescent mental health practice over time.

INTRODUCTION
Issues specific to the mental health of adolescents have been a top priority of occupational therapy practitioners, other health professionals, and policy makers since the early days of the occupational therapy profession, as evidenced by the First International Congress on Mental Hygiene, which was held in 1930 in Washington, DC, (American Occupational Therapy Association [AOTA], 1929), with representatives from 26 countries around the world in attendance. Today, the need for society to attend to the mental health needs of adolescents continues, with mental illness identified as a leading cause of disability worldwide (U.S. Department of Health and Human Services [DHHS], 2003). Increasing rates of adolescent homicide, suicide, pregnancy, substance abuse, weapons brought to school, and diagnoses of HIV/AIDS continue to impact society (Clayton, Brindis, Hamor, Raiden-Waught, & Fong, 2000; DHHS, 1999). Early in the profession, several authors believed that the greatest value of occupational therapy would be its impact on the mental health arena (AOTA, 1940; Bonner, 1929; Conte, 1960; Dunton, 1930; Haviland, 1927; McGuirre, 1941; Palmer, 1935). Haviland (1927) identified the specialty area of mental health practice as having the greatest need for occupational therapy and predicted that this would be the area of practice that would employ the majority of occupational therapy practitioners across the profession. These authors were accurate in their prediction of the need for mental health services in the community; however, they fell short in their prediction of the number of occupational therapy practitioners who would continue to specialize in this practice area. Although occupational therapy practitioners address mental health within all areas of practice and in all types of settings, currently only 3% of occupational therapy practitioners practice specifically in mental health settings, which is the lowest percentage of any specialty area in occupational therapy (AOTA, 2010).

CLINICAL PRACTICE SETTINGS
The literature reveals key practice areas that traditionally served the mental health needs of adolescents, including inpatient hospital settings, transitional living settings, homes, juvenile correctional facilities, and community-based practice settings (Bonner, 1929; Davies, 1925; Ellis, 1930; Haviland, 1927; Loveland & Little, 1974; Palmer, 1935; Preston, 1942; Richmond, 1960; Schad, 1963; Tower, 1932; Wade, 1941; Watanabe, 1967). These settings continue to exist, and occupational therapy practitioners have opportunities to function as key mental health providers within these settings. Within the hospital setting, the role of the occupational therapy practitioner has progressed over time from providing diversions for children in waiting rooms (Bonner, 1929), to facilitating children’s ability to leave the hospital altogether and function effectively in the home and community (Preston, 1942), to facilitating children’s ability to adapt to the abnormal stresses of the hospital environment (Schad, 1963).

Early in the profession’s development, transitional community living settings centered on performing various homemaking and farming tasks in order to prepare the adolescent for a working role in the community (Tower, 1932). “Curative occupations” played an essential role within institutions, including both medical and
forensic settings (Ellis, 1930). The goal of occupational therapy within the context of juvenile correctional facilities was to ensure the return of the adolescent to mainstream society (Ellis, 1930). The concept of home-based psychiatric services was first introduced in the occupational therapy literature by Palmer in 1935. The mobility of the provider traveling to the consumer, rather than the consumer needing to go to the provider's facility, allowed individuals increased access to psychotropic medications and other mental health services while living within their natural environments. Watanabe (1967) wrote, “If the fundamental principles of occupational therapy are carefully examined, the idea emerges that the most meaningful place to carry out such treatment would be in the home and in the community” (p. 353). Regardless of the setting, the key purpose of occupational therapy was regarded as preparing the individual for life outside of the facility and to promote optimal functioning in the community (Davies, 1925; Ellis, 1930; Haviland, 1927; Preston, 1942; Wade, 1941; Watanabe, 1967). This theme of preparing individuals for optimal functioning in the community remains consistent with contemporary adolescent mental health practice.

In 1963, President Kennedy signed the Community Mental Health Centers Act, authorizing funding to support the construction of community mental health centers across the country and establishing standards of service delivery, including access to comprehensive services, client- and family-centered care, and continuity of care (Orazin, 1965). This law facilitated a major shift in mental health service delivery, forcing all mental health professions, including occupational therapy, to reexamine their roles and modify their treatment philosophies and clinical practices accordingly (Christiansen & Davidson, 1974; Conte & Meuli, 1966; Llorens, 1968a; Llorens, 1972; Orazin, 1965; Stein, 1972). This transition from inpatient hospitals to community-based settings also sparked a social movement to decrease the stigma attached to persons diagnosed with mental illness, including a movement toward a more person-centered approach to treatment as well as the use of person-first terminology (Orazin, 1965; Reilly, 1966).

The Community Mental Health Centers Act had tremendous implications for the occupational therapy profession. Here was an opportunity for occupational therapists to play a central role in the community-based treatment of individuals living with a mental illness (Christiansen & Davidson, 1974; Conte & Meuli, 1966; Howe & Dippy, 1968; Llorens, 1968a; Llorens, 1972; Orazin, 1965; Stein, 1972). Describing this time as a mental health “revolution,” Conte and Meuli (1966) wrote, “We are involved in a fabulous and exciting march to the sea of community-based treatment services in mental health. The move is on and the pressure is great. It is good that we are thinking and planning together for this new approach to the emotional problems of mankind” (p. 147). They encouraged the profession to seize the opportunities of the changing times within mental health practice. “Occupational therapy is a vital part of the ‘new look’ in mental health programs; it is part of a changing concept in a changing time” (Conte & Meuli, 1966, p. 150). Likewise, Bonder (1987) emphasized the need for the profession of occupational therapy to be able to adapt to current trends and foster innovation in mental health service delivery models in order to remain competitive.

Currently, the profession of occupational therapy has similar opportunities at stake. In 2003, the New Freedom Commission on Mental Health (DHHS) called for completely restructuring our nation’s mental health system, in which occupational therapy can play a fundamental leadership role in the delivery of adolescent mental health services. Additionally, within the state of California, the Mental Health Services Act of 2004 presented an opportunity for occupational therapy to play a key role in preventing and providing early intervention for adolescents and individuals of all ages at risk. The Patient Protection and Affordable Care Act of 2010 offers yet another opportunity for the occupational therapy profession to take action and participate fully as a leader in transforming mental health services delivery in our country. As the legislation continues to strive to support the improvement of access and quality of mental health services delivery, it is necessary that the profession of occupational therapy be prepared to contribute to this effort. With our knowledge and skills centered on the health-promoting effects of occupation, we can and should be at the forefront of this charge.

INTERDISCIPLINARY COLLABORATION

Interdisciplinary collaboration has been a topic of discussion within mental health practice settings throughout the history of the profession (Bonner, 1930; Conte, 1960; Dippy & Scott, 1964; Ellis, 1930; Florey, 1993; Kaplan, 1986; Klapman & Baker, 1963; Klopp, 1929; Lapidakis, 1963; Llorens & Young, 1960; Maeda, 1960; Mitchell, Rourk, & Schwarz, 1989; Preston, 1942; Schad, 1963; Tower, 1932; Wade, 1941). For occupational therapy practitioners in any setting, interdisciplinary collaboration can be both challenging and rewarding. The trends discussed in the literature vary with attempts to articulate the role of occupational therapy within the mental health treatment team. Wade’s (1941) impression was that the occupational therapist should not discuss the symptoms or the illness, because this role was strictly for the psychiatrist. This concept is in striking contrast to today’s mental health practice, in which occupational therapists take an active role in managing the symptoms and recovery of individuals.

Preston (1942) identified that psychotherapists reduce individuals’ fears, whereas occupational therapists help individuals develop the skills needed to leave the hospital setting and return to the community. Kaplan (1986) proposed an interdisciplinary group model in which occupational therapists and psychiatrists co-facilitate group sessions for individuals with mental illnesses. Lapidakis (1963) emphasized the important program development role that occupational therapists can play in residential treatment centers for children. A case study by Llorens and Young (1960) portrayed a unique interdisciplinary collaborative strategy between occupational therapy and psychotherapy to facilitate a child’s ability to consciously deal with his feelings of hostility. By engaging in finger painting with the occupational therapist over time, with the finger
painting used as the hands-on modality for addressing the child’s mental health goals, a child could express hostility through shouting, swearing, and physical aggression, allowing him or her to then openly and effectively address key issues in psychotherapy.

Although many authors historically describe the role of the occupational therapy practitioner as an “aide” or an “adjunct” player on the team (Bonner, 1930; Dippy & Scott, 1964; Wade, 1941), it has been consistently emphasized that the occupational therapy practitioner is nevertheless a necessary member of the psychiatric treatment team (Bonner, 1930; Conte, 1960; Ellis, 1930; Florey, 1993; Lapidakis, 1963; Llorens & Young, 1960; Preston, 1942; Tower, 1932; Wade, 1941).

Schlessinger (1963) confronted the issue of “separateness” between disciplines, in which each functions as a silo, and promoted a more unified approach. Lapidakis (1963) reinforced this idea that stronger interdisciplinary collaboration is more effective, and described the “total team effort” among occupational therapists and other treatment staff that existed within the first child residential programs in the 1930s. Klapman and Baker (1963) built on this concept, identifying their interdisciplinary treatment strategy as “Task Force Treatment.” All treating professionals would come together once a week to discuss the issues of a case, and a new short-term goal would be established as the focus for all team members. The authors noted that effectiveness improved when each team member had confidence in his or her own unique role; when the implementation of the Task Force occurred shortly after admission into the facility; when they met more often, such as weekly; and when there was supportive and solid leadership within their treatment team. The concept of Task Force Treatment foreshadowed the present-day model of team-based case conferences, which are common across practice settings today.

In the early 1990s, Florey (1993) discussed how to strategically position occupational therapy within the interdisciplinary team, specifically as it relates to communication and the use of terminology during interdisciplinary case conferences. Florey acknowledged areas of overlap among team members from different disciplines, but she emphasized how each professional uses his or her own unique perspective. Florey (1993) encouraged clear, concise, accurate information focused on the adolescents’ behaviors.

Regardless of the composition of interdisciplinary team members, Maeda (1960) reminded the occupational therapy practitioner that the child’s needs come first.

**THERAPEUTIC APPROACH & TYPES OF INTERVENTIONS**

Case studies specific to adolescents labeled with a mental illness have been identified in the occupational therapy literature from the 1920s to the present (AOTA, 2007; Burgess, Mitchelmore, & Giles, 1987; Buskirk, Cunningham, & Kent, 1968; Christiansen & Davidson, 1974; DeAngelis, 1976; Dippy & Scott, 1964; Dirette & Kolak, 2004; Farnworth, 2006; Klopp, 1929; Lapidakis, 1963; Llorens, 1974; Llorens & Bernstein, 1963; Loveland & Little, 1974; Maeda, 1960; Palmer, 1935; Pezzuti, 1979; Reese, 1974; Ricker, 1934; Shapiro, 1992; Stein, 1972; Tower, 1932; Zinkus, Gottlieb, & Zinkus, 1979). These cases reveal complex issues, behaviors, and concerns for adolescents at risk of or diagnosed with a mental illness, including emotional disturbances, cognitive impairments, low self-esteem, disciplinary problems, poor social skills, poor relationships with peers and/or adults, basic skills deficiencies, learning disabilities, impulsiveness, disorganization, pregnancy, stealing, poor academic performance, criminal offenses, substance use or abuse, aggressive behaviors, inappropriate sexual behaviors, avoidance behaviors, school suspensions or expulsions, destructive behaviors, and/or violence. Treatment approaches to address these needs have varied across time. Since the inception of the profession, psychiatric problems have been interpreted as problems of adaptation and disruptions within the everyday balance of work, rest, and play (Meyer, 1922). In the 1920s, psychoanalysis was central to treating individuals with mental illness, and Haviland (1927) believed that occupational therapy was a primary form of psychotherapy. The 1950s saw the emergence of psychotropic medications that aided in managing difficult symptoms and behaviors (Schwartzberg & Tiffany, 1988), along with the development of formalized assessment tools intended to guide mental health intervention (Schwartzberg & Tiffany, 1988). A behavioral treatment approach became more prevalent in the 1960s (Burgess et al., 1987; Llorens, 1968a; Maeda, 1960; Rausos, 1960; Richmond, 1960). Richmond (1960) emphasized, “We need to know the rate at which behavioral patterns emerge and the appropriateness of the behavior” (p. 183). Additionally, the effectiveness of family-centered treatment is noted throughout the literature of the 1960s (Llorens, 1968a; Llorens & Bernstein, 1963; Orazin, 1965; Richmond, 1960). Sensory considerations also became prevalent in the literature in the late 1960s and early 1970s, with visual-perceptual-motor dysfunction in children with emotional disturbances documented in various studies (Cermak, Stein, & Abelson, 1973; Llorens, 1968b; Rider, 1973). Cermak et al. (1973) discussed self-regulation in children with symptoms of hyperactivity. Gillette (1971) encouraged consideration of cognitive-perceptual-motor skills in persons with psychosocial and physical disabilities. Loveland and Little (1974) identified sensory-integrative dysfunction in adolescents who were incarcerated and encouraged occupational therapy practitioners to assume a leadership role in this practice area. In 1990, Fanchiang, Snyder, Zobel-Lachiusa, Loeffler, and Thompson published a second research study that confirmed sensory integrative dysfunction in adolescents with a history of delinquency. Currently, sensory-related issues among adolescents with mental illness warrants ongoing research. Added research in this area remains an opportunity, originally identified by Loveland and Little (1974), for occupational therapy to step to the forefront in adolescent mental health practice.

The concept of prevention in mental health has also been documented across the occupational therapy literature (Finn, 1972; McGuire, 1941; Richmond, 1960; Wiemer, 1972). Wiemer (1972) predicted that “prevention in community health care can be the unique contribution of this profession” (p. 1).
Historical Timeline: Occupational Therapy Practice in Adolescent Mental Health

18th to 19th Centuries
• This was the moral treatment era, during which individuals with mental illness were moved from being shackled in jails to being cared for in state hospitals in a more dignified and acceptable manner—an era that lasted through the mid-1900s.

1917
• Occupational therapy founded as a mental health profession.
• A humanistic philosophy toward treating individuals with mental illness emerged.
• Activities can be diversional or therapeutic.

1922
• Mental illness is a problem of adaptation.
• Occupational therapy promotes balance of work, rest, and play.
• Occupational therapy uses behavioral interventions to promote children's social development.
• Occupational therapy is considered a form of psychotherapy.
• Pre-vocational/vocational treatment approaches are being used within occupational therapy.

1929
• First case study of an adolescent labeled with a mental illness appeared in the literature (Klopp, 1929)

1930
• First-ever International Congress on Mental Hygiene held in Washington, DC, with 26 countries focusing special attention on children and adolescents.
• Occupational therapists sent overseas to provide therapy for WWI soldiers.

1940s
• WWII ends with 900,000 individuals left “emotionally unfit to serve in the armed forces” (Orazin, 1964, p. 105).
• Occupational therapy contributed to rehabilitating WWII veterans.
• Developmental perspective emerges (McGuirre, 1941).

1946
• National Institute of Mental Health established, providing funding support for research and training personnel, and providing technical assistance to state and local levels (Orazin, 1965)

1947
• First Willard and Spackman Occupational Therapy textbook published, which eventually becomes the primary text used to educate and train occupational therapy practitioners.

1950s
• Psychodynamic theories emerge.
• Behavioral interventions continue to be used within occupational therapy to promote improved daily functioning of children and adolescents.

1955
• Joint Commission on Mental Illness and Health established to analyze mental health service delivery in the United States; 36 national organizations, including the American Occupational Therapy Association, participate in this commission (Orazin, 1965).

1957
• Advisory Committee on Mental Health Demonstrations emphasizes social justice.

1961
• The Joint Commission on Mental Illness and Health publishes its report, Action for Mental Health; promoting community-based treatment, research, and training (Orazin, 1965).

1963
• President John F. Kennedy signs the Community Mental Health Centers Act of 1963.

1964
• First occupational therapy study published that examines the impact of the profession within an outpatient psychotherapy setting (Dippy & Scott, 1964).

1965
• President Lyndon B. Johnson approves financing to support the staffing of community-based mental health facilities (Orazin, 1965).
• Sensory integration issues are considered for individuals with learning disabilities and/or mental illness.
• Emergency services and screening are developed to help prevent inpatient hospitalization for mental illness (Orazin, 1965).
• Inpatient hospital units are unlocked.
• Day programs and outpatient programs allow individuals to remain at home, yet have access to services.
• Families are involved in treatment.
• Psychotropic medications are used more frequently.
• Psychotherapy is of shorter duration and more focused on achieving key goals.
• Interdisciplinary treatment teams are formed.
• The group model for intervention is used more frequently to engage participants.

1966
• Reilly (1966) calls for research within the psychiatric occupational therapy specialty.

1970s
• Consideration given to cognitive perceptual motor skills in persons with psychosocial disabilities (Gillette, 1971).

1975
• The Education of All Handicapped Children Act of 1975 is signed into law, which initiated special education programs, access to occupational therapy, physical therapy, speech, psychological services, and other supportive services (Rourk, 1984).

1980s
• “Renaissance in mental health” offered a renewed focus and emphasis on mental health and the role of occupational therapy in mental health treatment.
• Health and wellness in health care and society are emphasized.
• Medicaid serves as the primary funding source for public mental health services for economically disadvantaged children and families across the country (Rourk, 1984).

continued
**Selecting Treatment Activities and Goals**

Several authors presented key principles for the occupational therapist and treatment team members to abide by when selecting activities for children and adolescents (Cermak et al., 1973; Clark, 1925; Lapidakis, 1963; Llorens & Young, 1960; Maeda, 1960; Rausos, 1960). Maeda (1960) described how occupational therapists worked closely with counselors at the National Institute of Mental Health in Bethesda, Maryland, to develop a treatment program specifically for children. Key considerations for this program related to the concepts of time, space, and content when selecting activities. Rausos (1960) recommended that programs use play in any therapeutic program for children, because this is the primary context in which children learn. Cermak et al. (1973) encouraged consideration of the type of environment that is most conducive to treatment and promoted “mindful selection” of the activity.

Lapidakis (1963) encouraged adolescent mental health settings to offer an array of activity-based programming, such as “arts and crafts, …swimming,…dances,…field trips, cooking, parties, play therapy, psychodrama, art, music,…baton twirling, …[and] clubs” to be used in conjunction with clinical reasoning to achieve treatment goals (p. 23). It is evident that the mindful selection of activities has created transformative effects among adolescents and individuals of all ages (Davies, 1925; Ellis, 1930; Llorens & Bernstein, 1963; Maeda, 1960; Meyer, 1922; Palmer, 1935; Rausos, 1960; Richmond, 1960; Tower, 1932).

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### Historical Timeline: Occupational Therapy Practice in Adolescent Mental Health (continued)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>The Americans with Disabilities Act of 1990 is signed into law.</td>
</tr>
<tr>
<td>1990</td>
<td>Fanchiang et al. (1990) published research study that identified sensory integrative dysfunction in juveniles with a history of delinquent behaviors.</td>
</tr>
<tr>
<td>1994</td>
<td>Consideration of infant mental health for occupational therapy practice within neonatal intensive care units (Olson &amp; Baltman, 1994).</td>
</tr>
<tr>
<td>1996</td>
<td>Occupational science was established by University of Southern California as the scientific foundation supporting the practice of occupational therapy.</td>
</tr>
<tr>
<td>1999</td>
<td>The Supreme Court’s Olmstead decision ruled that forced and continued institutionalization violates human rights (Cottrell, 2005). The purpose of the ruling was to ensure that individuals living with disabilities are afforded the same rights and opportunities as individuals living without disabilities.</td>
</tr>
<tr>
<td>2003</td>
<td>The New Freedom Commission on Mental Health asserts that the national mental health system is in disarray, and that individuals with mental illness should have opportunities to “live, work, learn, and participate fully in their communities” (DHHS, 2003, p. 107).</td>
</tr>
<tr>
<td>2004</td>
<td>The Mental Health Services Act in California (Proposition 63) dedicated funding to support the mental health needs of individuals of all ages, and provided the first mechanism within the state of California to support the prevention of mental illness and early intervention for individuals of all ages.</td>
</tr>
<tr>
<td>2006</td>
<td>AOTA (2006) report indicates that only 4% of occupational therapists currently practice in mental health. This is the lowest percentage of any specialty across the profession.</td>
</tr>
<tr>
<td>2007</td>
<td>Unveiling of the AOTA Centennial Vision Statement: “We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (AOTA, 2007).</td>
</tr>
<tr>
<td>2007</td>
<td>President Obama signs the Patient Protection and Affordable Care Act of 2010, which will give more Americans with mental illness insurance coverage and access to needed services, as well as provide new opportunity for occupational therapy to participate in transforming mental health services delivery.</td>
</tr>
</tbody>
</table>

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### Group vs. 1:1 Structure

A task-based group model for occupational therapy intervention has been presented in the literature since the inception of the profession and throughout the decades (Cermak et al., 1973; Clark, 1925; Falk-Kessler, Monich, & Perel, 1991; Gillette, 1971; Jones, 1963; Kaplan, 1986; Lapidakis, 1963; Llorens, 1968a; Llorens & Young, 1960; McGuire, 1941; Orazin, 1965; Rausos, 1960; Richmond, 1960). Cermak et al. (1973) advocated for a group model of intervention, as opposed to a one-on-one setting, because a group context is more similar to a school environment. Within a group context, behaviors such as cooperating, interacting with peers and socializing, taking turns, sharing, controlling aggressive or other kinds of impulses, and developing attention skills can be addressed. Rausos (1960) emphasized that groups can aid in developing appropriate communication skills. Other authors advocated for a balance between both group- and individual-based interventions (Lapidakis, 1963; Richmond, 1960).

### Occupational Therapy Treatment Goals

Occupational therapy treatment goals for adolescents past and present have been focused on performing activities of daily living and independent living skills (Davies, 1925); pre-vocational skills (Clark, 1925; Mitchell et al., 1989); social development and well-being (Clark, 1925); employment skills (Clark, 1925; Dunning, 1975); and leisure (Henry & Coster, 1997). Ultimately, occupational ther-
apy in mental health practice with adolescents has been concerned with helping young people to achieve their highest potential as individuals and as occupational beings (Farnworth, 2000; Richmond, 1960).

CONCLUSION

Occupational therapy was founded in mental health practice (Meyer, 1922). Today, adolescent mental health should continue to be at the forefront of the agenda of the occupational therapy profession. The profession of occupational therapy can make a meaningful contribution and help to meet the mental health needs of adolescents. The evidence of occupational therapy’s effectiveness in treating adolescents and individuals of all ages with mental illness is widespread (Bonner, 1929; Davies, 1925; Henry & Coster, 1996; Llorens, 1972; Maeda, 1960; McGuire, 1941; Meyer, 1922; Palmer, 1935; Rausos, 1960; Richmond, 1960; Tower, 1932). Ongoing research in occupational science supports occupational therapy practice in mental health, and the lives of adolescents can be transformed through occupational therapy intervention (Brockelman, 2002; Christiansen & Matuska, 2006; Clark, 1993; Clark, 2006; Farnworth, 2000; Hakansson, Dahlin-Ivanoff, & Sorn, 2006; Helbig & McKay, 2003; Meyer, 1922; Reilly, 1962; Townsend, 1997; Wilcock, 2001; Yerxa, 1998).

In striving to achieve the 2017 Centennial Vision (AOTA, 2007), the profession of occupational therapy can and should continue to play a powerful role in meeting the occupational needs of adolescents in today’s society. In the midst of the chaos that encompasses adolescence, the occupational therapy practitioner can help the adolescent find a sense of self and purpose through engaging in occupation. With our focus on the transformative, humanizing, and health-promoting effects of occupation (Brockelman, 2002; Christiansen & Matuska, 2006; Clark, 1993; Clark, 2006; Farnworth, 2006; Hakansson et al., 2006; Haviland, 1932; Helbig & McKay, 2003; Meyer, 1922; Reilly, 1962; Townsend, 1997; Wilcock, 2001; Yerxa, 1998), the profession of occupational therapy can be at the forefront of adolescent mental health practice, improving the lives of adolescents, families, and society for years to come.

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Mental Health Services Act of 2004 (Proposition 63). California Department of Mental Health. http://www.dmh.ca.gov/Prop_63/MHSA/docs/MHSAafterAB100.pdf


Earn .1 AOTA CEU (one contact hour and 1.25 NBCOT PDU). See below for details.

How To Apply for Continuing Education Credit

A. After reading the article The History of Occupational Therapy in Adolescent Mental Health Practice, register to take the exam online by either going to www.aota.org/cea or calling toll-free 877-404-2082.

B. Once registered you will receive instant e-mail confirmation with password and access information to take the exam online immediately or at a later time.

C. Answer the questions to the final exam found on page CE-8 by March 31, 2015.

D. Upon successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

Final Exam CEA0313

The History of Occupational Therapy in Adolescent Mental Health Practice March 25, 2013

To receive CE credit, exam must be completed by March 31, 2015.

Learning Level: Entry

Target Audience: Occupational therapists and occupational therapy assistants

Content Focus: Category 3: General Professional Issues

1. Which of the following has not been a role for occupational therapy practitioners working with children and adolescents with mental illness in a hospital setting?

A. Facilitating diversional interventions for children in the waiting rooms

B. Facilitating children’s ability to adapt to stress in the hospital environment

C. Facilitating the ability to leave the hospital and function effectively in the home and community

D. Facilitating behavior management...
2. Which of the following best represents the concept that broadened the scope of “mental health” as being embedded across all areas of occupational therapy practice?
   A. Increased awareness of the psychosocial impact of physical disabilities
   B. The 1963 Community Mental Health Act
   C. Increased advocacy by mental health practitioners
   D. Increased advocacy by clients and their families

3. Historically, which of the following least represents the goal of occupational therapy working with adolescents with mental health issues?
   A. Managing medications
   B. Ensuring the return to of the adolescent to mainstream society
   C. Preparing the adolescent for a working role in the community
   D. Facilitating optimal functioning in the community

4. Which of the following least represents the standards of service delivery defined by the 1963 Community Mental Health Act?
   A. Facilities are accessible within the community.
   B. A comprehensive array of services should be offered.
   C. The mental health professional will identify what services should be delivered and when.
   D. Continuity of care should be maintained.

5. Which of the following best describes the relationship between the psychotherapist and occupational therapist as described by Preston?
   A. The psychotherapist uses talk therapy to uncover an individual's unconscious issues, whereas the occupational therapist uses crafts and other art-related media.
   B. The psychotherapist reduces an individual's fears, and the occupational therapist helps the individual develop skills needed to leave the hospital and return to the community.
   C. The psychotherapist engages in mindfulness activities, whereas the occupational therapist engages in psychosocial skill development.
   D. The psychotherapist engages in cognitive therapy, and the occupational therapist engages in behavioral therapy.

6. Which of the following best represents “Task Force Treatment” in today’s health care arena?
   A. Partial Hospital Programs
   B. Hospital-Based Grand Rounds
   C. Psychosocial Rehabilitation Programs
   D. Interdisciplinary Team-Based Case Conferences

7. Since the inception of the profession of occupational therapy, occupational therapy practitioners have interpreted psychiatric problems as:
   A. Neurocognitive disorders
   B. Problems of adaptation and disruptions within the everyday balance of work, rest, and play
   C. The result of bad parenting
   D. A biological disorder best addressed with medications

8. Results of research studies have identified the presence of sensory-integrative dysfunction in adolescents with a:
   A. History of incarceration and/or delinquency
   B. Diagnosis of attention deficit hyperactivity disorder
   C. History of self-regulation impairments
   D. None of the above

9. Which of the following best represents the advantage of group treatment over 1:1 treatment in adolescents with mental health issues?
   A. The group context best replicates a school environment.
   B. Groups allow individuals to address behaviors such as cooperating, taking turns, sharing, and controlling aggression.
   C. Groups allow an individual to work on developing appropriate communication skills.
   D. All of the above

10. Which of the following best describes the purpose of the Olmstead decision?
    A. It ruled that outpatient involuntary commitment is legal.
    B. It ruled that all states should engage in anti-stigma campaigns against mental illness.
    C. It ruled that forced and continued institutionalization is a violation of human rights.
    D. It ruled that occupational therapy should be included in all treatment of adolescents with mental illness.

11. Which of the following best represents the recommendation of the New Freedom Commission on Mental Health?
    A. Individuals with mental illness should have opportunities to participate fully in their communities.
    B. Individuals with mental illness should have opportunities to engage in community mental health settings.
    C. Individuals with mental illness should have opportunities to refuse medication.
    D. Individuals with mental illness should have opportunities to obtain a driver's license.

12. People with mental illness account for the largest population of individuals living with a disability in the world.
    A. True
    B. False
Questions and Answers

Occupational therapy practitioners do not need to work in hospitals or psychiatric facilities to provide skilled mental health services. That’s the message Susan Bazyk, PhD, OTR/L, FAOTA, of Cleveland State University, is spreading with the help of a recently approved 3-year grant through the Ohio Department of Education’s Office of Exceptional Children. Bazyk is a member of the AOTA School Mental Health Workgroup and participates in the Individual with Disabilities Education Act Partnership, in which AOTA is an active player to help promote community building. Bazyk’s Every Moment Counts: Promoting Mental Health Throughout the Day grant brings together 12 school-based practitioners in the Cleveland area to develop, test, and implement school programs supporting positive mental health. The activities are meant to fit naturally into common settings like classrooms, playgrounds, and lunchrooms. Bazyk spoke about her project with OT Practice associate editor Andrew Waite.

Waite: Your project aims in part to convince occupational therapy practitioners that they already have the skills to address mental health. Are you essentially trying to reframe the way some people in the profession view mental health?

Bazyk: During my first session with [my fellow investigators], I started off with a slide that asks: “What is mental health? Can you recognize mental health?” Then I showed a whole series of slides of children engaging in occupations and activities—children with and without disabilities. In all these slides you see these children engaging in enjoyable activities, and you see the positive affect on their faces. They are smiling or they appear to be concentrating. Then, after the whole series of slides, I asked again, “What does mental health look like?” and they all said, “It’s engaging in meaningful activities, doing enjoyable activities,” and they noticed in the slides that the children were smiling and looked mentally healthy. That was a big “aha” because when therapists walk into a classroom and look at any student, they can begin to assess mental health. How do the children look? And if you are working with a student who is typically pretty happy and then all of a sudden you notice them maybe isolating themselves or looking sad, then that caution light better start flashing in the therapist’s mind and we better start looking a little more carefully.

It’s that whole lens of mental health; once therapists have it, they see how attending to mental health needs to be an important part of what they do every day.

Waite: Part of the grant involves setting up occupational therapists to lead development and implementation of lunch, recess, and afterschool programs that promote mental health. What might such programs look like?

Bazyk: During Mental Health Awareness Month, in May, we would start a project to create posters, bookmarks, activity sheets, and handwriting sheets that teach children about mental health as a positive state of functioning. When working with students with handwriting or fine motor problems, they [could also] be learning about something related to mental health. Last year we asked students in an art class in a local high school to design posters and bookmarks promoting healthy attitudes, and we selected the top five designs. All these materials were [disseminated] throughout Cleveland area schools in May, and it was one way to get people to build their awareness of mental health. We will be building on that component of how to embed an understanding of mental health promotion in schools.

Waite: Another key part of your grant project is to disseminate information around the state about how occupational therapists can implement these types of programs and seminars and create online resources and toolkits to help them do so and then properly follow up. What will this look like?

Bazyk: We are going to tap into the state’s online resource center and post all of the professional development materials related to mental health promotion on this site. Occupational therapists will have access to toolkits, PowerPoints, information and tip sheets, and activity instructions that will help guide them through starting their own in-school program like, say, how to create a positive cafeteria and mealtime environment. So we will have materials available online for occupational therapists as well as parents, teachers, and students.

Waite: What do you want to see at the end of this grant in order to feel successful?

Bazyk: I want to see occupational therapists in schools make mental health their business. If they see themselves as mental health promoters, and they know how they can do that throughout the day, and they visualize themselves as part of the team that helps promote mental health as well as address mental health challenges, the grant will have been extremely worthwhile.
How To Use
AOTA’s Mental Health Information Sheets

DESCRIPTION

The free downloadable information sheets at http://www.aota.org/Practitioners-Section/Children-and-Youth/Browse/School/Toolkit.aspx were developed for occupational therapy practitioners working with children and youth in school and community settings to obtain specific knowledge about mental health (MH) promotion, prevention, and intervention and to guide service provision. Each information sheet provides an overview of the topic, implications for occupational therapy, and strategies for MH promotion, prevention, and intervention in a variety of settings. Each sheet also provides important references and Internet resources for further reading and resource allocation. These information sheets are intended to provide: 1) foundation information about the topic to familiarize the OT practitioner about the subject; and 2) references and Internet resources to extend learning about the topic.

1. Content draws on current literature about a public health approach to MH emphasizing MH promotion for all children with and without identified disabilities or MH challenges
   - **MH Promotion:** strategies for optimizing mental health
   - **MH Prevention:** strategies to reduce mental health problems before identification of a specific mental health problem
   - **MH Individual Intervention:** strategies to diminish or end the effects of an identified mental health problem after the problem has been identified

2. Services are depicted in tiers
   (see diagram at right):
   - **Tier 1:** Universal (for whole population emphasizing promotion and prevention efforts)
   - **Tier 2:** Targeted (prevention and early intervention for children at risk of developing MH challenges)
   - **Tier 3:** Intensive individualized interventions (for children already identified with MH challenges or illness)

3. A variety of topics are addressed specific to MH promotion, prevention, and intervention including but not limited to:
   - Mental health literacy
   - Social and Emotional Learning (SEL)
   - Positive Behavioral Supports (PBS)
   - Obesity
   - Bullying
   - Grieving loss
   - Strength-based approaches
   - Anxiety disorders
   - Depression
   - Thought disorders or Schizophrenia
   - Bipolar disorder
   - Autism spectrum disorder
   - Recess promotion

Continued on the next page
RECOMMENDATIONS FOR HOW TO USE THESE RESOURCES

• Select and read one of the information sheets prior to a staff meeting. Assign occupational therapy practitioners to read one of the reference articles or review one of the Internet resources and report useful information at the staff meeting.
• Discuss strategies for applying the information at the team’s work site.
• Repeat the process until you have covered all of the information sheets.
• Keep track of how the team addresses MH promotion, prevention, and intervention at Tiers 1, 2, and 3. Articulate occupational therapy’s role in written reports and verbally in team meetings.
• Pair the information sheets with related resources found at the Children and Youth area of the AOTA website http://www.aota.org/en/Practice/Children-Youth.aspx. For example, refer to the AOTA pediatric virtual chat (www.talkshoe.com/tc/73733) on obesity after reviewing the “Childhood Obesity” information sheet.

Developed by: Initially developed by occupational therapy students under the supervision of Dr. Susan Bazyk at Cleveland State University in 2010 and used to host a Children’s Mental Health Day open house event. The AOTA School Mental Health workgroup revised these original information sheets in 2011 and 2012.

Contributing authors: Susan Bazyk, PhD, OTR/L, FAOTA; Lisa Crabtree, PhD, OTR/L; Donna Downing, MS, OTR/L; Claudette Fette, PhD, OTR, CRC; Deborah Marr, ScD, OTR/L; Laurette Olson, PhD, OTR/L, FAOTA; Michael Pizzi, PhD, OTR/L, FAOTA, and Sandy Schefkind, MS, OTR/L.

ADDITIONAL RESOURCES


The Cafeteria: Creating a Positive Mealtime Experience

**OCCUPATIONAL PERFORMANCE**

How might the cafeteria influence Occupational Performance? Occupational therapy practitioners and cafeteria staff can work together to create a positive cafeteria environment in order to help students with:

**Social participation**
- Learn appropriate mealtime behaviors and manners (e.g., talk at an appropriate volume, chew with mouth closed, clean up after lunch).
- Learn appropriate social behaviors (e.g., how to initiate conversations, appropriate listening skills).
- Prevent social exclusion and bullying of other students.

**ADL (Eating)**
- Enjoy eating lunch in the cafeteria.
- Eat more lunch.
- Learn healthy eating habits and develop a positive relationship with food.
- Eat at an even pace and without hurrying.
- Use utensils and napkins properly.
- Learn to advocate for one’s sensory needs in order to feel relaxed during lunch.
- Independence in self-feeding.

**Education**
- Be ready to concentrate and learn in the afternoon.
- Feel positive about and more connected to school.

**Sleep/rest**
- Feel rested and restored for the rest of the school day.

**OCCUPATIONAL THERAPY PRACTITIONERS** use meaningful activities to help children and youths participate in what they need and/or want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social participation, activities of daily living (ADLs: e.g., eating, dressing, hygiene), instrumental ADLs (e.g., preparing meals, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

**THE CAFETERIA: A place to enjoy a meal and socialize with peers.** Lunch should be an enjoyable part of the school day for students, offering a break from classroom work and a place to relax, socialize, and become nourished. Mealtime in the cafeteria can also be used to promote healthy eating habits and encourage children to try new foods. The cafeteria, especially in elementary schools, can be one of the best contexts where appropriate social interaction and behavior is modeled and taught. It is important for supervising adults to interact with students in positive ways without resorting to strict discipline. Learning these skills in the early grades can potentially help prevent more disruptive behaviors in the cafeteria in later grades.

**Consider the cafeteria a place to embed services.** Occupational therapy’s scope of practice includes eating/mealtimes and social participation. As such, it makes sense for occupational therapists to embed services in this natural context, with a focus on helping create a positive cafeteria environment, so that all students can enjoy their meals and socialize with friends.

**Team collaboration is essential.** Building a positive cafeteria climate is a team effort that includes administrators, teachers, cafeteria supervisors, food service personnel, students, and parents.

**Challenges in the cafeteria.** School cafeterias may not be pleasant environments if students are not allowed to talk during meals and feel pressured to eat. Disruptive behaviors and bullying in the cafeteria can spill over into the classroom. Also, the pressure to eat fast may hinder making good food choices and cause more food waste.

**Benefits of a pleasant cafeteria experience.** When the cafeteria environment is pleasant, students eat more of their lunch, do better in their academic work, and have fewer behavioral problems (Center for Ecoliteracy, 2010).

**PROFESSIONAL RECOMMENDATIONS**

1. **Educate cafeteria supervisors and students.** In the beginning of the school year, provide inservice education and follow-up coaching to cafeteria supervisors on strategies for creating a positive cafeteria experience. Help supervisors learn what to say and do to create a calm and comfortable environment. Provide a short inservice to students in the beginning of the school year to educate them on appropriate mealtime behavior, manners, and ways to make mealtimes pleasant.

2. **Promote positive mealtime behavior.** Provide information to cafeteria supervisors on strategies for promoting positive behavior and mealtime manners, and handling problem behaviors. Implement preventive programs based on positive behavioral interventions and supports. Clearly posting rules may foster good behavior. Have students work together to clear and wipe the tables and sweep underneath so that the next group of students has a clean space to eat. This teaches respect for others.

3. **Foster enjoyable social interaction.** Consider providing round tables with chairs instead of rectangular tables with benches to decrease the number of students in a space, giving students a less crowded more social place to eat. Encouraging inside voices and signaling when noise levels get too loud helps promote a calmer, more pleasant environment.

4. **Promote good nutrition and a healthy relationship with food.** “A growing body of research connects better nutrition with higher achievement on standardized tests; increased cognitive function, attention, and memory; and an array of positive behavioral indicators, including better school attendance and cooperation” (Center for Ecoliteracy, n.d., p. 5). Use lunchtime as an opportunity to teach students about eating healthy foods.

5. **Modify the environment.** Designing the cafeteria to look more like a café, with décor promoting healthy eating, may make it more inviting. Make sure the cafeteria is clean and free of clutter. Staggering classes so that everyone does not show up at once may decrease the amount of time students spend in line, giving them sufficient time to eat lunch.

6. **Hold recess before lunch.** Provide recess before lunch so that children come to lunch ready to sit down, eat, and socialize. Holding recess before lunch has been shown to encourage eating at a slower pace and decreases food waste (Center for Ecoliteracy, 2010). This also gives students a chance to calm their minds and bodies before sitting down to lunch.

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This information was prepared by AOTA’s School Mental Health Work Group (2013). This information sheet is part of a School Mental Health Toolkit at http://www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx

continued
Tier 1: Universal, whole-school approaches focus on promoting a positive cafeteria environment.

- Get everyone on board! A positive cafeteria environment and healthy eating habits should be a school-wide initiative involving all staff, students, and parents. Form a committee of parents, students, and school staff to create a shared vision and action plan for improving lunch.
- Educate and support cafeteria staff. Provide an inservice at the beginning of the school year on creating a positive cafeteria experience. Offer follow-up coaching to provide ongoing support and problem solving regarding challenges.
- Be creative in suggesting ways to make lunch an enjoyable experience. For example, create fun ways for cafeteria staff to interact with students (e.g., “silly hat day,” joke of the day).
- Schedule recess before lunch. Studies have shown that holding recess before lunch improves food and milk intake and cafeteria behavior, and decreases discipline referrals (Center for Ecoliteracy, 2010).
- Ensure adequate time to eat. Students should have 20 minutes of seat time to eat lunch so that they are not hurried.
- Schedule lunch between 11 a.m. and 1 p.m.

Physical environment: Consider increasing the number of lunch periods in order to decrease the number of children in the cafeteria at any given time. Arrange traffic flow in the cafeteria to make sure children move in clear smooth patterns to access food items and assigned seating. Make sure the cafeteria is a clean, safe, and attractive place (e.g., colorful posters, flowers on table). Provide hand washing supplies like hand sanitizer at convenient places so that students can wash hands before eating. Ensure that tables and chairs are the right size for students.

Sensory environment: Implement strategies for minimizing noise (e.g., educate students on using a conversation voice and only speaking to students at the table; use a visual signal to communicate when the noise level gets too high). Softer table coverings and floor surfacing may cut down noise levels. Ensure that tables and the floor are kept clean to cut down on odors. Avoid “eat in silence” rules, whistles, or buzzing traffic lights that monitor sound levels.

Social environment: Encourage cafeteria supervisors to make students feel welcome and show a personal interest (e.g., call them by name, smile). Develop clear rules that outline expected cafeteria behavior and teach these to the students during the first 2 weeks of school. The rules should be posted and reviewed regularly. Consider using round tables to encourage conversations during meals. Help students engage in pleasant conversations during lunch and include all peers at the table. Teach and reinforce mealtime manners (e.g., chewing with mouth closed, eating correctly with utensils, using a napkin to wipe mouth).

Encourage and reinforce healthy eating habits. Collaborate with the nutrition services staff and health educators to promote healthy eating and weight.

Tier 2: Targeted strategies focus on accommodations for students at-risk of experiencing challenges in the cafeteria.

- Pay attention to students with disabilities to ensure they feel welcomed, comfortable, and included in the cafeteria.
- Attend to the sensory needs of students at risk of sensory processing challenges. Teach students to develop self-calming strategies as needed to help them feel calm and safe in order to eat their meals. Students who are hypersensitive to auditory, visual, tactile, and/or olfactory input may feel more comfortable eating in a quieter, less distracting section of the cafeteria or in a classroom with a small group of peers.
- Educate cafeteria support staff about signs of sensory overstimulation (e.g., putting hands over ears, rocking, avoiding interaction) and teach strategies for reducing sensory input and responding to students’ emotional needs.
- Consider eating at a table with students if there are issues related to social interaction and/or behavior. Adults can help model social inclusion, positive manners, and appropriate mealtime conversation.

Tier 3: Intensive:

- Develop a lunch bunch group program to bring students with and without disabilities together to share lunch and a recreational activity (Heyne et al., 2012). The occupational therapy practitioner can facilitate such groups on a weekly basis.
- Embed social and emotional learning strategies in the cafeteria to help students with behavioral challenges interact positively with peers and make friends (Fenty, Miller, & Lampi, 2008).
- Collaborate with the cafeteria supervisors to develop an individualized behavior support plan for students demonstrating significant behavioral challenges during lunch.
- For students with significant sensory defensiveness, create a “sensory-friendly” space in a quiet corner of the cafeteria with calming music. In addition, communicate with cafeteria supervisors and caregivers about possible sensory strategies for helping students cope with overstimulating food environments both in and out of school to ensure consistency across settings.
- For students with physical disabilities and feeding challenges, the occupational therapy practitioner can advocate for the student to have added time to eat their meal as needed to foster and encourage independence in self-feeding.

For references, see page 3.
REFERENCES AND RESOURCES


Anxiety Disorders

**OCCUPATIONAL PERFORMANCE**

Children who experience anxiety disorders may be challenged in the following areas of occupation:

**Social Participation**
- May avoid social situations due to fear of being in an unfamiliar setting, embarrassing themselves, or having a panic attack
- May “flee” when uncomfortable
- Can appear irritable and unapproachable to other children
- May choose to withdraw as a way to manage symptoms
- Overall discomfort interferes with enjoyment of social activities

**ADLs**
- Excessive worry, poor concentration, slowed information processing, and fatigue can disrupt daily routines and the ability to carry out bathing, toileting, dressing, and eating tasks
- May demonstrate poor initiation and low motivation

**Education**
- Potential for social isolation at recess and in the cafeteria
- Difficulty concentrating and processing information can interfere with activity engagement, ability to understand and follow instructions, and completion of assignments
- May lose train of thought due to intrusion of worrisome thoughts
- Generally avoids speaking up in class or calling attention to self

**Work**
- May avoid work settings where there is a need to interact with the public and/or the environment is busy and unpredictable

**Play/Leisure**
- Tendency to engage in familiar occupations, either alone or with a good friend
- May find it hard to relax and enjoy themselves

**Sleep/Rest**
- Can be disrupted due to worry, which leads to daytime fatigue

**OCCUPATIONAL THERAPY PRACTITIONERS** use meaningful activities to help children and youth participate in what they need and want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social participation, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental activities of daily living (IADLs; e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

**About Anxiety**

Everyone experiences anxiety as a response to stress from time to time, even children. Mild anxiety can help a young person cope with a difficult or challenging situation, such as taking an exam, by channeling that anxiety into positive behaviors, e.g., reviewing course material ahead of time in order to prepare for the exam. However, when anxiety is constantly present and appears to be an irrational fear of familiar activities or situations, then it is no longer a coping mechanism but rather a disabling condition (National Institute of Mental Health (NIMH, n.d.).

**Anxiety Disorders**

These disorders often begin in childhood as early as 6 years of age, or in adolescence, and can interfere significantly with the performance of everyday occupations (NIMH, n.d.). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) identifies 5 types of anxiety disorders: obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), social or specific phobias, panic disorder, and generalized anxiety disorder. Common symptoms are:

1. excessive, unexplained worry
2. difficulty managing the worry
3. restlessness or unexplained nervous energy
4. tiring easily
5. difficulty concentrating or loss of thoughts (“mind going blank”)
6. irritability
7. muscle tension
8. sleep disturbances

Brain imaging can now demonstrate the biology of anxiety disorders (NIMH, n.d.). These types of studies have revealed atypical brain activity in children with anxiety disorders (e.g., not being able to differentiate between threatening versus non-threatening situations), as well as brain circuitry changes during adolescence which make females more prone than males to developing mood and anxiety disorders. Research is also helping determine effective treatment methods other than prescribed medications, such as family-based cognitive behavioral therapy and social skills training (Bonder, 2010).

**How do Anxiety Disorders Impact Participation?**

Anxiety symptoms can interfere with a child’s ability to engage in school activities, chosen occupations, and social opportunities. Fear of failure, concern about having a panic attack, or fear of embarrassment can lead to a child’s lack of participation even though he or she may want to be engaged. These experiences can lead to social isolation and result in poor occupational performance in all life skill areas.

**How Do Anxiety Disorders Impact Emotional Health?**

Decreased participation in social situations and occupations can exacerbate feelings of low self-esteem, distort a child’s self-image, and disrupt habits, routines, and roles. Overall quality of life and well-being are affected because of the underlying symptoms.
Strategies for Managing Anxiety

- Create a sensory modulation kit and/or a sensory diet.
- Use Cognitive Behavioral Therapy (CBT) and Social and Emotional Learning (SEL) to help students develop skills to recognize and manage their emotions, thoughts, and behaviors.
- Teach relaxation techniques and positive self-talk that students can use in the classroom and at home.
- Promote participation in meaningful leisure activities.

CHECK THIS OUT!

- Anxiety and Depression Association of America Web site: http://www.add.org Useful information about anxiety disorders and depression, as well as resources for families and professionals.
- CASEL Web site: http://casel.org Explains the SEL framework and provides examples of what principals, teachers, and parents can do to promote it within the school environment.

OCCUPATIONAL THERAPY PRACTITIONERS can play an important role in addressing anxiety disorders in children in a variety of settings, including schools, communities, and home. In each setting, intervention may focus on a number of areas, including establishment of routines and habits, enjoyable activities that promote optimal levels of arousal or relaxation, and strategies for managing symptoms to enhance occupational performance. These services can help children build self-esteem and establish supportive relationships with family members, school personnel, and peers. Occupational therapy practitioners can play a critical role in working with teachers and other school personnel, as well as with family members to address the occupational performance needs of children with anxiety disorders.

LEVELS OF INTERVENTION

Promotion: Occupational therapy practitioners can promote whole population approaches fostering mental health at the universal level (e.g., school-wide efforts to reduce stress and sensory overload throughout the day, such as inclusive recess experiences).

Prevention: Practitioners may introduce targeted interventions to help at-risk students manage their symptoms more easily without necessarily singling them out (e.g., collaborating with teachers to create sensory-friendly environments that incorporate self-regulating strategies within the classroom, such as making fidget toys available, providing quiet corners in which to work, and offering relaxation breaks).

Intensive/Individualized: Occupational therapy practitioners can collaborate with teachers to implement classroom interventions designed to enhance an anxious child’s occupational performance (e.g., modifying assignments by breaking them down into smaller steps, allowing flexible deadlines for harder assignments, reducing homework load, creating opportunities for stress reduction, adhering to a sensory diet, or partnering with a friend during more challenging learning activities).

Home: Work with families to establish daily routines that include time together, as well as time alone for de-stressing. Educate family members about anxiety symptoms and how they can interfere with functioning. Help develop coping strategies (e.g., sleep hygiene routine, quiet retreat, sensory diet, sensory modulation kit). Encourage enjoyable family activities that alleviate stress and promote social participation.

School: Educate all school personnel about anxiety disorders and how they impact learning and socialization (e.g., in-service sessions, handouts). Promote sensory-friendly areas indoors (e.g., create sensory modulation areas in classrooms) and outdoors (e.g., create a reflective garden or nature trail on the edge of the playground). Encourage school curriculum that supports stress management and promotes socialization (e.g., yoga, team-building activities, walking clubs). Promote inclusive after-school activities.

Community: Partner with local after-school and community organizations to create activities that help youth manage stress (e.g., community service projects, exercise clubs). Reach out to parent groups or youth service organizations to educate members about anxiety disorders and offer strategies for managing symptoms (e.g., ask to speak at a meeting, create a handout with helpful hints, write an article for a newsletter or community newspaper).

REFERENCES & RESOURCES


Occational Therapy’s Role in Mental Health Promotion, Prevention, & Intervention With Children & Youth

Bullying Prevention and Friendship Promotion

Occational Therapists are “front line providers” who can address bullying...or prevent bullying...during school, play, and work routines

OCCUPATIONAL PERFORMANCE

Children and teens who experience bullying may be challenged in the following areas of occupational performance:

Social Participation
- Rejection from peers
- Isolation due to fear of being bullied or feelings of inadequacy
- Family stress and tension can result from the youth’s depression and anxiety related to bullying

ADLs
- Changes in eating patterns or loss of appetite

Education
- Difficulty concentrating and completing assignments due to anxiety or depression
- Avoiding school to prevent being bullied
- Experiencing illness associated with the stress of being bullied (e.g., stomachaches, headaches), resulting in frequent absenteeism

Work
- Difficulty completing work tasks due to poor concentration and anxiety
- Isolation and low morale leads to absenteeism

Play/Leisure
- Lack of interest in previously enjoyed activities

Sleep/Rest
- Disruptions in sleep patterns, such as difficulty falling or staying asleep

OCCUPATIONAL THERAPY PRACTITIONERS

use meaningful activities to help children and youth participate in what they need and or want to do to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in education, play and leisure, social participation, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental activities of daily living (e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

BULLYING

is considered one of the most common forms of violence in schools and as such, most schools have adopted programs to reduce bullying and create emotionally and physically safe places contexts for learning (Espelage & Swearer, 2003; National Center for Mental Health Promotion and Youth Violence Prevention, 2009). Approximately one in three students ages 12–18 years report being bullied during the past year, with peak ages being 11–13. Forty nine states have passed anti-bullying laws (http://bullypolice.org).

What is bullying?

Bullying is an act of intentional aggression carried out repeatedly over time and occurring within a relationship characterized by an imbalance of power (Center for the Study and Prevention of Violence, 2008). Three major types of bullying include:

- Direct bullying: physical acts of aggression (e.g., hitting, pushing) or verbal (e.g., taunting, name calling, malicious teasing)
- Indirect bullying: characterized by one or more forms of relational aggression (e.g., peer exclusion, spreading rumors, manipulating friendships to hurt the victim)
- Cyberbullying: threatening or hurtful messages or images being sent using an electronic device (e.g., cell phone, computer) (www.casel.org).

Boys tend to be involved in more direct acts of bullying whereas girls are more likely to engage in indirect forms (Jenson & Dieterich, 2007). Because indirect and cyberbullying are less visible to external parties, it is often difficult for adults to detect and address such behavior (Nansel et al., 2001).

Relevance to mental health.

Bullying is viewed as a situational stressor that may result in mental health challenges for all the parties involved (e.g., victims, bullies, bystanders).

- Victims of bullying report a number of symptoms, including absenteeism, illness, and poor academic performance. Higher levels of depression, anxiety, and externalizing behaviors such as aggression are reported in those who have been bullied (Swearer, 2011).
- Children who bully generally like to dominate and often bully when adults are not around. Children who bully can have conduct disorders but also can be the popular kids. Bullies tend to have a sense of entitlement and intolerance for differences. A range of negative outcomes are often associated with those who bully, including poor school adjustment, conduct problems, depression, and peer rejection. Bullies tend to choose victims who have little social support.
- Bystanders who witness bullying can experience feelings of fear, anger, guilt, and sadness. Although they experience negative feelings, they may also play a role in maintaining bullying behavior by positively responding (e.g., laughing, joining in) or passively watching instead of intervening to help the victim.

Lastly, bullying should be taken seriously because of how it can negatively affect the entire school. Bullying creates a climate of fear and disrespect that can ultimately affect learning. It is especially important to look out for children who are at greater risk of being bullied, such as those with physical, cognitive, or emotional disabilities; who have different sexual orientation; and minorities.

continued
OCCUPATIONAL THERAPY PRACTITIONERS can serve an important role in helping to prevent bullying and promote positive student interactions. Participation in enjoyable occupations, teaching coping strategies, and fostering friendships can serve as important “buffers” in the prevention of bullying and mental ill-health (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002).

LEVELS OF INTERVENTION

Tier 1: Universal, whole school approaches. Because bullying can affect the entire student body and school climate, existing research supports universal school-wide programs as opposed to involving only victims and bullies. Effective whole-school approaches consist of a variety of strategies such as teacher training, school-wide rules, classroom curricula and management strategies, parent education, improved playground supervision, and peer involvement to combat bullying. A recent systematic review identified a variety of bullying prevention programs (Swearengin, Espelage, Love, & Kingsbury, 2008; Tofio & Farrington, 2009). Bully prevention in positive behavior supports (PBS) emphasizes remediating problem behavior and prevention of further bullying (see side bar for information Positive Behavioral Interventions & Supports (PBIS) bully prevention program manuals). Bully prevention within a social and emotional learning (SEL) framework emphasizes promoting a positive school climate (e.g., warmth, respect) and positive student interactions (increasing SEL competencies). Students who have greater SEL competency are less likely to be aggressors, targets of bullying, or passive bystanders. A document describing an SEL and bullying prevention framework is available on the CASEL Web site (www.casel.org).

In addition to contributing to school-wide PBS and SEL efforts, the occupational therapy practitioner can:

- Teach children appropriate ways for standing up to a bully, such as (1) stand or sit tall with hands at side; (2) take a deep breath and let it out slowly; (3) maintain eye contact; and (4) Speak in a calm, clear, and confident voice (Storey, Slaby, Adler, Minotti, & Katz, 2013).
- Be vigilant! Observe interactions during unstructured times and less supervised places – recess, lunch, restrooms, hallways. Talk to students and take an interest in their social life. Ask about friendships and what they do out of school. Look out for the loner!
- Focus on friendships! Research suggests that having high-quality friendships, or at least one good friend, can help prevent children from being a victim of bullying (www.casel.org). Friendships are a source of happiness and provide opportunities for companionship, having fun together, and receiving support. Children who have friends tend to be more sociable, self-confident, cooperative, and emotionally supportive than those without friends (Wentzel, Baker, & Russell, 2009).

Tier 2: Targeted strategies focusing on students at risk of bullying. Students at greater risk of bullying are perceived as “different,” for example, students with disabilities, those who are overweight/obese, gay/lesbian/transgendered, or shy or anxious, to name a few.

- Teach friendship skills during individual or group interaction. Examples include, knowing how to enter a group, giving compliments appropriately, cooperating in groups, and demonstrating empathy. (Atwood, n.d.)
- Help children identify interests and join a club or group after school in order to develop friends with similar interests. Use coaching strategies for those who are reluctant.
- Encourage teachers to embed reading books on topics related to bullying and the importance of tolerating differences (Carnegie Library of Pittsburgh, n.d.)

Tier 3: Intensive, Individualized services when you see or hear bullying.

During the bullying incident

- Intervene immediately, even if you’re not sure it’s bullying.
- Respond calmly but firmly. Describe the bullying behavior observed and why it is unacceptable; indicate the bullying must stop.
- Avoid lecturing the bully in front of peers.
- Praise any helpful bystanders.
- Stick around to ensure the bullying has stopped.

Follow up after the bullying incident

- Bullies must be told that bullying will not be tolerated. They must understand what they did, why it was wrong, and how it affects their victims and others. Assist the bully in apologizing or making amends with the victim.
- Victims must know that adults care and support them. Listen to what happened; offer support; help them develop strategies for preventing further bullying.
- Inform appropriate staff. Follow procedures at your school. Parents must be informed.
- Record the incident.
- Check up regularly with the victim, bully and staff to ensure the bullying does not continue.

(Storey et al., 2013)

For references, see page 3.

Bully Prevention Manual—Elementary School Level

Bully Prevention Manual—Middle School Level

Authors: B. Stiller, S. Ross, & R. H. Horner

Published by OSEP Technical Assistance Center on Positive Behavioral Interventions & Supports (n.d.). www.pbis.org

Bully Prevention in Positive Behavior Support was designed for school-wide implementation to reduce incidents of bullying by teaching all students behaviors that will reduce the probability of bullying. This manual provides clear methods and user-friendly worksheets for teaching this program to students and staff.

Students are taught a three-step response to problems behavior to prevent the reinforce-ment of bullying and to extinguish it. (Separate sections apply the three steps to the problems of gossip, inappropriate remarks, and cyberbullying). The three steps involve:

- **Stop**: Teach students the school-wide “stop signal” (verbal and physical action) for problem behavior, and practice when and how to use it appropriately.
- **Walk**: Teach students to “walk away” when the problem behavior continues after the stop signal. Walking away removes the reinforcement for problem behavior.
- **Talk**: Teach students to “talk” to an adult if the problem behavior continues after using stop and walk.

CHECK THIS OUT!

- **Steps to Respect**—Bullying prevention and friendship development (Committee for Children) http://www.cffchildren.org/steps-to-respect.aspx


- **15+ Make Time to Listen, Take Time to Talk…About Bullying**—Conversation starters (Substance Abuse and Mental Health Services Administration) http://store.samhsa.gov/shin/content//SMA08-4321/SMA08-4321.pdf

- **Words That Heal: Using Children’s Literature to Prevent Bullying** (Anti-Defamation League) http://www.adl.org/education/curriculum_connections/winter_2005/

- **PACER’s National Bullying Prevention Center** http://www.pacer.org/bullying/
REFERENCES


OCCUPATIONAL PERFORMANCE

Children who are overweight or obese may be challenged in the following areas of occupation:

Social Participation
- Difficulty in making and keeping friends due to weight bias
- At risk for bullying and/or social isolation
- At risk for mental health disorders such as anxiety and depression
- May struggle with limited self-esteem and poor body image

ADL
- Difficulty in choosing and preparing healthy meals

Education
- At risk for decreased endurance and capacity on playground and in physical education
- Potential decrease in academic performance due to social stresses

Work
At risk for experiencing physical and/or social barriers at workplace, such as after-school jobs or internships

Play/Leisure
- Possible imbalance between sedentary and physical activities
- Too much screen time (computers, television) leading to isolation and weight gain

Sleep/Rest
- Excessive rest and sleep due to depression and/or low energy levels
- Poor sleep patterns at night could lead to decreased energy and academic performance

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social participation, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental ADLs (e.g., preparing meals, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (sensory, motor, social-emotional, and cognitive) that may limit successful participation across a variety of settings. Activities and accommodations are used in intervention to promote successful performance in school, home, and community settings.

ABOUT CHILDHOOD OBESITY

Childhood obesity is defined as a condition in which excessive body fat negatively affects a child’s overall health or well-being across all environments, including home, school, and the community. Obesity is further defined as an individual with a body mass index at or above the 95th percentile for children of the same age and gender. The most common causes are genetic factors or family history of obesity; decreased participation in physical activities; unhealthy eating patterns or behaviors; and, in rare cases, medical conditions.

Who’s at risk of becoming overweight or obese?

1. Children who live in impoverished areas with limited access to:
   - Safe Parks
   - Nutritional foods such as fresh produce
   - Local recreational centers
   - After-school clubs such as gardening
   - Affordable fees for team sports and equipment
   - Information for youth and family regarding nutrition

2. Children with developmental disabilities are 40% more likely to develop obesity due to secondary conditions (pain, social isolation, de-conditioning) and/or predisposing factors (genetic syndromes such as Prader-Willie, medications that increase weight gain). They also may have limited access to:
   - Accessible playgrounds and parks
   - Trained staff to adapt programs for inclusion
   - Equipment and assistive devices that allow for participation

How does obesity impact physical health?

Children who are overweight or obese are at risk for developing the following health conditions: asthma, type 2 diabetes, cardiovascular disease, high blood pressure, high cholesterol, and fatty liver disease. They may also be at risk of:
- Decreased joint flexibility and orthopedic problems leading to limitations in physical play.
- Sleep apnea and inability to develop proper sleep patterns, which may limit energy levels and attention at school.

How does obesity impact social and emotional health?

Children who are overweight are at risk of weight bias (or weight stigma), which refers to negative judgements of an obese person based on social attitudes or stereotypes (e.g., lazy, poor self-control). Weight bias from adults and peers may result in negative remarks about appearance, verbal teasing, name calling, social exclusion, and physical bullying, leading to:
- Poor self-esteem and body image
- Feelings of loneliness and isolation
- Difficulty in making friends
- Withdrawal

This information was prepared by AOTA’s School Mental Health Work Group (2012). This information sheet is part of a School Mental Health Toolkit at www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx
OCCUPATIONAL THERAPY PRACTITIONERS can play important roles in addressing childhood obesity in a variety of settings, including in schools and communities and at home. In each setting, intervention may focus on a number of areas, including culturally appropriate healthy food preparation and meals, enjoyable physical and social activities, and strategies for decreasing weight bias/stigma and bullying. Messages should focus on “health and a healthy lifestyle” rather than weight loss. Services can help children identify personal character strengths (e.g., creativity, humor, thoughtfulness) and build on them. Occupational therapy practitioners can play a critical role in working with school teachers, nutritionists, and other professionals to enhance healthy lifestyles in all children and youth.

LEVELS OF INTERVENTION

Promotion: Whole population approaches fostering mental and physical health at the universal level (e.g., school-wide efforts to promote healthy lunches and opportunities for physical activity).

Prevention: Targeted, culturally appropriate interventions focusing on at-risk groups such as children living in poverty or those with disabilities (e.g., small-group after-school clubs emphasizing nutritious food preparation and enjoyable physical activities).

Intensive: Interventions designed for those who are overweight or obese (e.g., individualized programs to foster healthy habits and routines, including enjoyable activities and nutritious meals).

Home: Work with families to promote health meal choices and routines consistent with their culture. Encourage designated family dinner time. Promote family participation in enjoyable physical activity such as riding bikes or walking. Develop graduated physical programming so that family members can participate.

School: Promote anti-bullying programs that teach respect for differences. Teach children to use respectful language, such as phrases like “above average weight” rather than offensive words like “chunky,” “obese,” or “fat.” Join or help develop wellness committees that promote health and positive lifestyle behaviors for children of all body sizes—with the overall message being “healthy at any weight.” Work with school officials and administration to decrease availability of vending machines that offer foods containing high calories and sugars. Create a gardening program in the school. Help infuse physical activity throughout the school day. Promote after-school clubs such as performing arts and sports to increase physical activity and social participation. Pair the AOTA Backpack Awareness campaign with a school walking program. Work from a strengths-based perspective to increase positive growth and self-esteem.

Community: Encourage inexpensive community activities such as Walking Networks, Cycling Networks, Public Open Spaces, and Recreational facilities. Encourage participation in non-competitive sports teams to increase self-esteem, confidence, socialization, and friendships.

FOR MORE INFORMATION


Depression

OCCUPATIONAL PERFORMANCE

Children and teens who experience symptoms of depression may be challenged in the following areas of occupational performance:

Social Participation
- Isolation due to a loss of interest/enjoyment, feelings of inadequacy, and low energy.
- Family stress and tension can result from the youth’s social withdrawal.

ADL
- Changes in eating patterns
- Loss of interest in self-care, such as bathing regularly and/or wearing clean clothes.

Education
- Difficulty with concentration and other cognitive tasks interferes with engaging in and completing assignments.
- May be labeled as “lazy” or disinterested.
- May refuse to attend school, complain of feeling ill often, or ask to leave early.

Work
- Similar cognitive challenges as demonstrated in school.
- May appear disinterested in tasks.
- May arrive late or not at all.
- Slow or inadequate work, e.g., may misunderstand directions, leave out steps, etc.

Play/Leisure
- May show disinterest in previously enjoyed leisure activities.

Sleep/Rest
- Disruptions in sleep patterns, such as difficulty falling or staying asleep, add to constant fatigue.

OCCUPATIONAL THERAPY PRACTITIONERS (OTs) use meaningful activities to help children and youth participate in what they need and/or want to do in order to promote physical and mental health and well-being. OTs focus on participation in the following areas: education, play/leisure, social participation, activities of daily living (eating, dressing, hygiene), instrumental activities of daily living (e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (sensory, motor, social-emotional, cognitive) that may limit and/or enhance successful participation. Activities and accommodations are used in intervention to promote successful performance in school, home, and community settings.

ABOUT DEPRESSION

Everyone feels sad or “blue” at times, even children and teens. However, youth who experience prolonged and variable periods of sadness may have a more serious medical condition, such as major depressive or dysthymic disorders. Depression is classified as a mood disorder with cyclical symptoms that can disappear and reappear. These symptoms can interfere with a young person’s thoughts, feelings, and behaviors, resulting in difficulties with occupational performance and overall well-being.

Depression in children and teens is considered one of the most serious illnesses due to its impact on functioning and mental health, creating a significant risk for suicide. According to the Centers for Disease Control and Prevention (2012), 8% of females and 5% of males between 12-17 years report depression on a Patient Health Questionnaire (PHQ) (Gilbody, Richards, Brealey, & Hewitt, 2007). Two-thirds of teens who experience symptoms do not seek help, and therefore do not get identified (CDC, 2012). Symptom presentation varies among youth and should be assessed on an individual basis. Depression during adolescence is often accompanied by comorbid diagnoses such as anxiety, bipolar disorder, and substance abuse (CDC, 2012).

Some symptoms of depression that can appear in youth include:
- Loss of enjoyment or interest in activities and other people
- Difficulty with cognitive tasks—especially concentration and decision-making
- Sudden, enduring changes in affect, such as an increase in irritability
- Sudden, enduring changes in behavior, such as resistance to participation in social activities with family and/or friends, school avoidance, and a preference for being alone
- Changes in sleep patterns, e.g., having difficulty falling asleep or awakening early
- Changes in activity levels, e.g., low energy and rapid fatigue or excitability
- Changes in appetite, such as eating too much or too little
- Increased feelings of incompetence, hopelessness, and helplessness
- Expressions of worthlessness and thoughts of unfounded guilt

Who’s at risk of developing a mood disorder such as depression?

1. Children with a family history of mood disorders, such as Major Depression, Dysthymia or Bipolar Disorder
2. Children who live in unstable situations that might include
   - financial uncertainty or poverty
   - substance use/abuse
   - high levels of conflict
   - frequent moves

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This information was prepared by AOTA’s School Mental Health Work Group (2012). This information sheet is part of a School Mental Health Toolkit at www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx
OCCUPATIONAL THERAPY PRACTITIONERS can serve an important role in addressing depression in youth because of its negative impact on all areas of occupational performance. OTs can offer guidance, support, and interventions to youth, families, and other disciplines in a variety of settings, such as home, school, and community.

LEVELS OF INTERVENTION

Promotion: Whole population approaches fostering mental and physical health at the universal level (e.g., school-wide efforts to promote healthy lifestyles, self-esteem, acceptance of individual differences, non-tolerance of bullying, resources for support, etc.). Educate about the value of enjoyable activities in improving mood. Encourage children to share feelings and experiences through everyday conversation, social interaction, and creative expression.

Prevention: Targeted interventions focusing on at-risk groups, such as those living in unstable situations or those showing new occupational performance difficulties (e.g., small group after-school clubs that promote self-esteem, sensory modulation, and non-threatening socialization and social skill-building).

Intensive: Interventions designed for those dealing with decreased occupational performance due to depression (e.g., modified school demands and schedule, targeted sensory processing needs, family education).

Home: Work with youth and family to develop low-stress home routines that incorporate opportunities for success with chores, homework, and social interactions. For instance, to avoid feeling pressured and stressed, the therapist might work with the family to: promote a morning routine that allows extra time for the youth to move at his/her pace; provide education about the impact of specific symptoms on occupational performance; focus on the youth’s favorite activities as a means of fostering engagement and success; and facilitate quiet social opportunities with one good friend and/or family member to enhance social participation.

School: Collaborate with the teacher(s) and other school staff to raise awareness of the youth’s performance challenges that are related to illness. Modify assignments as well as the environment when possible in order to reduce stress and to create a positive learning situation. If the youth cannot get out of bed early enough each day due to side-effects of medications or symptoms, then an adapted school schedule may need to be developed.

Community: Become an integral part of the youth’s intervention team by helping to set realistic functional goals. Offer opportunities for participation in low-stress social situations and enjoyable activities/interests that do not challenge the youth’s sense of security or self-worth, e.g., avoid venues with high sensory input and activity until the youth feels better.

REFERENCES


Minnesota Association for Children’s Mental Health, http://www.macmh.org/


DID YOU KNOW?

Suicide is the third leading cause of death of 10-24 year olds. It is important to refer someone who has suicidal thoughts or expression to trained professionals and not ignore these signs, either written, verbal, or creative. www.teenscreen.org

CHECK THIS OUT!

• Resources on various mental health and health issues for children and teens: www.healthcentral.com

• Non-profit organization that provides resources for social skills training and social-emotional intelligence: www.wingsforkids.org

• Chart on the presentation of depressive symptoms in children and adolescents, as well as other resources: www.keepkidshealthy.com/welcome/conditions/depression.html

• Information and resources for teachers, parents and clinicians: www.schoolmentalhealth.org

• Free depression screening tool for teens that is used in primary care practices and schools: http://www.teenscreen.org/programs/primary-care/
Grief and Loss

IMPACT ON OCCUPATIONAL PERFORMANCE:
Social Participation
Changes in behavior, such as irritability, acting out, social withdrawal, or clinging to parent.

ADL
Changes in appetite and the development of unhealthy eating habits, bedwetting, or alcohol or drug abuse.

Education/Work
Difficulty following directions or concentrating on schoolwork or changes in academic performance, and challenges assuming responsibility at internships or volunteer or paid opportunities.

Play/Leisure
Limited participation in activities of interest (Ayyash-Abdo, 2001).

Sleep/Rest
Altered sleeping patterns.

The stress associated with grieving may negatively affect health in the following ways:
- Physical symptoms: headaches, stomachaches
- Emotional symptoms: anxiety, panic attacks, depression, irritability, absence of emotion

These expressions of grief can manifest themselves in many areas of a child’s life, including home, school, and community.

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and or want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social participation, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental activities of daily living (e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

GRIEF AND LOSS

Grief is conflicting feelings caused by a change in or an end to a familiar pattern of behavior (James, Friedman, & Landon Matthews, 2001). This broad definition encompasses a wide variety of losses that might result in grieving, including death of a loved one (e.g., parent, friend), parental divorce, a major move, death of a pet, military deployment of a parent, or loss of function as a result of illness or injury. It is estimated that 1 in 20 children will lose a parent by death before 18 years of age; 1 in 5 families will move each year; and 1 in 3 children 18 years or younger have divorced parents (McLoughlin, H. (1998). Given all of the possible situations that bring about loss for children and youth, it is likely that occupational therapy practitioners will routinely interact with children who are grieving.

“The death of a loved one can be one of the most severe traumas one may encounter and the sense of loss and grief which follows is a natural and important part of life” (Ayyash-Abdo, 2001, p. 417). The grief process in children differs from adults because children do not have the communication skills to express how they feel (especially young children). Also, because of developmental changes, the grieving process tends to be more cyclical in youth, resulting in the child revisiting and processing feelings in different ways based on maturity (Willis, 2002). When addressing grief and loss with children and youth, it is important to remember that grief can manifest itself in many different ways, depending upon the individual experience of grief and where the person is in the grief process.

It is important that all school personnel and adults involved in youth activities learn about grieving as a normal response to significant loss and also learn appropriate strategies for supporting healthy grieving and minimizing further stress. When children receive support from parents and other adults around them, it helps the child and entire family cope (Schonfeld & Quackenbush, 2009).

MILITARY FAMILIES

Because of issues unique to military families, all school personnel need education about how to support grief and loss particular to children in military families (Swank & Robinson, 2009). These children experience many challenges, including deployment and the potential death of a parent. Deployment may cause feelings of loss for children. Families may only have a short period of time to emotionally and physically prepare for the change. Experiences associated with the death of a parent in the military are unique because of the number of changes that occur following a funeral. If families live in military housing, they generally have a limited time to move, which reduces the time that children have to say good-bye to friends. Children may attend a new school that is not a Department of Defense School, resulting in the loss of support from other military children. Professionals in the new school may lack an awareness of issues specific to military families.

Additional Resources:

continued
With knowledge and skills in the therapeutic use of self and facilitating therapeutic groups, occupational therapy practitioners can help support children in their grieving process through the use of meaningful occupations.

**OCCUPATION-BASED STRATEGIES**

- Help children get back to regular routines and activities, because these can have an organizing effect on feelings of well-being.
- Consult with teachers to help modify assignments or learning environment if behavioral changes cause difficulty with completing homework or participating in class.
- Encourage participation in enjoyable but low-stress activities with close friends to minimize feelings of isolation.
- Provide creative activities such as art projects and journaling to foster self-expression, which can help with processing difficult feelings. Drawing, painting, craftwork, scrapbooking, making memory boards with photographs, and collages naturally lend to meeting the needs of the grieving child (Milliken, Goodman, & Bazyk, 2007).
- Provide activities that create memorials of those who have died (e.g., picture frame, potted plant, dipped candle) to help to preserve what was cherished in the relationship.

**TIER 1: SCHOOL-WIDE**

Grief awareness training could be provided to all school staff in order to promote interactions that support the grieving process. School staff also need to be educated on what not to do, such as acting as if nothing happened, making comments that minimize the loss (e.g., “You’ll be stronger for this”), or telling the student that it’s time to move on (McGlauflin, 2003).

**TIER 2: TARGETED**

Services provided to small groups of children experiencing loss provide opportunities to offer and receive support while participating in meaningful activities. Such groups can be co-led by staff with expertise in mental health, such as school nurses, occupational therapists, school psychologists, and social workers.

**TIER 3: INTENSIVE INDIVIDUAL**

For a student demonstrating functional changes due to grief, occupation-based services are used to engage the person in meaningful activities to foster the expression of feelings (e.g., journaling), help establish routines (e.g., organizing school materials), and maintain feelings of wellness (e.g., yoga, taking daily walks).

**THERAPEUTIC USE OF SELF**

Everyday interactions can help or hinder the grieving process. Sometimes children worry that they will forget the person who died, so it is important to help the child remember what was valuable in the relationship and preserve such memories through stories, pictures, and mentioning the person in everyday conversation. It is also important to anticipate grief triggers, such as anniversaries of important events, the birthday of the deceased, and favorite family meals. Such triggers can bring about strong emotions. Reassuring children that these experiences are natural can help normalize the experience (Schonfeld & Quackenbush, 2009).

**REFERENCES**


OCCUPATIONAL PERFORMANCE
Practitioners can focus on using the child’s strengths and abilities to increase participation in the following areas of occupation:

Social participation
- Sensitivity to others
- Empathy
- Prosocial behaviors such as turn-taking and sharing

ADLs
- Self-confidence and positive identity
- Attention to and independence in self-care

Education
- Academic skills and performance
- Group skills necessary for learning
- Rule compliance
- Class engagement

Work
- Striving behaviors such as leadership and initiation
- Sense of mastery and accomplishment
- Flexibility and adaptive performance
- Persistence and dependability
- Identification of abilities targeted for future college and career

Play/Leisure
- Use of play as a successful coping strategy
- Resilience and social skills

Sleep/Rest
- Balance of daily routines including rest and relaxation
- Promotion of general mental and physical health and happiness

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DEFINITION: PROMOTING STRENGTHS DURING EVERYDAY PRACTICE
In strength-based approaches, the practitioner focuses on identifying and building upon the student’s abilities versus focusing on their limitations or disabilities (Hoagwood et al., 2007; Reddy, DeThomas, Newman, & Chan, 2009). For example, a student with vocal talent would be encouraged to participate in the school chorus or other opportunities to sing in community programs.

Who benefits from a strength-based approach?
1. Children in general education without identified problems or risks. All children can benefit from identifying and fostering their preferences and abilities.
2. Children in general education who are at risk of school failure due to:
   - Dyslexia or learning needs
   - Mild to moderate mental health challenges
   - Having bullied or having been bullied
   - Occupational deprivation or socioeconomic needs
3. Children served in special education with:
   - Significant learning disabilities, developmental delays, or school failure
   - Severe mental health needs
   - Multiple systems involvement (e.g., mental health, juvenile justice, child welfare)

What traits are promoted?
Recent research (Fette, 2011) suggests that the following student strengths are associated with positive psychosocial and academic outcomes and should be promoted:

- Contextual Supports
  - Caring adults: relationships with teachers and others who model positive values and behaviors
  - Positive peer relations: acceptance by positive friends who model prosocial behavior
  - Family bonds: active engagement with good fit, communication, supportive relationships
  - Community participation: sense of belonging and meaning, commitment to roles
  - Cultural factors: importance of differing meanings in and identification with different cultures
  - School foundations: for social, academic, and study skills; peer group with whom to transition
  - School environment: positive classroom with high-quality education environment
  - Respect from others: people show consideration for the individual’s needs or preferences
  - Material possessions: building identity or interests

- Personal Traits
  - Attention: ability to focus and follow directions; affects quality of effort
  - Cognition: self-knowledge, accurate interpretation or processing, intelligence, grasp of concepts
  - Creativity: original expression, inventiveness, imagination, openness to ideas, aesthetics
  - Interests: skills, fascinations, hobbies, engagement in self-targeted subjects
  - Health: physical and mental health, symptoms well controlled, free of med side effects
  - Temperament: individual qualities, values, and personality
  - Optimism: emotional well-being, joy, enthusiasm, hope, humor, positive mood
  - Positive identity: self-confidence, esteem, respect, happiness with life choices, authentic

This information sheet is part of a School Mental Health Toolkit at www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx
Strength-based service may include strategies such as:

- Promoting activities in which a child takes a special interest and encouraging further participation and skill development (e.g., art activities, sports)
- Asking the child to make a list of favorite activities
- Interviewing the child and those who know him or her best to identify top abilities
- Asking the child to complete sentences such as “I like to…” or “I am really good at…”
- Verbally acknowledging a child’s positive behaviors, unique talents, and accomplishments
- Helping the student to develop a portfolio of work samples
- Sharing a child’s strengths with teachers and helping to identify applications in the classroom

CHECK THIS OUT!

- Strength-based practice overview: http://www.fyi2.org/Strength-Based.html
- Strengths OPEN Model Overview: http://www.fyi2.org/Strengths_for_School.html
- Breaking Ranks in the Middle: http://www.nassp.org/portals/0/content/53495.pdf

Strength-based occupational therapy supports may be applied at the universal, targeted or intensive levels of interventions in the following ways:

**Individual or small group intervention:** The use of activity and environmental analysis are applied individually and during group interventions to promote the “just-right” challenge and a successful experience that will foster self-confidence. Occupational therapy practitioners can develop interventions that begin with individual children’s strengths and use those to craft carefully selected occupation-based activities, thus creating opportunities to practice increased adaptive behaviors in the context of strengths. Occupational therapy can assist with generalization within the school. A fundamental belief is that the student is capable of producing an adaptive response. Practitioners may foster role-shift experiences by observing student roles, identifying activities that are part of successful student routines, and facilitating opportunities to participate. Where access is restricted, practitioners can design meaningful tasks using their strengths that require use of restricted areas (Schultz, 2009).

**Whole-school strategies:** Occupational therapy practitioners can promote positive behaviors during whole-school initiatives, such as anti-bullying campaigns, cafeteria and playground time, and when consulting with educators and specialists. They may model use of student strengths in evaluation and intervention and give examples of how to use student strengths during staff in-services.

**Collaboration with teachers:** Practitioners may consult with teachers and other school personnel on how to adapt the school environment so that students can use their strengths during classroom activities. Sometimes this includes explaining behaviors that may be interpreted as oppositional but may have an underlying function, or by suggesting activities that utilize a student’s strengths (e.g. artistic or musical talent). A practitioner can support a student by developing a portfolio of his accomplishments to share or coach a student to take a leadership role during his or her individualized education program meetings, thereby promoting self-advocacy skills.

**Home:** Occupational therapy practitioners build on adaptive responses in play, self-care, and social participation of the individual child and when interacting with family members and caregivers. Promoting participation in family routines, such as mealtime participation and grooming activities, helps to build independence, play skills, and strong family bonds. Sharing a child’s positive behaviors will enhance family engagement.

**Community:** Occupational therapy practitioners may help promote a child’s interests and abilities by identifying settings within the school and community that offer opportunities for leisure participation, such as sports teams, drama club, dance studios, martial arts, or after-school activities and groups that are associated with the child’s strengths.

**Roles for college and career:** Practitioners can modify environments and curriculum to decrease barriers and increase participation. The occupational therapy practitioner can support positive transition outcomes by offering assistive technology training and helping the student develop work skills. Practitioners can help to identify and build on existing strengths for future employment or leisure participation.

References:


OCCUPATIONAL THERAPY PRACTITIONERS’ role in the school setting is to promote student academic achievement and social participation. They support students’ occupational performance in the following areas: education, play, leisure, social participation, activities of daily living (e.g., eating, dressing, hygiene), sleep and rest, and work. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation. Practitioners promote a student’s strengths and abilities throughout all school routines and environments, including recess and playground time.

Recess defined: active, free play with peers.

Recess is an important part of each school day and an opportune time for OTs to implement innovative programs to address a variety of issues related to school performance. Although many areas of function can be addressed during recess, play and social participation are the most natural areas for OTs to target. Recess is an important time for students to develop important performance skills in the areas of emotional regulation and communication and social skills.

The problem: School districts are cutting the amount of time devoted to recess in order to increase the amount of instruction time. A study by the Center on Education Policy found that 20% of districts recently reduced recess by 50 minutes per week in order to dedicate more time to academics (Ramstetter, Murray, & Garner, 2010).

Benefits of recess

• Increased opportunity for engagement in social participation, improved physical and emotional health, development of leisure and play to counteract the imbalance between sedentary and physical activity, and preparation of the body and mind for attentiveness and engagement in the classroom.
• Recess is a time to “recharge [students’] bodies and minds” (Robert Wood Johnson Foundation, 2010, p. 4). Play in any form is a stress reliever from the world of more and more academic instruction and benchmark testing (Miller & Almon, 2009).
• Better classroom behaviors are found in classrooms receiving at least one 15-minute recess break each day (Barros, Silver, & Stein, 2009).
• Attention to classroom tasks is improved after recess time (Holmes, Pellegrini, & Schmidt, 2006).

Professional Recommendations

• The Centers for Disease Control and Prevention (2000) recommend that elementary school children participate in recess at regularly scheduled periods during the school day. Recess should be supervised by trained adults who can encourage physical activity, enforce rules, and prevent bullying. Appealing equipment and materials should be provided.
• The National Association for Sport and Physical Education (NASPE; 2004) recommends elementary school children have unstructured play time in order to increase physical activity and encourage enjoyment of movement. Recess should not replace physical education and should not be withheld as punishment. NASPE also suggests recess be supervised by qualified adults to facilitate conflict resolution and enforce safety rules.
• The National Association of Early Childhood Specialists in State Departments (2002) of Education recognizes recess as an “essential component of education” and recognizes the restorative effect of recess for students with attention disorders (Ramstetter et al., 2010).

WHY SHOULD OTS CARE ABOUT RECESS?

• Only 36% of children meet doctor’s recommendations for daily physical activity.
• Recess represents about half the available time for children to dedicate to physical activity.
• Recess may be removed because of behavior problems. OTs can help prevent this by helping recess staff learn how to structure recess to promote positive behavior and reduce problem behaviors.
• Funding for structured play often goes to after-school programs and physical education. Recess is an untapped resource and OTs have both the skills to develop new programs and the responsibility to advocate for the importance of play (Robert Wood Johnson Foundation, 2007).

A 2010 study showed that urban schools and schools with 75% of students receiving free lunch have LESS recess time than rural & suburban schools. (Ramstetter et al., 2010)

The Challenges of Keeping Recess:

• Limited equipment or supplies;
• Unsafe conditions;
• Disorganization;
• Discipline problems;
• Bullying;
• Lack of awareness of play benefits.
OCCUPATIONAL THERAPY’S ROLE IN ADDRESSING RECESSION TIME

BELOW ARE EXAMPLES of intervention strategies at varying levels of intensity that could be implemented by occupational therapy practitioners:

Tier 1—Universal (whole-school efforts emphasizing promotion and prevention)
- Promote physical health through meaningful activities. For example, OTs could implement a “Recess Activities of the Week” (e.g., Frisbee golf, dancing, obstacle course) program to increase motivation to participate and be active (Sinclair, 2008).
- Advocate for recess in your local school districts by sharing evidence demonstrating the benefits of recess and collecting data demonstrating positive behavior or increased academic achievement when recess and physical activity is included throughout the school day.
- Ensure recess is supervised by trained adults who can encourage physical activity, enforce rules, and prevent bullying. Adults can model appropriate behavior, provide reinforcement, and facilitate cooperation in-service recess supervisors on strategies for promoting positive behavior and ideas for age-appropriate play activities.
- Help teachers understand that throughout the school day, there needs to be balance between child-initiated and teacher-led activities, active and passive activities, and indoor and outdoor activities to maximize young children’s ability to attend to learning activities (Holmes, Pellegrini, & Schmidt, 2006).
- Ensure appropriate and safe equipment on school playgrounds.
- Pair AOTA Backpack Awareness campaign with a school-walking program.

Tier 2—Targeted (prevention and early intervention for students at risk of developing mental health challenges)
- Collaborate with the physical education teacher and playground staff to identify students who struggle with social participation or physical activity during recess time. Target play activities for this “at-risk” group by reducing barriers, modifying a playground apparatus, or by offering a range of challenges to this select group.
- Facilitate inclusion for children who may be at risk for social exclusion such as those living in poverty, those with differing sexual orientation, those in marginalized ethnic groups, and those who are overweight.
- Partner with physical therapists to provide obesity prevention programs.
- Offer staff trainings on bullying prevention and monitoring for signs of concussion. Work collaboratively with school nurses, social workers, and psychologists.

Tier 3—Intensive individualized interventions (for students identified with mental health challenges or illness)
- Modify activities and environments for greater inclusion for students with disabilities or mental health challenges.
- Promote social participation for children with emotional disorders by teaching peer models to provide pivotal response training (Harper, 2008).
- Form a motor skills play groups during recess time for students with identified coordination issues.

REFERENCES
**OCCUPATIONAL PERFORMANCE**

Social and emotional competencies (see Table 1) are required for successful participation in almost all areas of occupational performance. Examples include:

**Social Participation**
- develop appropriate relationships with others
- resolve conflicts
- resist inappropriate social pressure

**ADLs**
- understand social expectations and manners during eating
- recognize appropriate dress for the context
- use good judgment in personal safety and care

**Education**
- participate in social groups
- respond appropriately to criticism and feedback
- understand social expectations
- maintain academic performance despite frustrations

**Work**
- develop skills for obtaining and maintaining work
- set and make progress toward personal work goals

**Play and Leisure**
- cooperate during play and leisure activities
- develop relationships based on mutual interests
- regulate emotions during competitive games

**IADLs**
- set and make progress towards personal financial and transition goals
- recognize and use family, school, and community resources

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**SOCIAL AND EMOTIONAL LEARNING (SEL)** is defined as a process for helping children gain critical skills for life effectiveness, such as developing positive relationships, behaving ethically, and handling challenging situations effectively (Zins et al., 2007). Specifically, strategies that foster SEL help children to recognize and manage emotions, think about their feelings and how they should act, and regulate behavior based on thoughtful decision making.

| Table 1: Below is a list of the five SEL competencies, adapted from the Collaborative For Academic, Social and Emotional Learning (CASEL) |
| SEL Framework: |
| Self Awareness | identify one’s emotions, thoughts, interests, and values; understand how internal characteristics influence actions; maintain a sense of self-confidence and self-efficacy |
| Self Management | regulate emotions, thoughts, and behaviors across contexts; cope with stress and manage impulses; set goals |
| Social Awareness | understand subtle social and cultural norms and rules of engagement; take others’ perspectives; respect and empathize with others |
| Relationship Skills | establish and maintain relationships with others; resist inappropriate social pressure; work cooperatively; prevent and resolve interpersonal conflict; seek help when needed |
| Responsible Decision Making | accurately identify and evaluate problems; make decisions based on ethical and social norms; consider context in decisions; contribute to well-being on school and community |

According to CASEL, research shows that embedding SEL strategies within school curricula promotes improved behavior, academic performance, and social skills (Wilson, Gottfredson, & Najaka, 2001; Greenberg, et al., 2003; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). SEL skills directly influence academic, social, home, and work participation. As a national leader in the field, CASEL focuses on the development of high-quality, evidence-based SEL as a necessary part of preschool through high school education. For example, in 2004, SEL standards were developed in Illinois along with a plan to incorporate them into each districts’ educational program.

With research to support its effectiveness, it is important for occupational therapy practitioners to:
1. become knowledgeable about SEL and its implementation (e.g. read CASEL training materials);
2. determine if the local school district or state has adopted SEL standards or a SEL curriculum, obtain information about such initiatives, and assist in implementation; 3. identify school committees that may address SEL programming and volunteer to become a member; 4. embed SEL strategies into occupational therapy services (group, individual, and consultative); and 5. collaborate with other disciplines who may be conducting skills training to enable opportunities for generalization and practice in natural contexts such as the classroom, cafeteria, and on the playground.

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This information was developed by Lauren Foster, OTD, OTR/L, with contributions from AOTA’s 2013 School Mental Health Work Group.

This information sheet is part of a School Mental Health Toolkit at http://www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx
**OCCUPATIONAL THERAPY PRACTITIONERS** serve an important role in promoting SEL at the universal, targeted or intensive levels of intervention. Occupational therapy practitioners have specialized knowledge of the interaction of student contextual, psychosocial, and performance factors. Acquisition of SEL skills improves participation within and outside of the school setting. Teachers and occupational therapy practitioners can work together to infuse SEL strategies into the school day. For example, literature suggests that the school context (e.g. physical, virtual) influences SEL; Occupational therapy practitioners can help teachers modify and adapt the instructional materials and the environment so that students have more opportunities to learn SEL skills. Occupational therapy practitioners can also help school personnel create opportunities for SEL during non-instructional times (e.g. hallways, recess, after school programs, and lunch). This may enable increased contribution by occupational therapy in *Response to Intervention* and *Early Intervention* supports for students. School-wide and small group interventions across multiple authentic contexts have the potential to reach more students on a more comprehensive level than pulling students out for individualized, one-on-one therapy.

**LEVELS OF INTERVENTION:**

**Tier 1: Universal, whole school approaches focus on promotion**
- Help teachers infuse SEL interventions into instructional materials
- Implement interventions targeted toward all individuals. For example, have a ‘theme-of-the-week’ in which all teachers, staff, and students learn about and practice a specific SEL skill, like ‘identifying emotions’
- Promote positive peer interaction during recess (for more information see “Recess Promotion” information sheet that is included in the School Mental Health toolkit)
- Modify and adapt the environment to support a safe “bully-free” zone, so students can learn and practice SEL
- Evaluate lunch, recess, and hallway factors that promote or impede student participation
- Provide in-services to faculty and staff on specific SEL interventions
- Communicate (via email, in person, letters home) to family members on SEL strategies and interventions
- Screen all children for behaviors that suggest risk for impaired social and emotional development
- Promote routines for identification of student strengths and positive youth development
- Develop school-wide visual supports (e.g. posters) that display specific interventions. Because SEL strategies often involve learning about oneself and others, providing concrete examples through the school and day can facilitate learning for all students
- Work with educators to implement positive classroom management strategies

**Tier 2: Targeted strategies focus on accommodations for students at-risk**
- Develop groups that emphasize social and emotional skills
- Create a lunch-time group aimed at addressing the SEL framework
- Facilitate or co-facilitate a group targeted toward those who struggle with conflict resolution. Use strategies such as role-play, emotion identification, attribution, and other cognitive-behavioral interventions
- Identify student strengths and promote development of positive roles to create opportunities to generalize SEL successfully

**Tier 3: Intensive**
- Alter assignments and interventions to increase student sense of self-efficacy and confidence
- Support strengths-based interventions to balance focus on deficit reduction with identification and development of positive traits
- Teach specific behaviors, pro social skills, and advocacy strategies
- Establish sense of self confidence through independence in daily living skills
- Use skills in task analysis to modify group activities to specific needs of each student

**REFERENCES & RESOURCES**


“Extensive evaluations have found that SEL enhances academic achievement, helps students develop self-management and self control, improves relationships at all levels of the school community, reduces conflict among students, improves teachers’ classroom management, and helps young people to be healthier and more successful in school and life” (http://casel.org/).

A 2011 meta-analysis found that participation in SEL positively impacts student SEL competencies and prosocial behavior (Durlak, Weissberg, Dymnicki, Tayor, & Schellinger, 2011).

**CHECK THIS OUT!**

- The Collaborative for CASEL [http://casel.org/] offers policy, programming, and state specific initiatives.
- Do to Learn offers free, re-printable resources that can be used to teach SEL. [http://www.do2learn.com/]
- The Whole Child offers professional development, capacity building, and educational leadership resources at [http://www.wholechildeducation.org/](http://www.wholechildeducation.org/)
I recently read that the Centers for Medicare & Medicaid Services (CMS) is proposing new rules requiring community mental health centers (CMHCs) to create physician-led teams that include an occupational therapist.1 How can I approach my local CMHC to see if it would consider hiring an occupational therapist as part of its service team?

This is exciting news for occupational therapy practitioners interested in community mental health. This proposal is targeted toward CMHCs that provide Medicare-funded Partial Hospitalization Programs (PHPs). CMS is proposing conditions of participation with the purpose of establishing health, safety, staff, and provider requirements, and encouraging clients to participate in planning their care.2 Although the number of Medicare-funded PHPs is relatively small, the CMS rules are often considered when other programs are establishing requirements. It is therefore important for occupational therapists who have a passion for community mental health to be able to articulate the knowledge, skills, and services they can provide to the CMHC programs and clients.

One helpful tool for extolling the benefits of occupational therapy is the AOTA 2010 document Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice3, developed by AOTA’s Mental Health Competencies Ad Hoc Committee in collaboration with the Commission on Practice and approved by AOTA’s Representative Assembly. This document can help occupational therapy practitioners educate administrators, physicians, and providers in community mental health settings about the training and skills occupational therapists offer. The document has two sections. The first, Core Mental Health Professional Knowledge and Skills, addresses the entry-level knowledge and skills that occupational therapists share with other core mental health professionals. These skills are grouped into domains—Evaluation and Intervention, Professional Role, and Service Outcomes and Mental Health Systems—that include basic information on mental health conditions, medical and nonmedical evaluations and interventions, consumer and family partnerships, individual practitioners and interdisciplinary teams, mental health policy, and the systems that influence and provide care.

The second half of the document, Core Occupational Therapy Knowledge and Skills Applied to Mental Health Practice, addresses the unique contribution of occupational therapy to mental health service provision. Along with the previously noted domains, this section also includes the domain of foundational knowledge, outlining occupational therapy’s belief in the inherent need for all humans to participate in occupations that are central to engaging in life roles, interacting with the environment, and sustaining health and well-being. The three other domains contain items specific to occupational therapy evaluations and interventions focused on occupational engagement, the role of occupational therapy in a client-driven system, and the larger system of care.

The document lists 121 related and specific types of knowledge and skills that occupational therapy practitioners have when entering practice, delineating which items are characteristic of entry-level training for occupational therapists and which are characteristic of entry-level training for occupational therapy assistants. There are numerous details in the items, but the table format of the document allows occupational therapy practitioners to highlight those items that interest them and CMHC administrators to review the document and determine fairly quickly if occupational therapy is a good fit with their organization and mission.

References

Lisa Mahaffey, MS, OTR/L, is an assistant professor in the Occupational Therapy Program at Midwestern University, in Downers Grove, Illinois. She is a member of AOTA’s Commission on Practice.
OTs Walk With NAMI: Promoting Community Health and Wellness by Building Alliance and Advocacy

By Suzanne White, MA, OTR/L; Amy Anderson; and Amanda Roberts

“Each one of us has the capability to form an idea, seek an opportunity, knock on a door, and lead change. Now is the time for each one of you to take action which should include the three elements: values, ideas, energy.” —Penelope Moyers Cleveland (2008, p. 740)

Wellness is a conscious, deliberate process that requires a person to be aware of and make choices for a more satisfying healthy lifestyle. Achieving mental health through the recovery process includes wellness. As such, programs like The 10 by 10 Campaign have noted the importance of overall physical health as an essential component of mental health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010; Swarbrick, 2010). In 2007, through the organization of the New York State Occupational Therapy Association’s (NYSOTA’s) Mental Health Task Force of the Metro New York District (MNYD), occupational therapy students, faculty, and clinicians met to plan a community outreach initiative to expand their wellness advocacy role in the practice of mental health occupational therapy.

Each year, occupational therapy faculty, clinicians, and students are encouraged to form partnerships with mental health facilities throughout New York City and the local chapters of the National Alliance on Mental Illness (NAMI). The project’s aim is to provide support and encouragement to consumers to actively increase physical activity by making walking part of their daily routine as a health benefit and to promote self-advocacy by participating in the NAMI-NYC Metro NAMIMWalk crossing the Brooklyn Bridge (Tewfik & White, 2007). This annual NAMIMWalk is a joint effort of NAMI national and local chapters to fundraise for their organization in order to provide free education and family support. MNYD Mental Health Task Force leaders envisioned that occupational therapy students, supported by faculty and clinicians, would introduce the OTs Walk With NAMI program to consumers during their fieldwork and would start walking groups throughout New York City (Haiman & Learnard, 2010). The collective goal is to foster physical wellness, combat the negative effects of chronic illness, promote mental health awareness, and promote consumer advocacy.

OTs Walk With NAMI is a Web-based program with online materials and resources. It is designed to use evidence which shows that weight control and physical exercise are effective physical and mental health interventions for this population. The program includes detailed protocols, goals, session plans, evidence-based articles, and outcome measurements. The program also includes an annual walk preparation tool kit and fundraising ideas, tools to monitor changes, a consumer-friendly video, and PowerPoint presentations to help make walking become part of a wellness routine. The project coordinators created a Web site repository of accessible program materials to be shared and serve as an inspiration for students and consumers [http://www.downstate.edu/CHRP/ot/nami.html].

Community Health and Wellness

Interventions for prevention and health promotion in mental health communities need to match the challenges of the affected population. Physical exercise has been known to have many benefits, physically and mentally, that are recognized universally (Parks, Svendsen, Singer, & Fott, 2006). The positive impacts of physical exercise include weight loss, reduction in cardiovascular complications, relief from depression, and reduced stress and anxiety (Priest, 2007). It is well known that the recovery oriented populations include both co-occurring physical and substance-dependent disorders. These populations are considered vulnerable due to an increase in mortality and morbidity which is largely due to treatable medical conditions that are caused by modifiable risk factors, such as lack of exercise, smoking, and lack of access to medical care (Parks et al., 2006; Virmani, Binienda, Ali Syed, & Gaetani, 2007). Therefore, access to exercise could greatly benefit this underserved population in multiple ways (Brown, Goetz, Van Sciver, Sullivan, & Hamera, 2006; Ogilvie et al., 2007; Siegfried, 1998).

Many populations that would show the most benefits from exercise are, in turn, the populations with restricted access to physically active lifestyles (e.g., persons with co-occurring mental illness and substance-related disorders). SAMHSA recognizes that co-occurring disorders are widely present in this population and need to be treated concurrently. Physical activities are not often included as a structured part of many programs due to perceived and actual barriers that include cost, available time, staff training, client motivation and precautions for those who have not exercised in a long time (Emerson, Glovsky, Amaro, & Nieves, 2009; SAMHSA, n.d.).

Building Alliances

Staff from both the NAMI national office and local NAMI NYC-Metro welcomed the idea of building a large base of support with
this occupational therapy program. NAMI was established in 1979 and has, since then, been dedicated to the advocacy, support, education, and research related to mental illnesses. NAMI focuses numerous efforts on educating the public on mental illness. It provides resources to decrease stigma and increase awareness of the disease. It promotes understanding into one’s own illness and how to maintain a healthy lifestyle with the disease. Programs provide education, information, insight, and support networks, which were drawn from the feedback and advice of professionals, but most importantly, from those individuals who have lived with a mental illness (NAMI, n.d.).

As the OTs Walk With NAMI program developed, NAMI recognized the thoughtfulness with which the project considered the needs of the consumers by providing them with a no-cost method to engage in physical wellness activities and tying this into a larger recovery intervention. NAMI and its affiliates also appreciated the use of consumer-friendly adaptive designs of the professional materials for its members. NAMI staff members are fully committed to the project and speak each year at the OTs Walk With NAMI pep rally to educate diverse audiences about NAMI’s purposes, free programs, and the NAMIWalk.

To build alliances with occupational therapy students, the MNYD board of managers decided the OTs Walk With NAMI project was an opportunity to introduce students to its professional organization. The board initiated an annual pep rally open to all of the metropolitan New York area occupational therapy education programs. The pep rally introduces the occupational therapy and occupational therapy assistant students to the district, the OTs Walk With NAMI program, NAMI, and the wellness and prevention group protocols, which are designed by clinicians and/or students and are based on evidence and supporting the tenets of occupational therapy. This gives the students ideas that they can use during their mental health fieldwork or community practice courses.

This is a City University of New York College occupational therapy student’s reaction after participating in the NAMIWalk. She stated,

NAMI 2011 was a great experience. While you’re out collecting donations, you realize that you also get a chance to advocate for OT and NAMI and it works! You also get a chance to meet people in other professions and walks of life who support the cause as well. Every year it’s more exciting than the last.

To build consumer alliances, Eileen LaMourie, an occupational therapy student at SUNY Downstate Medical Center, designed a 12-minute motivational video (Doyle & LaMourie, 2008) for the project as part of her community practice coursework. She explained,

Oxidation is a national problem; it’s not just a problem for people who are at risk for metabolic syndrome. I really started to think about how we were going to best facilitate going into outpatient centers and clubhouses, presenting people with this walking program, and then expecting them to get up and actually start walking. I wanted to do something dynamic. (as cited in Strzelecki, n.d.)

Jeni Dulek, a senior occupational therapy clinician at St. Luke’s, worked extensively with a client before the Walk to address the anxiety he felt related to getting to the Walk on time, and by himself. As a result of their work, the client wrote the article below. It sums up why anyone would want to be involved in the NAMIWalk, and particularly why occupational therapy practitioners and students should consider getting their clients involved for health, wellness, and self-advocacy. You see the results of their work together as reflected in the client’s writing:

I saw my psychologist, my OT, and my peers. It was a wonderful feeling to be a part of something I search for: community. And the positive feeling lingered long after the walk was over, and in my heart I felt hope.

Building Evidence: Evaluating a Walking Intervention Based on the OTs Walk With NAMI Protocol

This group walk took place at Starhill Palladia Inc., a 400-bed residential substance abuse facility located in Bronx, NY. Many of the residents at Starhill have co-occurring conditions and are court mandated to participate in the program. At the time of this intervention, the residents did not have a consistent outlet for physical exercise. The OTs Walk With NAMI protocol was adapted by two of the authors (Anderson and Roberts) as part of their Psychosocial Fieldwork I and Master’s Research Project at SUNY Downstate Medical Center. They designed the Mind and Body Wellness Scale which is composed of six questions that address present levels of energy, tension, self-confidence, social mood, worrying thoughts, and openness to new ideas. The scale was used to quantify the intervention outcome. The goal was to demonstrate that walking can be a positive leisure activity that may be used when replacing old habits that are be deemed harmful to recovery or wellness. Feedback about the members’ experiences was collected with the aim of providing insight for future development and continuation of walking groups.

This group walk took place once a week for an hour, which included walking for 45 minutes and then spending 15 minutes on processing, which included self-assessment, group stretching, and discussion. For each walking session, a pre- and posttest were used for the Mood Scale (which is part of the original protocol) and the Mind and Body Wellness Scale, which were self-administered and self-reported. Throughout the 12 weeks, participants volunteered to stay after the walk to answer interview questions that would provide qualitative feedback about their personal experience.

The interview was based on two open-ended questions: (a) Do you feel that this group will benefit you during your recovery? (b) Do you plan on incorporating walking into your life as a positive leisure activity? If so, in what ways?

The walking group members were educated about NAMI services throughout the 12 weeks. The last meeting of the walking group was composed of a presentation by NAMI to prepare the members for participating in the annual NAMIWalk in May. Many members of Starhill were excited about participating in the event, and they felt a sense of accomplishment and involvement in this meaningful activity. Seventeen members were able to attend the NAMIWalk.

The overall walking group consisted of 42 participants, who varied in attendance. The following are the results of the Mind and Body Wellness Scale, a six item assessment with a 4-point Likert scale questionnaire, interview questions, and written comments. To determine differences between mean scores for the overall Mind and Body Wellness Scale, a paired sample t-test was calculated, resulting in a statistically significant difference from pre- (mean=18.11) and post-test scores (mean=21.33). These six questions were also examined
individually to see whether any area had a greater effect than others. The question relating to body tension had the greatest difference, meaning that after the walk the participants felt less tense. Closely following was change in energy level, showing an increase in energy directly following the walk.

The decision to implement the OTs Walk With NAMI program for members at the therapeutic drug community at Starhill was built upon the need to integrate physical exercise with mental health care in efforts to provide a healthy and supportive recovery. One member shared, “My walk was very enlightening and very stimulating mentally as well as physically. This walk does my body and heart very good towards maintaining my health.” (sic)

The results supported our efforts in providing a positive leisure activity that would promote health and wellness. The results displayed improvement for the group overall as well as individual improvement for each member’s mood after each walk. All of the areas of the Mind and Body Wellness Scale were hypothesized to be positively affected by participating in group exercises, which our results supported. Another member shared that, “Since I began the walks, I have experienced a great deal of physical and emotional recovery.”

Feedback from members emphasized a need for motivational support, showing the effectiveness of a group atmosphere to positively influence socializing and to be a motivating factor for adherence. The social aspect resulted in a valuable impact on the members, facilitating an increased ability to communicate and relax with one another during walks. This was portrayed as extremely beneficial in building supportive relationships in a time and place that is often regarded as stressful and challenging. The walking group reflected a holistic approach to health and recovery that recognizes the importance of encouraging wellness. Members repeatedly reported that they felt healthier in their bodies as well as their minds.

The study demonstrates the adaptability of the OTs Walk With NAMI program. The intervention feedback supports recovery components by integrating mental illness and substance-related disorders, and providing opportunities for links to health, wellness, and self-advocacy.

As occupational therapy practitioners look to expand the wellness and prevention aspects of their practice, the holistic benefits of a walking group should be considered. The positive results of this group walk for participants were many, including gaining a sense of control of their health, releasing tension, getting social support, and becoming motivated to exercise. The results of this walking project provide a continuing basis of support to encourage both inpatient and outpatient facilities to include walking groups as a therapeutic activity. It is important to highlight that this activity is not only free, but has a positive impact on clients and encourages self-care strategies for maximizing health and independence.

Conclusion

The OTs Walk With NAMI project is multi-purpose, as it provides an adaptable Web-based intervention, and builds a coalition of educators, clinicians, students, fieldwork sites, and an advocacy organization. It supports recovery while preserving and expanding the rich heritage of occupational therapy mental health practice. It educates students about the power of advocacy by joining with consumers to promote participation in society for an underserved population, where stigma can prevent people from receiving evidence-based wellness and recovery interventions. For additional inquiries about OTs Walk With NAMI, contact Suzanne White at Suzanne.White@downstate.edu.

Acknowledgements

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References


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Using Evidence to Inform Occupational Therapy

AOTA offers members a series of important EBP resources to guide practitioners with clinical decision-making, discuss the value of OT interventions with clients and external audiences, stimulate academic and continuing education programs, share with students as they develop critical appraisal skills, and guide the development of clinical research projects.

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- Critically Appraised Papers (CAPS)
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In honor of supporting advocacy and the local community, the 2011 Massachusetts Occupational Therapy Association (MAOT) conference committee asked members of Waverley Place, the Belmont, Massachusetts, community support day program of McLean Hospital, which serves adults living with mental health issues, to create MAOT conference centerpieces this year.

Over several months leading up to the conference, which was held October 28 in Norwood, Massachusetts, members worked together on decorating boxes for the centerpieces. Waverley Place members regarded the making of the boxes as part of their creative approach to recovery. Julie, for example, said she felt the process of making the box had real consequences and meaning, more so than any other project she had worked on in the program’s art room. It provoked anxiety for her, however, so I paired her with the “just right” member to build on that sense of camaraderie within the program. Julie found the confidence and safety she needed to follow through with the creative process and face the fear of engaging in a new occupation.

After she finished making the box, Julie said she felt a sense of accomplishment and acceptance, stating, “Little increments in my recovery, like working on this box, spring me to do more positive things and talk to more people.” Her small, yet significant, choice to engage and make the box with her community for another community led her to make more positive changes in her recovery.

As the occupational therapist of Waverley Place, I am continually thinking of innovative ways to connect members’ meaningful roles and occupations with the sense of community and recovery. At the conference, whose theme this year was Advocacy: Inside the Bedrail and Outside the Box, keynote speaker Julia Fox Garrison, author of Don’t Leave Me This Way (or When I Get Back on My Feet You’ll Be Sorry), discussed the importance of not letting “the system” dictate the direction, pace, and objectives of one’s recovery, an approach that is also given great emphasis within our program.

Within Waverley Place’s art room, which serves as a setting for building and strengthening the occupation of social participation through projects as MAOT centerpieces, members have opportunities to relate to others, express themselves, practice self-regulation, explore and strengthen healthy leisure activities, and socialize. Members get a say in what projects they do, pick and purchase supplies, and collaborate with outside agencies, which helps to strengthen decision making skills, leadership roles, budgetary skills, and community interaction. Most importantly, members working in the art room continue to build and strengthen personal relationships and a sense of belonging.

Conference attendees were asked to reflect on this
Two themes are apparent in their feedback: connecting communities and valuing our clients. Attendees felt the boxes raised the occupational therapy community’s awareness of recovery for adults with mental health issues and most likely raised the program’s knowledge of occupational therapy. The boxes “help [Waverley Place members] feel a part of our community as well as us [feel] a part of theirs and are a reminder that we are all in this [recovery] together,” said one attendee. Attendees commented on the placement of the box in the center as a symbolic gesture of our professional core value of autonomy; that, as one attendee said, “All individuals have value and should be in the center of all decisions in their own recovery in one way or another.”

Through creativity, education, and advocacy, individuals can navigate their own recovery journey in the most meaningful way. At Waverley Place, we do this by linking our own roles, strengths, occupations, and personal experiences to the sense of community and belonging that has been created at the program—and in the art room.

I encourage occupational therapy practitioners everywhere not to downplay the important role that the social context and demands play on every occupation we engage in. After all, the only aspect of our lives that is self-sustaining is our relationships.

Please support and advocate for your profession by joining your state’s occupational therapy association. MAOT plans on connecting with another local community by recruiting them to create next year’s conference centerpieces. For more information as it becomes available, visit www.maot.org.

Reference

Megan Fowler, MS, OTR/L, is the community services occupational therapist at Waverley Place in Belmont, Massachusetts.
An Exploratory Study of Social Participation in Occupational Therapy Groups

Mary V. Donohue, PhD, OTR, FAOTA; Henry Hanif, MA, OTR; and Lilya Wu Berns, BS Psych., BS OT

Evaluation of social behavioral changes in occupational therapy activity groups is an objective that clinicians hope to achieve to build up evidence-based practice with interventions and research in psychosocial treatment groups (Gutman, 2010). The World Health Organization (WHO) encourages therapists to assist in social rehabilitation through the guidelines of the International Classification of Functioning, Disability and Health (ICF; WHO, 2001). An exploratory study was designed using Social Profile (Donohue, 2010) scores of levels of social interaction to examine the changes in social participation in psychiatric occupational therapy activity groups following 1 month of intervention with a full spectrum of activities. It was hypothesized that the social participation scores of study participants would improve after 1 month of intervention in occupational therapy groups, as measured by the Social Profile (Cole & Donohue, 2011).

Treatment Intervention and Research Design

This was an exploratory, descriptive study of 31 individuals receiving psychiatric occupational group therapy on two similar units, measured by using a pretest and posttest design, examined at the beginning and end of a month’s stay on their units. The design includes a post hoc power analysis.

Procedures

Treatment modalities. The daily sessions designed for participants in this study included activities with social participation, such as planning a meal, cooking, grooming, doing wood crafts, listening to music, managing stress, participating in patient government, getting assertiveness training, learning life skills, movement to music, setting goals, and planning a weekend. These activities encouraging social participation were organized as opportunities to practice social skills in occupational therapy groups on two psychiatric units. The activities were selected to reflect a variety of psychosocial, physical, and cognitive components.

Concepts for group levels of participation. This study used the Parten (1932) and Mosey (1986) five ordinal developmental levels of social participation to gauge the progress and appropriateness of group interaction for a variety of activities. The five levels are: (1) Parallel, (2) Associative, (3) Basic Cooperative, (4) Supportive Cooperative, and (5) Mature. Table 1 provides definitions and examples as a continuum of these concepts to clarify their meanings and enable more rapid comparison of levels of participation. These concepts will be expanded upon in the Methodology section, as they are the major concepts of the Social Profile, the assessment tool used in this study.

Group Treatment Levels

Single level group activity participation. In practice, single level group activities are less common than groups with multiple levels of activity participation in each session. For the sake of clarity, activities such as moving to music, and participating in yoga and tai chi, provide opportunities for adults that are parallel in nature, with some awareness of others present, but without social interaction. At the Associative level adults are encouraged to carry out brief social greetings in the occupational therapy groups and on the unit. Adults playing games such as charades, baseball, and cards work at a Basic Cooperative level during the game. Eating a meal together that they have prepared may stimulate interaction at the Supportive Cooperative level.

Table 1. Levels of Group Participation of the Social Profile Assessment Tool

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parallel level</td>
<td>Group members listen, work, or play next to each other without interaction.</td>
<td>Yoga class</td>
</tr>
<tr>
<td>Associative level</td>
<td>Group members have brief verbal or nonverbal interactions.</td>
<td>Call-name, ball toss</td>
</tr>
<tr>
<td>Basic Cooperative level</td>
<td>Group members can select and perform in longer periods of work and play, following rules.</td>
<td>Soccer, card game</td>
</tr>
<tr>
<td>Supportive Cooperative level</td>
<td>Group members understand and fulfill others’ emotional needs. They frequently express feelings. Goals are secondary to camaraderie and interactions.</td>
<td>Student elections</td>
</tr>
<tr>
<td>Mature level</td>
<td>Group members take a variety of roles, combining the Basic and Supportive Cooperative level skills to achieve goals.</td>
<td>Audubon club</td>
</tr>
</tbody>
</table>

Vote for MHSIS Chairperson

Online voting begins in January for the next chairperson of the Mental Health Special Interest Section. Go to AOTA’s Web site at www.aota.org for details.
Commitment to complete the Social Profile and the need to fill out the work time to observe one patient per month due to the time commitment. The study was conducted for 16 months, as the therapists were only allotted social participation observed one patient per month. The study had two occupational therapists carrying out the assessment of therapy group environment, as well as to appreciate and enjoy challenging social interaction levels skills in the supportive occupational therapy leaders to gradually try out more complex and challenging social interaction levels in the schedule. Combinations of Social and Supportive Cooperative level activities were provided about 30% of the time; and combinations of Supportive Cooperative and Mature level activities were provided about 30% of the time. These types of groups were offered in an effort to provide balance in experiencing a spectrum of activities at a variety of levels of participation.

Patients in these groups were encouraged by the two occupational therapy leaders to gradually try out more complex and challenging social interaction levels skills in the supportive occupational therapy group environment, as well as to appreciate and enjoy participation in all group levels.

Therapists’ Observations

The two occupational therapists carrying out the assessment of social participation observed one patient per month. The study was conducted for 16 months, as the therapists were only allotted work time to observe one patient per month due to the time commitment to complete the Social Profile and the need to fill out the assessment tool twice, once at admission and once at discharge from the occupational therapy groups.

Participants. A convenience sample of 31 adults with psychiatric diagnoses from two similar inpatient general psychiatric units was used in this study. The criteria for admission to the study limited the participants to those who were able to attend the activity groups on a regular basis during their 30-day stay on the unit and were capable of participating in the activities.

Conditions. The participants in the study included patients with diagnoses of bipolar disorder, major depression, schizo-affective disorder, and schizophrenia. Initially, patients in the activity group frequently manifested negative symptomatology with behaviors such as lack of eye contact with other group members, disinterest in the statements of other participants, and inability to be assertive about their needs and desires. This study received ethics approval from the Beth Israel Medical Center and New York University’s Human Subjects Review Board. The participants in the study provided written, informed consent to the Institutional Review Board.

Methodology Designed To Examine Levels of Social Participation in Activity Groups

Measurement. The Social Profile was used in this study to examine social participation behaviors during occupational therapy groups. The Social Profile is a measure of social interaction in activity groups in families, schools, clinics, clubs, cultural groups, sports, political groups, and community groups. It is designed as a developmental sequence of interactive abilities in a progression of increasingly complex social skills. Based on the work of Parten (1932) and Mosey (1986), the Social Profile reflects the principles of the WHO’s ICF (2001). The ICF section on Social Participation emphasizes interpersonal interaction, relationships, community, and social and civic life as essential to health and daily activities required for participation in recovery.

The Social Profile has 39 items that can indicate the percentage of time spent at several participation levels during an activity in a group. The five levels are rated on a 6-point Likert scale. Higher Likert scores indicate increased social participation. Previous studies of the Social Profile indicate that it demonstrates good validity and reliability (Donohue, 2003, 2005, 2007).

Data Analysis Protocol. Data was analyzed using the Statistical Package for the Social Sciences (SPSS; Version 17, 2008). Because the Social Profile includes five developmental levels in an ordinal scale, as well as Likert interval ratings, both parametric and nonparametric statistical tests were used to examine the test and re-test results. A Wilcoxon signed ranks test, a nonparametric test, was used to examine the change in the Social Profile Likert scores of the participants before and after occupational therapy activity group intervention. In addition, a parametric t analysis was carried out to measure the difference between participants’ pre- and posttest scores to address both parametric and nonparametric dimensions of the Social Profile scaling.

Results

The descriptive statistics indicated that the subjects’ pretest scores on the Social Profile had a mean of 62.58 with a standard deviation of 13.961, and posttest scores of 83.23, with a standard deviation of 18.031. A skewness test examining the distribution of the pre- and posttest scores indicated that both pre- and post-test data were normally distributed, with no significant skewness.

The Wilcoxon signed rank test analysis of the pre- and posttest scores showed that there were no tied scores, and 29 out of 31 participants had higher posttest ranks than their pretest ranks. A one-tailed test was used, as it was expected that the results were going in a positive direction, with the data scores from the posttest of the
Social Profile improving over a month’s time of occupational therapy activity group process intervention with five levels of groups ($Z = -2.220, p < .0001$). According to the results of the Wilcoxon signed ranks test, the posttest score is statistically significantly higher than the pretest scores. The $Z$ symbol is used by SPSS (2008) for the final calculation of the Wilcoxon test, whereas Kielhofner (2006) and Stein and Cutler (2000) use a $T$ symbol for their final Wilcoxon calculation.

A paired-samples $t$ test showed a mean of $-20.645$ (SD = 15.248, df = 30). The results of this $t$ test yielded $-7.538, p < .0001$, indicating statistically significant higher posttest scores on the Social Profile after the occupational therapy activity group treatment was provided for 1 month (see Figure 1). The graph in Figure 1 illustrates the paired $t$ test scores on a box-and-whisker plot, indicating considerably higher scores following occupational therapy intervention.

A power analysis using G*Power (Dusseldorf University G*Power 3, 2010) indicated a power of 0.835357, with an effect size of 0.5 for this study’s paired $t$ test. An effect size between 0.3 to 0.5 is considered moderate by social scientists, so the effect size of 0.5 in this study with an $N$ of 31 is moderately important or meaningful (My Environmental Education Evaluation Resource Assistant, 2008).

Conclusions

This study examined social participation changes in group behaviors of 31 people receiving 1 month of inpatient unit psychiatric services including occupational therapy activity group psychosocial interventions and unit psychiatric services. There was considerable improvement in Social Profile scores from the pretest to posttest observations, according to both the Wilcoxon and the $t$ test analyses. These results are positive but are tempered by the small sample size of 31 participants and the lack of a comparison group. However, these results indicate that the Social Profile is sensitive enough to illustrate change in social participation levels, as had been expected by the hypothesis of this study.

The occupational therapy group activities were designed by the occupational therapists to provide a variety of psychosocial, physical, and cognitive experiences. The general goals for these groups addressed behaviors suitable for the five levels of social participation appropriate for each activity. While this exploratory study sample was 31 participants, the results suggest that occupational therapy group activities may assist in learning or recovering social participation skills, as measured by the Social Profile.

For the future, a study with a comparison group design is recommended to include a control group to offset the limitation in this study of psychosocial treatments simultaneously offered by multiple professionals on the unit (Scheinholtz, 2010). One group that would be valuable to compare with patients who do attend groups regularly is patients who generally do not attend occupational therapy groups on a consistent basis. This would enable the study to provide an internal occupational therapy contrast, ruling out influence by additional professional intervention on the unit.

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Living Life To Its Fullest"
Drama: Still a Tool for Healing and Understanding

Heather Javaherian-Dysinger, OTD, OTR/L, and Michelle Ebert Freire, MFA

Many of us enjoy going to a performance, whether it be a play, musical, or movie. Depending on the story line, we may laugh, cry, or learn something new about ourselves or the world in which we live. Not only does the audience grow from the performance, the actors grow as they develop their character, and find ways to make sense of the characters’ experiences and circumstances. An actor uses all the resources that are available to him or her such as research, observation, and perhaps most importantly, self-reflection, to make a personal connection between his or her real life and that of the character. For a professional actor, this process is part of the craft. For an individual in a therapeutic milieu, the opportunity to experience acting or drama opens a door to exploring and embodying behaviors, feelings, and attitudes. This can be a transformative experience with a considerable effect on one’s personal journey.

Drama is a means of self-expression; the actors share a story conveyed with emotions, symbolism, and meaning. The use of drama in occupational therapy for clients with mental illness dates back to the early 1920s and 1930s (Phillips, 1996). Drama initially provided opportunities for active engagement and socialization, and later evolved into a means of exploring repressed emotions and psychosocial issues. The therapeutic benefits of drama were realized when activities such as role playing were employed in more traditional forms of therapy. Action-oriented approaches introduced in the mid-20th century such as Gestalt therapy, play therapy, and especially psychodrama, further revealed the benefits of “creative processes to help clients express and resolve problems” (Landy, 1994, p. 17). Beginning in the mid-1970s, practitioners began employing the use of structured dramatic activity as a primary therapeutic process (Landy, 1994), eventually leading to the creation and codification of specific drama therapy techniques and the oversight of the National Association for Drama Therapy. Drama therapy is an active experience through which drama is intentionally used to set and achieve therapeutic goals, express feelings, reduce symptoms, develop interpersonal skills, build self-esteem, and foster personal growth (National Association for Drama Therapy, n.d.; Phillips, 1996).

Therapy Techniques and Goals
As the field of drama therapy grew, practitioners created and implemented their unique techniques, often blending concepts of drama therapy with those of education, sociology, performance theory, and other therapeutic methods. One such technique is narradrama, which uses the concepts of narrative therapy, “an approach that strives to separate the person from the problem and helps the client create alternate stories to replace problematic ones that are prevalent in their lives, and combines them with drama and other creative arts therapies” (Dunne, 2006, p. 22). Often done in community settings with people who have mental illness, narradrama uses a variety of methods to help individuals tell their stories so their unique experience of life can be better understood. Narradrama is a process-oriented technique that also incorporates performative elements, such as the creation and presentation to others of a restored script, also known as life script. A life script performance “is a live performance with aesthetic and personal elements that highlights...a significant current aspect of an individual’s life” (Dunne, 2006, pp. 217–218). It portrays the individual’s life stories, identities, and unique experiences, and externalizes internal struggles and emotions.

Mental illness is a disease accompanied by numerous social justice issues, such as stigma, discrimination, and inequality. A survey by the Mental Health Foundation showed that “56% [of clients with mental illness] reported experiencing stigma within their own family, 51% experienced it from friends and 47% said they had been harassed and abused in public” (Twardzicki, 2008, p. 68). So persons with mental illness not only deal with their disease, they often face a daily battle of discrimination within their own family, community, and the greater society. Society’s misperceptions, such as classifying them as “others” and creating barriers to employment, social engagement, and health care, also create a misunderstanding of individuals with mental illness. No longer are they seen as a “friend,” “colleague,” “parent,” or “son,” but as a diagnosis. This stigmatization negatively affects their recovery process.

Individual and Community Benefits
People with mental illness have a story to tell. Many have creative talents and artistic abilities as they express their life experiences and perspective through media such as painting or poetry. These creative talents and abilities can be channeled in a therapeutic fashion to help individuals engage in self-expression, develop a positive self-identity, connect to their community, and transition through life (Petridou et al., 2005; Van Lith, 2008). Twardzicki (2008) used performing arts with people who had mental illnesses to promote social inclusion and to challenge stigmas associated with mental illness. Students from a partnering college who were involved in the project reported an increased understanding of mental health issues, more positive attitudes toward mental health, and more empathy for people with mental health issues, and stated that they were willing to help people with mental health problems. Similarly, Essler, Arthur,
Jefferson Transitional Program (JTP) is a peer-run program that serves individuals who have a mental illness, substance abuse diagnosis, or both. Through a variety of programs, JTP helps participants transition into employment, education, and citizenship, and emphasizes principles of hope, personal responsibility, and empowerment. Recently, JTP received a county grant from the health department to establish “Art Works,” a therapeutic arts program. The program offers workshops and classes in various visual and performing arts media, such as drawing, wire sculpting, crafts, drama, expressive movement, and creative writing, as well as a gallery that displays and sells artistic works created by program participants.

Another aspect of the Art Works program is the Performance Troupe. Students and two faculty members from Loma Linda University's Department of Occupational Therapy were invited to observe the theatrical process and to develop evaluation tools to assess the Performance Troupe's effectiveness for the peer participants as well as the audience. These outcomes were beneficial not only for program grant and funding efforts but also to make sure that the program was meeting the mental health needs of the JTP participants.

Through a process facilitated by a theatre educator and drama therapist, five peers at JTP used a life scripts approach to devise, rehearse, and perform an original play titled Scrambled Eggs. This play told their stories and reflected their fears, strengths, and journey to recovery.

Devising and Rehearsal

The National Alliance on Mental Illness (NAMI) uses a peer-led recovery model that details five elements of recovery: Dark Days; Acceptance; Treatment; Coping Strategies; and Successes, Hopes, and Dreams. Participants complete training in a program called “In Our Own Voice,” in which they make presentations detailing their own and others’ stories of the road to recovery. Since the peers at JTP worked with this model and were familiar with it, either as presenters or viewers, it was used as a framework for the devising process and the organization of the script. Seven sessions were devoted to devising, or developing the material.

Each session began with ensemble exercises designed to establish an atmosphere of trust and mutual respect among the participants. Following these exercises were central activities that delved into a major component of the recovery process. The first session explored a “big picture” of mental illness and what it means to those who hold a diagnosis and to others who do not. The next five sessions were devoted to one of the five elements of the recovery process. For example, the second session focused on “Dark Days.” Each participant of the peer group used markers, crayons, and colored pencils on a large sheet of paper to write and draw words, pictures, and symbols expressing his or her own version of a dark day. They then posted their papers on the wall, and the group quietly walked through the “Dark Days Gallery.” Afterwards, the Performance Troupe director guided them through a series of sound and movement activities to explore some of the words, themes, and images that were present in the gallery.

In the next step, the group worked in pairs to share true, personal Dark Days stories. One partner then shared the story of the other in a “once upon a time” fashion with the rest of the group. Finally, the group discussed and processed thoughts and emotions they had experienced in sharing and witnessing the stories. The final session explored aspects of the performer’s stories that they felt merited further attention.

Other activities included designing a map of one’s self-acceptance process; creating a board game dealing with the individual’s experience with treatment; writing stories using a representative animal protagonist coping with a problem; and writing poems about successes, hopes, and dreams. Next, aspects of these activities were explored dramatically using a combination of improvisation, drama therapy, psychodrama, and Playback Theatre techniques such as sculpting, which involves creating group images with bodies; “fluid sculptures” (i.e., moving body images with sound); storytelling; improvised scenes; minimally rehearsed mini-performance pieces; role-reversal and “doubling” (someone speaking someone else’s inner thoughts); talking to an important being using an empty chair; and many more. Discussion was integrated throughout the process as the performers actively reflected on their emotions and experiences.

After the devising sessions, the Performance Troupe director used the material created from the seven sessions, which included writings, drawings, posters, and recorded videos, and organized it into a cohesive script. Nearly the entire script used the participants’ actual words. As the performers moved into the rehearsal phase they read the script repeatedly and modified it to better reflect their individual stories.

Rehearsals

Next came the rehearsal period. Each rehearsal session began with a series of warm-up activities, leading to the major focus in a central activity such as blocking a scene (determining where and how the performers move onstage to best tell the story); or acting exercises to help develop the physical, vocal, and imaginative skills necessary to bring the story to life before a live audience. Each session culminated in reflection and a closing activity. This process was essential in preparing the performers for acting and rehearsing their lines as it helped them to relax and begin exploring their creativity. After 2 months of rehearsal, the group performed for their peers and then held evening performances for family and the community.

Evaluating Program Effectiveness

Graduate occupational therapy students from Loma Linda University collaborated with JTP staff to develop evaluation tools to assess the effectiveness of the Performance Troupe program. This project was approved by the affiliated university’s institutional review board. The students developed a 40-item survey that addressed the perceptions and experience of being a member of the Performance Troupe. A 7-item audience survey was designed to assess potential change in the audience’s perceptions of mental illness. Four survey items rated
the performance and audience members’ perceptions using a 5-point Likert scale, ranging from “Strongly Agree” to “Strongly Disagree.” The final three items were open-ended questions expanding on the audience members’ perceptions of mental illness after watching the performance. In addition, the students asked the audience a series five open-ended questions to facilitate live dialogue between the performers and the audience after the show.

Audience Perception: “It has opened my eyes”

Twenty-eight audience members from three different performances completed and submitted an audience feedback form. Nearly all audience members (89%) indicated having a more positive view and understanding of mental illness after viewing the performance. They saw people with mental illness as sons, daughters, husbands, wives, and friends. They realized that they were real people like themselves. Eighty-nine percent noted that the performance was clear and easy to follow. One member commented, “It just brought it to life. Took it out of the textbook.” The performers captured the essence of mental illness and what it was like to live with it. Audience members understood the pain of depression as they watched the story of a young girl unfold; a girl abused by her father, a girl cutting herself in an attempt to relieve her pain. They saw the man gambling and spending everything he had as the mania took over, only to realize that everything that was important to him—his family and his sense of pride—was gone, too. They saw the performer’s journey to a place of understanding, acceptance, and perseverance as they won their battle with mental illness.

The Performer’s Perceptions: “Awesome”

The Performance Troupe experience was powerful for the five peer participants. First, it provided a means for the participants to safely explore and process their own struggles and victories with mental illness in a non-judgmental environment. Secondly, it empowered the participants. By sharing their stories with audiences, they became ambassadors for raising awareness and understanding of mental illness, whether through the message to others with mental illness that they are not alone, or through the message to family members, friends, and caregivers that people with mental illnesses think, feel, and contribute to society. Lastly, it helped the peers to show the audience and community that the journey they travel towards healing is very, very difficult. In their individual stories and metaphors, they were able to convey their fears and efforts at denial, as well as the pain of facing societal stigma, challenges within the health care system, and living with the side effects of medication. They were able to show that their journey to healing will continue as they grow and experience new jobs, relationships, and families. Sharing this empowered the five participants and opened doors, allowing many others to understand them.

By acknowledging their own struggles, the performers were somewhat freed of the stigmas that held them captive. For Donald, having mental illness felt “like a hard game, a really hard game to win.” Each day he had to wake up and play; there are no days off. It is a continuous journey. There were many emotional times throughout the process as the performers confronted painful memories, yet with the support of their peers and the troupe director they worked through them, focusing on the journey, the process, and their accomplishments. Sal shared, “It [the Performance Troupe] allowed me to share a lot of personal things. It’s been very beneficial to share a lot of things that I haven’t been able to share in other groups and stuff.” Being able to step into a character, even though it was his own character, created a safe place for Sal to share experiences that contributed to the onset of his illness. He found performing to be a more effective therapeutic outlet than traditional groups that he attended in the past. Similarly, Angela noted that the Performance Troupe “helped me work through several really underlying issues in my life.”

The performers described many other benefits of the Performance Troupe. They acknowledged that it helped them develop their interpersonal skills and work through issues. Josh commented, “Ever since I started the Performance Troupe my self-esteem has dramatically increased. I am able to express myself more artistically, and I feel my social skills have vastly improved.” Angela also noted that it helped her socially as well as personally, commenting, “I’ve met a lot of new friends. It’s really something that’s helped me grow. I’ve cried with these people and laughed with them. And I feel even more like family with them.” The Performance Troupe provided a supportive and caring environment for the participants. One of the performers, Sheri, had been in theater for years. For her, this troupe was more than acting, it was educational for herself as well as the community. She was proud to use her skills and talent to help educate others about mental illness. Through that she acknowledged, “It’s actually educating me even more; I’m learning more about myself. I’m just really happy to be a part of this.”

Conclusion

Drama is a powerful tool for people with mental illness as it creates a safe environment to explore and share experiences. As the performers reenact their life scripts they are empowered on their journey to recovery. By sharing their stories in their own voices, performers challenge societal stigma and encourage self-reflection through performer–audience discussions. Occupational therapists and educators can collaborate with local performing artists to develop and provide drama programs for people with mental illness. Such programs meet individual therapeutic goals as well as provide opportunities to address social justice issues in our communities.

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For more information about Art Works and the Performance Troupe visit http://jtpfriends.org/Site/News/News.html.

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From the Chair

Tina Champagne, OTD, OTR/L

I am pleased to announce the addition of a new mental health specialty subgroup under the MH SIS forum on OT Connections, which was realized after a formalized petition was circulated and completed at the 2010 Annual AOTA Conference & Expo in Orlando, Florida. The new subgroup is titled “Sensory Approaches in Mental Health Care: An Emergent Practice Area” (http://otconnections.aota.org/forums/7156.aspx). In addition to the new forum subgroup, there is also a new OT Connections group titled “Sensory Approaches in Mental Health Recovery” (http://otconnections.aota.org/groups/sensory_approaches_in_mental_health_recovery/default.aspx). Discussions will take place on the forum, and the group will be used to post resources and links that are related to the subforum topic. Please consider joining in the rich and lively discussions taking place on both the MH SIS forum (http://otconnections.aota.org/forums/22.aspx) and the new MH SIS subforum, as well as joining the new OT Connections group.

Regardless of practice area, occupational therapy practitioners are no strangers to using group treatment approaches. For occupational therapy practitioners working in mental health settings, group treatment historically has accounted for the majority of services rendered. Although many mental health settings have seen a slight shift away from strictly group work, it still continues to be an important aspect of mental health treatment. To date, many of the resources describing group work in occupational therapy have focused primarily on factors affecting group leadership and group process, including group classifications, group dynamics, group protocols, group stages, group leader roles, pros and cons of coleading, task analysis, ice breakers, and strategies for closing (Cole, 2005; Howe & Schwartzberg, 2001; Posthuma, 2002). Little is known about how occupational therapy practitioners design groups and the clinical reasoning that goes into designing group interventions, which is unfortunate because it is precisely in the design process where some of our most sophisticated clinical skills lie. As we embrace occupation-based, client-centered practice, we must become more aware of our role in designing groups; essentially, we must see ourselves as designers. One such resource that can assist with focusing our attention on the creative demands of clinical practice is the Seven Phases of Design Process, which is included in the book, *Occupation by Design: Building Therapeutic Power* by Doris Pierce, PhD, OTR/L, FAOTA (2003). This article describes how we applied these seven phases to develop an occupation-based group at a recovery home for persons dealing with homelessness and HIV/AIDS.

Pierce’s Seven Phases of Design Process

Borrowing from current models of creative design and the design process in three distinct professions—medicine, engineering, and architecture—Pierce (2003) developed a seven-phase occupational therapy design process that she described as the many ways occupational therapy practitioners use their creativity to problem solve, set goals, create new ideas for interventions, and identify multiple routes from problem to solution. More specifically, the design process “includes all the creative thinking from the realization of why you want to do something, through considering different ideas, to doing and reflecting on your action” (Pierce, 2003, p. 16). Based on this definition, we can assume that our design skills are the means by which we meet our clients’ needs. Occupational therapy practitioners can use the design process to meet the creative demands of clinical practice. Pierce’s seven phases proceed from motivation to investigation, definition, ideation, idea selection, implementation, and evaluation. According to Pierce, it is important to keep in mind that the creative process is rarely linear and that one should not be too dogmatic about when one phase ends and the next begins. She has provided strategies for each phase that foster divergent and convergent thinking, as it is “alternations between divergence, which opens and stretches thinking to incorporate new ideas, and convergence, which carefully weighs action choices” (p. 33) that reveal the true strength of the creative design process and provide a framework for designing interventions that “accurately and effectively address client goals” (p. 294).

Occupational Therapy Practitioners as Designers

Occupation-based interventions put high creative demands on occupational therapy practitioners (American Occupational Therapy Association [AOTA], 2006). As such, the design process is now more than ever a big part of our professional backbone, even though many practitioners still are not formally recognizing these skills. For occupational therapy practitioners in mental health settings to view themselves as designers, and to do so confidently, they must first become aware of their design skills and their approach to the design process when planning groups. As we continue to move away from cookie-cutter groups, which do nothing more than insert an activity into a group protocol, we are strongly reinforcing the idea that design is responsible for producing therapeutically powerful, occupation-based interventions. As we forge ahead to be a “powerful, widely recognized, science-driven, and evidence-based profession” (AOTA, 2006) and reclaim our role as primary mental health providers, we must gain a better understanding of how to articulate the explicit design skills behind our group interventions. Doing so will speak not only to our unique emphasis on occupation, but also to our unique design skills that we use to provide care, further distinguishing us from other mental health providers who also use group interventions.
Bonaventure House is a 35-bed transitional living facility and licensed recovery home that serves persons struggling with HIV/AIDS, homelessness, and substance abuse issues. The primary services at Bonaventure House include case management and substance abuse counseling, which typically encourages 12-step participation. To further prepare residents for the transition to independent living, the facility also offers several weekly occupational therapy groups. In an attempt to embrace client-centered therapy, we have chosen to pay particular attention to our clients’ voices—quite literally the words and metaphors they use—while generating possibilities for group topics and design. One particular design challenge became evident during a weekly group when several participants suggested that working a 12-step recovery program made them feel “boxed in.” They described this feeling as being both good and bad. Working the steps, according to the participants, sometimes led to boredom and confinement, but at the same time, it superimposed structure, purpose, and a framework that many of them acknowledged as a necessary evil in the beginning stages of recovery. Although it was clear that feeling boxed in affected the participants’ occupational performance, it remained unclear how exactly it did so. Even after further probing, many participants were unable to articulate the specific ways they felt boxed in by the steps. Instead, they spoke in generalizations, saying things like, “it just feels limiting.” And so addressing these feelings of being boxed in became our motivation and challenge: to design a group that could address and explore the juxtaposition of the “boxes” in our client’s lives and the resulting effects on occupation. Using Pierce’s seven phase model, we initiated the design process to meet this challenge.

Motivation

The motivation phase challenges the occupational therapy designer to hone in on why he or she really wants to design a particular group. This convergent phase serves the creative process by focusing specifically on the enthusiasm needed to see the intervention from the beginning through to the end. To own the project, as Pierce suggested, we focused on creating a work environment that could regularly and deliberately remind us of our original challenge: to better understand the intersection of feeling boxed in and its impact on occupation.

After organizing our workspace, we used other strategies that Pierce recommended. With the help of clip art, we made a sign of a fish in a bowl and a parrot in a cage and hung it in the office; created a poster highlighting the pros and cons of designing a group around boxes; and made a list of the potential benefits that might result from better understanding a boxed-in life. Slowly, the office was transformed into a creative shrine to boxes as we filled it with all different types to remind us of our design goals and promote later dialoguing efforts.

Investigation

Investigation, a divergent phase, is fueled by the goal to accumulate as much information as possible. Creative thinking tends to flourish when seemingly unrelated ideas come together, so we placed a high value on the quantity rather than the quality of ideas, reserving any editing and judgment for later phases. In the investigation phase, the goal for occupational therapy designers is to approach ideas for the group from as many different angles as possible. Following Pierce’s suggestions, we started the investigation by using a ballooning strategy. Ballooning is a visual tool that allows the designer to see how ideas are interrelated and how far the initial idea can be developed. We began by writing the word box in the middle of a large piece of butcher-block paper, drew a circle around it, and connected it to other related balloons. We started with literal examples of boxes, such as cereal, jewelry, cardboard, and pizza, and then identified less traditional concepts associated with boxes, such as aquariums, cages, jail cells, swimming pools, tanning beds, coffins, step aerobics, playpens, drawers, suitcases, toolboxes, and cubicles. By the time we were done, there were many words and ideas radiating from the initial balloon. Upon closer inspection, we began to see themes emerge that we would have never anticipated: boxes that provide protection, boxes that provide organization, and boxes that illustrate confinement.

Definition

The definition phase is convergent. Like motivation, definition prompts designers to specify exactly what the group will accomplish, a factor that is different from and sometimes confused with why one wants to design a particular group. To avoid the common pitfall of getting stuck on an idea too early in the creative process, we revisited the motivation phase and followed Pierce’s recommendation to create specific priorities. We identified the following as priorities for the group:

1. Have fun.
2. Address accurately the conceptual metaphor of feeling boxed in by the 12 steps.
3. Arc back to a metaphorically dense occupation.
4. Make appropriate for adults.
5. Provide easy access to group supplies.
6. Be cost-effective and provide the just-right challenge in a 1-hour session.
7. Develop or support a feasible future occupation.

Ultimately, our definition became the following: to identify an occupation that (a) naturally lends itself to more than one avenue for participation; (b) easily invites nonthreatening conversations about being boxed in, appreciating and exploring the box; and (c) requires participants to use the box. We used this more-specific definition as a filter for the rest of the project.

Ideation

Ideation encourages divergent thinking much like the investigation phase. In this phase, group designers specifically focus on identifying as many possibilities that would bring the definition to life without editing them on the basis of cost, feasibility, or other practical measures. To this point, we had been leaning toward a step aerobics group because it, like the 12 steps, restricts participants to a small box, has complex step demands, and provides positive health benefits. However, we took Pierce’s advice and dumped this...
idea in order to embrace the spirit of the creative design process and explored other untapped creative possibilities. Despite our efforts, one of the best creative ideas resulted from a random conversation with a coworker, who mentioned that a board member was a square dance caller. We quickly identified the possibilities between feeling boxed in by the 12 steps and square dancing.

Idea Selection

Idea selection is convergent in its aim. Occupational therapy group designers are encouraged to reflect back on the motivation and definition phases to accurately rank the criteria by which the final choice will be made. To assist us in picking our top-three activity choices—swimming, step aerobics, and square dancing—we used a ranking matrix based on our priorities, goals, and primary focus to assign a specific calculation to each idea, as Pierce suggested. In doing so, we determined that square dancing, which had not even been on our clinical radar until the previous phase, was the clear winner.

Once an idea has been selected, designers must again focus on quantity over quality as they move closer to implementation. Implementation is the fun, flashy, sexy part of the design process because it signals the time for picking the best idea from a pool of many good ideas. Unfortunately, it can quickly turn disastrous if the preceding design steps were not given adequate attention.

We decided to approach implementation by using a graphic project schedule much like the Gantt and critical path charts that Pierce recommended. This strategy identified a time schedule and to-do list, pointed us in the direction of a 6-week format, and confirmed further our notion that an experienced square dance caller would be better suited to actually lead the groups. Our focus then shifted from leading and planning the square dancing groups to designing the conversations that would inevitably explore the metaphors offered by square dancing and how it might compare to the feelings of being boxed in by a 12-step program.

Although the urge to move quickly from idea selection to the actual running of the group can be strong, we appreciated this phase because it superimposed a pause period, without which we would have been more vulnerable to both anticipated and unanticipated obstacles in starting the square dancing group.

Evaluation

The evaluation phase of the design process specifically allows for opportunities to reflect on the intervention. This phase involves getting feedback on what worked and what could have been better, which is essential for refining one’s design skills. We set aside the last session of the group for reflection. During this session, we interviewed the participants and facilitated a conversation about the similarities and differences between feeling boxed in by square dancing and by the 12-step recovery program. Many participants agreed that the square dancing lens provided a more positive and helpful way of looking at their own recovery boxes, allowing them the opportunity to express their feelings about the challenges of a 12-step recovery program and better understand the meaning of it and its relevance to their lives.

At face value, square dancing and the 12 steps of recovery mix like water and oil. However, as it turned out, the mere acts of do-si-do-ing and promenading home created many opportunities to explore how square dancing literally boxed in clients in similar ways that the 12 steps figuratively boxed them in. As the group conversations became more focused, several participants seemed to conclude that it was not the 12 steps, per se, that were boxing them in.

For one participant, feeling boxed in was the consequence of not paying more attention to the contents of her box. After reflecting on several dance calls that required partners to move within a square, she said, “My baggage is taking up space in my box. It’s not all about the box. Everybody thinks it’s the box. But, I gotta work on my baggage.” From this new perspective, the 12 steps were now considered more useful than limiting, as they offer practical strategies for working through painful memories, mistrust, and hurt.

For another participant, the square dancing group provided an opportunity to do just the opposite: to focus more on the box. As he elaborated on what being boxed in meant, it appeared that these feelings stemmed from his tendency to only recognize the negative consequences and sacrifices of recovery. He shared:

This group has opened my eyes...I didn’t realize how much fun I could have in my box. I always focus on the curfew and all the rules and the fear of relapse. What they say helps. Maybe I need to pay more attention to my box to appreciate it—kind of like I did in the dancing.

Like all forms of dance, square dancing takes not only knowledge, but also lots of practice. The 12 steps work similarly. When recalling the amount of practice required to finally master the allemande left and right-and-left-grand combination, one participant offered:

Working the steps of AA [Alcoholics Anonymous] are hard at first. Recovery isn’t easy. It’s so hard sometimes you can’t even believe it. Square dancing wasn’t easy either. Those steps did get easier with practice kind of like AA, well all of that except remembering my left and right. No, they got easier, and things get easier with practice. And when things get easier, that box seems to grow, or at least it feels easier to move around in.

For this participant, feeling boxed in was the result of “just going to meetings” and not fully practicing, integrating, and applying the 12 steps in his daily life.

Conclusion

Pierce’s seven-phase occupational therapy design process offers occupational therapy practitioners working in mental health settings new opportunities and a guiding framework to increase creativity in their group designs. Moving away from strategies where the group activity is simply chosen to strategies where the group activity is slowly revealed underscores our professional commitment to occupation-based practice.

This article describes how a square dancing group evolved conceptually at a recovery home for chronically homeless persons with HIV/AIDS. Based on quotes collected over the dance sessions and final reflection session, it appears that a carefully designed square dancing group served as one way to increase the specificity with which participants could describe their boxed-in lives. This benefit also served both the problem-setting and goal-setting phases.

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Multiple sclerosis (MS) is an autoimmune inflammatory demyelinating disease of the central nervous system that affects approximately 100,000 people in the U.K., 400,000 people in the U.S., and 2.5 million people worldwide (National Multiple Sclerosis Society [NMSS], 2010; Multiple Sclerosis Society, 2010). This neurological disease is often progressive, affecting both the physical and mental health of individuals. Common symptoms include fatigue, cognitive decline, mood changes, spasticity, balance problems, and visual impairments (NMSS, 2010). Studies show that mental health concerns, including depression, anxiety, and cognitive dysfunction, adversely affect well-being, perceptions of disease severity, and quality of life (QOL) in people with MS (Joffe, 2005; Lester, Stepleman, & Hughes, 2007). Therefore, it is important to consider the influence of MS-related mental health symptoms to best care for clients living with this unpredictable disease. Occupational therapy practitioners can have a unique and valued role in MS client care by bringing attention to how psychological health problems or challenges affect daily living and QOL. The purpose of this article is to review the major mental health issues associated with MS, outline recommendations for client-centered practice and research.

Major Mental Health Issues

Depression and Anxiety

Depression is a predominant symptom in MS with a generally accepted lifetime prevalence of up to 50% (Siegert & Abernethy, 2005), a rate significantly higher than that of the general population. High levels of depression may be associated with MS-related neurobiological factors, such as central nervous system lesions and altered immune functioning (Goldman Consensus Group, 2005). Research findings suggest that there is a significant correlation between greater depressive symptoms and lower age and education, increased functional limitations, and poorer QOL (Phillips & Stuifbergen, 2008). Other risk factors for depression include family history of depression, lack of social support, low levels of self-esteem, physical disability, and being female (Galeazzi et al., 2005). Depression severity is the single most important factor associated with suicidal ideation and intent in clients with MS (Feinstein, 2002; Turner, Williams, Bowen, & Kivlahan, 2006). Depression adversely affects physical, cognitive, social, and work performance (Katon, 1996). Thus, attention to depressed mood and diminished interest, as well as other manifestations of depression is critical.

Anxiety is a frequent response to the uncertainties of MS and the unexpected disruptions experienced during the course of the disease, as individuals with MS often perceive a loss of control (Kalb, 2007). The lifetime prevalence of anxiety disorder in people with MS is 35.7%. Those with MS who develop an anxiety disorder are more likely to be female, have a history of depression, drink to excess, report increased social stress, and have contemplated suicide in the past (Korostil & Feinstein, 2007). Higher levels of perceived physical impairment have been related to higher levels of anxiety and depression (Janssens et al., 2003). In addition, individuals experiencing anxiety often manifest associated physical symptoms. Increases in nervousness or worry, as well as the accompanying physiological effects, such as heart palpitations and restlessness, will affect client perceptions of overall wellness and functional performance.

Cognitive Dysfunction

Cognitive dysfunction affects up to 70% of persons with MS (Rao, Leo, Bernardin, & Unverzagt, 1991) with approximately 25% showing significant dysfunction. Detections of brain abnormalities, using magnetic resonance imaging, document cognitive dysfunction in clients with MS. Individuals in the early stages of the disease have shown lengthened reaction time, impaired nonverbal memory, and planning deficits (Rao et al., 1991). Memory, speed of information processing, executive functions, problem solving, visual spatial functions, abstract thinking, attention, and concentration are some of the other cognitive functions most often affected by MS (Schulz, Kopp, Kunkel, & Fais, 2006). Higher levels of self-reported cognitive impairments are related to higher levels of psychological distress, including anxiety and depression (Lester et al., 2007). Ultimately, these deficits have an adverse effect on daily living, functional capacity, relationships, and even employment, as employability is predicted by cognitive ability (Benedict et al., 2005;
Monitoring cognitive dysfunction is a critical aspect of occupational therapy practice when working with clients with MS, as it affects functional performance, treatment adherence, and social interactions.

Quality of Life

An increasing number of studies on MS have investigated the influence of health-related problems on individuals' general well-being and QOL. Quality of life appears to be strongly correlated to emotional adjustment to illness and perceived physical disability (Benito-Leon, Morales, Rivera-Navarro, & Mitchell, 2003). In addition to a person’s level of adjustment, QOL may be perceived differently based on age and duration of illness. Younger individuals with recent onset of MS who experience difficulties with mobility, but who are not yet wheelchair users, tend to report poorer QOL (Ford, Gerry, Johnson, & Tennant, 2001). Those with greater social support and less cognitive impairment report higher QOL (Schwartz & Frohner, 2005), whereas individuals with depression and anxiety tend to report poorer QOL (Janssens et al., 2003). Fatigue is another common manifestation of MS that negatively impacts QOL (Motl, Suh, & Weikert, 2010). Discussing with clients how MS influences QOL can offer valuable insight into their health, as well as provide essential information for implementing client-centered care.

Implications for Practice and Research

Depression, anxiety, and cognitive decline affect engagement in daily occupations and activities, thus, influencing health, social roles, and QOL. The focus for occupational therapy practitioners in the area of MS and mental health should include: (a) evaluating psychological distress (depression, anxiety, and cognitive dysfunction) and assessing the difficulty with adjustment to disease and its effects on performance in everyday tasks and social roles; (b) implementing interventions aimed to promote health and QOL; (c) providing education on the disease process and community resources to encourage improved coping skills and intervention follow-through; and (d) participating in MS and mental health research to develop evidence-based practice interventions. Occupational therapists are in a position, as prominent members of the client-centered care team through their clinical and research interactions, to identify and study mental health responses that impact individuals living with MS.

Strategies To Address Mental Health Needs

Client interviews and health intakes provide beneficial information on personal, family, and medical history that assist in determining probable risk factors for mental health problems. An emphasis on careful screening and evaluation of psychological, social, and occupational functioning, satisfaction and activity level, and functional health by occupational therapists is recommended. Occupational therapy practitioners should work with clients to evaluate suspected emotional, cognitive, or social changes; increased fatigue; decreased level of participation in desired activities; and poor adjustment, especially when these changes are affecting everyday function, social roles, and QOL.

The use of validated evaluation tools, such as the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) and the Canadian Occupational Performance Measure (COPM; Law et al., 1998), along with clinical observation and client report, will assist occupational therapists in identifying the effect of mental health responses on daily living and QOL. A comprehensive evaluation will lead to improvement in the development of client-centered intervention plans, implementation of interventions, documentation of changes in the client’s clinical status, and proficient communication with other health professionals to help address MS-related concerns. Similar procedures are followed in a stepped care model (Russell, Rafferty, & Joice, 2010) that takes a coordinated approach to screening, evaluation, intervention, and referral. This step-wise approach provides access to appropriate psychological interventions for people living with mild to moderate mental health problems. With early recognition and diagnosis, along with intervention and specialized care of mental health symptoms and disorders (National Institute for Health and Clinical Excellence, 2010), better health outcomes for individuals with MS will be achieved.

Research findings underscore the need to educate clients about the short-term prospects of important long-term effects of living with MS (Janssens et al., 2004). Providing education and support for clients and their families is known to influence their ability to cope with chronic illness (Burgess, 2010). Well-informed individuals are more likely to follow through with therapies (Epstein, Alper, & Quill, 2004), thus becoming empowered and active participants in their own care. Occupational therapy practitioners need to ensure that clients and their families are aware of the possible short-term prognosis, basic disease processes, long-term consequences, available interventions, and applicable community resources to promote coping, therapy participation, and intervention follow-through.

As part of a collaborative interdisciplinary team of specialists, occupational therapy practitioners ought to implement therapeutic interventions, such as skill-building programs, education and support groups, or protocols specifically designed to promote health, social interactions, work capacity, and coping skills to assist clients in breaking the cycle of low functioning (McCabe & Di Battista, 2004), and promote improved mental well-being, functional performance, and QOL. These interventions can be composed of educational workshops, fatigue management programs, adjustment groups, skills training, and vocational rehabilitation. Therapist-led educational workshops for individuals who have been newly diagnosed can be advantageous, as groups allow for participants to lend social support, provide health-related information, connect with other individuals with MS, and facilitate communication with clinic staff (Schwartz & Frohner, 2005), particularly in terms of recognizing the early signs of MS symptoms.

Participation in fatigue management programs promotes lifestyle and occupational changes, enhances social support, and alters thinking about fatigue. Positive outcomes following intervention include, but are not limited to, altered routines, the use of new strategies to perform activities, and a greater sense of personal responsibility for managing fatigue (Twomey & Robinson, 2010). In addition, interventions focused on increasing positive social interactions, expressed affection, emotional and information support, are...
related to less depression (Bambara, Turner, Williams, & Haselkorn, 2011). Individuals with MS and low mood who attend adjustment groups report lower depressive symptoms than non-participants (Forman & Lincoln, 2010). Evidence suggests that cognitive behavioral approaches can be effective in improving mental health responses and adjustment to disease (Walker & Gonzalez, 2007). Therefore, occupational therapy practitioners, trained in cognitive behavioral techniques, can employ this evidence-based approach to help address and manage psychological concerns. Protocols that include cognitive skills training, community reintegration, and self-care are also associated with positive health outcomes (Maitra et al., 2011). Individuals with MS and low mood who attend adjustment programs report lower depressive symptoms than non-participants (Mehnert, Krauss, Nadler, & Boyd, 1990). These clinical interventions and outcomes are an important component of client care and further research into therapeutic approaches in addressing mental health concerns in MS will lead to optimal patient outcomes.

Conclusion

Occupational therapy practitioners have an important role in client care to promote greater QOL through clinical practice and the use of research, thus benefiting persons living with MS and mental health comorbidities. In current occupational therapy practice, we recommend the assessment of psychological distress and difficulty with adjusting to having MS, the use of validated assessment instruments, implementation of evidence-based interventions, individual and group educational opportunities, and participation in MS and mental health research. It is through these endeavors that occupational therapists can advance client care practices, develop valuable interventions, and expand current knowledge of MS and mental health responses on occupational performance and participation in everyday tasks, social roles, and QOL.

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Self-Determination and Mental Illness

Linda M. Olson, PhD, OTR/L

Client-centered care is at the heart of occupational therapy practice (Law, 1998). Within the area of mental health this belief is consistent with the recovery model (Stoffel, 2011). According to Onken, Dumont, Ridgway, Dorman, and Ralph (2002) (as cited in Stoffel), facilitating an individual’s right to choose when and how to participate in treatment aids in the recovery process. However, this concept of choice and self-determination is contrary to the medical model that is still prevalent in many mental health settings today. The purpose of this article is to review the different models of self-determination and discuss the pros and cons of each.

Self-determination is defined as an individual’s right to accept or refuse medical or surgical care as well as the right to prepare advance directives (Patient Self-Determination Act, 1990). Advance directives include written directions for the provision of health care when an individual is incapacitated. This can include a living will or durable power of attorney for health care. Incorporated into the individual’s decision making regarding treatment is the right to receive an adequate explanation of the illness and potential treatment options available to address the illness (Hamann, Leucht, & Kissling, 2003).

Although there has been increased inclusion of the concepts of self-determination in the medical community, the psychiatric community has lagged behind in acknowledging clients’ rights to input in treatment planning and decision making (Geppert & Abbott, 2007). The provision of psychiatric care in general has continued to be delivered under the medical model where the physician is an active participant in the relationship, assuming responsibilities for decision making regarding diagnosis and treatment (Hamann et al., 2003). The physician provides selective information related to the diagnosis and treatment options based on what he or she thinks is best for the client. The client is a passive participant in this relationship, accepting the physician’s recommendations without question. The Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (Framework-II; American Occupational Therapy Association [AOTA], 2008) supports the use of a collaborative, client-centered approach throughout the occupational therapy process. However, this approach has not been consistently used by practitioners. For instance, Kyle (2008) found that although occupational therapy practitioners value a client-centered approach, issues and challenges outside the profession interfere with their ability to fully implement it. Furthermore, Maitra and Erway (2006) reported that although occupational therapy practitioners perceive themselves as using a client-centered approach, clients did not consistently report feeling like an active participant in their treatment and were unaware that their occupational therapy practitioner was using a client-centered approach. These findings suggest that as occupational therapy practitioners, it is important to increase our awareness of how we can collaborate with our clients and ensure they are an active member of their treatment team, especially in the area of mental health.

Within the mental health community, self-determination has been broadly defined as the right of individuals to have power and control over their lives (Cook & Jonikas, 2002). The development of self-determination within the mental health community began more than 100 years ago when a group of former state psychiatric hospital patients began meeting on the steps of the New York Public Library to offer support to one another as they struggled to deal with their mental illness within a community setting (Chamberlin, 1990). Since that time there has been increased involvement by former patients advocating against the traditional, paternalistic medical model that they believed generated dependence among and oppression against those with mental illness (Unzicker, 1999). The mental health community itself has begun to question a paternalistic approach to psychiatric care and advocate for increased client involvement in treatment decisions, including the right to refuse treatment.

In addition, there has been an increased call to include consumers of mental health services as providers of mental health care through peer counseling and mental health policy-making (Chamberlin, 1990; Tomes, 2006). Support for this inclusion stems from the belief that consumers have a better understanding of the struggles their peers are experiencing and can address the issues more effectively. In addition, their personal experiences make them prime candidates to advocate for policies that will effectively address the needs of this population (Tomes). Clinicians who oppose this inclusion state from the belief that consumers lack of education and their instability due to ongoing symptom fluctuation will be more damaging in the treatment of individuals with mental illness (Fisher & Ahern, 1999). A more general societal opposition is based on the belief that these individuals are violent, unstable, and unable to effectively engage in an effective consumer/survivor empowerment movement (Wahl, in press). In response to this opposition, consumers made increased acceptance of consumer-delivered services within the legislative and professional mental health community a top priority (Van Tosh et al., 1993).
Over the years there has been success in several areas in regards to consumer involvement in policy-making and other initiatives. In 1992, the Substance Abuse and Mental Health Services Administration (SAMHSA) made it a requirement that state and federal mental health planning committees include consumers of mental health services in their membership in order to receive federal funding (Tomes, 2006). Additionally, numerous mental health agencies have followed suit by hiring consumers as providers of mental health services (Moll, Holmes, Geronimo, & Sherman, 2009; Pascaris, Shields, & Wolf, 2008).

Consumer movement groups within this population have advocated for a treatment decision-making model that is at the opposite end of the continuum from the medical model. The informed choice decision-making model characterizes the physician as the passive participant and the client as the active participant in the physician–client relationship (Hamann et al., 2003). The physician provides information regarding diagnosis and treatment but withholds any recommendations, even if he or she has strong opinions about what is best for the client. The responsibility regarding treatment decisions lies with the client, and the physician is obligated to adhere to these decisions. Advocates of this model argue that living with mental health symptoms is not living with an illness but rather choosing to live in an alternate state of being and that individuals should not be coerced into treatment that goes against their belief system (Cook & Jonikas, 2002; Tomes, 2006). It could be argued that occupational therapy practitioners that engage in true client-centered care are actually using the informed choice model.

Another initiative that is more structured than the informed choice model is the shared decision-making model. This model is characterized by both the physician and client as active participants in the physician–client relationship, and both contribute to the treatment decision-making process (Hamann et al., 2003). This model provides for bidirectional sharing of information and decisions regarding treatment, and decisions are made through consensus. The shared decision-making model most closely resembles the collaborative, practitioner-client relationship that the Framework-II supports (AOTA, 2008).

Studies examining the benefits of the shared decision-making model related to treatment of individuals with mental illness have demonstrated mixed results. A study by Hamann, Cohen, Leucht, Busch, and Kissling (2008) found there were no clear benefits of those individuals with greater participation rates. In fact, those individuals demonstrated mixed results. A study by Hamann, Cohen, Leucht, Busch, and Kissling (2000) found that physicians were less likely to adhere to PAD when the PAD included treatment refusal in a psychiatric crisis. Based on these studies, the usefulness of PAD is questioned and warrants further investigation.

Studies also indicate inconsistencies in physician adherence to PAD. A study by Srebnik and Russo (2007) found that the appointment of a surrogate decision maker within the PAD increased adherence by the health care team. Wilder, Elbogen, Swartz, Swanson, and Van Dorn (2007) found that physicians were less likely to adhere to PAD when the PAD included treatment refusal in a psychiatric crisis. Based on these studies, the usefulness of PAD is questionable and warrants further investigation.

### Discussion

Self-determination is a complex issue in individuals with mental illness. This becomes more complex with people with serious mental illness (SMI), such as schizophrenia, major depression, or bipolar disorder. Theoretically, it’s difficult to argue that all people should not have input into their health care issues. However, as has been stated in this article, individuals with SMI have multiple issues that may interfere with their ability to acquire and retain adequate knowledge of their illness, treatment options, and the consequences of refusing treatment.

It appears that all the decision-making models presented in this article have a place within the treatment continuum for individuals with mental illness. The informed choice model appears best suited to individuals who demonstrate intact cognitive capacity and have mental illness that does not significantly impact functioning of daily living. However, as a treatment provider, it’s hard to accept the notion of not providing any input into the decision-making process or at least making recommendations of what treatment may be optimal. Research regarding the outcomes of the informed choice model is essential to increase acceptance by psychiatric health care providers. For individuals with more severe or persistent mental illness, it appears that both the medical and shared decision-making models are necessary for optimal care (Aldridge, in press; Callaghan & Ryan, 2011).
Although controversial, one could make a case that the medical model is appropriate when individuals demonstrate decreased decision-making capacity or are a danger to themselves or others. In fact, there is a strong legal precedent for moving to the medical model in these situations (Aldridge, in press; Callaghan & Ryan, 2011). When individuals with SMI experience an exacerbation of symptoms related to their mental illness there is typically a worsening of these cognitive impairments, further impacting their decision-making capacity (Bonder, 2010). If these individuals choose to forego treatment, is it ethical to abide by their wishes? Although advocates for individuals with SMI have argued that individuals who refuse treatment are choosing to live in an alternate state of being, it is known that untreated mental illness can lead to increased medical issues that can further compromise their overall well-being, as well as put them at risk of injury or harm (American Psychiatric Association, 2000). Assertive psychiatric care in these situations directed by the health care team or by a surrogate to make treatment decisions is consistent with what occurs when individuals with other medical issues are unable to make decisions regarding their care (Boyle, 2005). Therefore, it can be argued that over-riding the decision to refuse treatment by an individual with an SMI is being done in the best interest of that individual. As the individual’s symptoms are stabilized and decision-making capacity improves, efforts should be made to include him or her in the treatment planning process.

The shared decision-making model appears to be optimal for individuals with mental illness because it involves a reciprocal relationship between the individual with mental illness and the health care provider. It relies on a client-centered approach that is emerging throughout the health care arena (Ozmon, 2007). Through the use of this approach it is possible to begin a health care provider–client dialogue that would lead to a trusting relationship between the two and allow for increased input on the part of the client and respect of that input by the health care team. The benefits of this relationship may also be seen in the area of PAD. If the client is able to talk openly with the physician and work collaboratively to develop a PAD, it is more likely that the physician will respect the PAD when the individual is in a psychiatric crisis. In addition, client input would increase the individualization of treatment, which Stein and Cutler (2001) stated is missing in client care and leads to increased re-hospitalization. Although preliminary studies have demonstrated the effectiveness of PAD in increasing treatment compliance and investment, further studies are needed to determine its effectiveness throughout the continuum of mental disorders and at different phases of an individual’s illness.

Self-determination is an issue that affects individuals in all areas of health care, particularly as health care in the U.S. continues to become more consumer driven. Individuals with mental illness should not be exempt from their ability to contribute input regarding their psychiatric care. In order to optimize self-determination within the area of mental health, more education is necessary for all health care providers, clients, and the general public. This education should include what self-determination is, how the health care provider–client relationship can be enhanced through self-determination, and what situations may warrant more aggressive intervention by the health care provider. Through this education and increased participation by the client, there will be increased involvement and adherence to treatment, decreased use of inpatient hospitalizations, and reduced costs associated with mental illness. More importantly, there will be increased involvement for individuals with mental illness in community roles and activities.

References


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Occupational Therapy Interventions in Adult Mental Health Across Settings: A Literature Review

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This article describes a student project that specifically focuses on occupational therapy interventions across several mental health settings: inpatient and community-based geriatric settings, and inpatient and community-based adult mental health settings.

Students in the Master of Science in Occupational Therapy (MSOT) program at American International College in Springfield, Massachusetts, completed a scholarly project related to a topic of interest identified with their faculty project mentors. The basis for the project was to provide evidence-based support for various interventions currently used in occupational therapy mental health practice. The evidence made available in this article will benefit new and experienced practitioners alike.

Students were asked to develop a research question regarding the therapeutic use of occupations and activities within mental health settings. The students developed the following questions in completion of this requirement: (a) What types of occupational therapy interventions are offered, and (b) what is the effectiveness of these interventions?

For the purposes of this review, students located 22 intervention studies; 12 studies were level 1, 2, or 3 evidence, and 10 studies were level 4 or 5 evidence.

Geriatric Settings

Preventive Interventions

Following up on the well-known 1997 large scale randomized effectiveness study by Clark et al., The Well Elderly Treatment Program (Lifestyle Redesign), students located a pilot study conducted by Horowitz and Chang (2004) that applied a Lifestyle Redesign program to a geriatric population with depression in an adult day program. The results of the study found evidence suggesting that Lifestyle Redesign programs are beneficial for participants and are effective in helping to prevent further declines in functional abilities and may help to decrease the negative effects of depression in older adults (Horowitz & Chang, 2004).

Inpatient Interventions

In a qualitative study conducted by Sirey, Raue, and Alexopoulos (2007), geriatric patients with depression and chronic obstructive pulmonary disease (COPD) in an inpatient mental health setting participated in an intervention plan that was designed to improve their state of depression. The occupational therapy approaches used in the study were client-centered and included individual occupational profiles that were used to establish intervention plans. These intervention plans were created to target each client’s individual psychological barriers interfering with treatment participation (Sirey et al., 2007). Psychoeducational groups addressing depression and its impact on the course of COPD were used. The results of the study showed that many of the intervention participants had depression in full remission or depression that had improved since the interventions were implemented, suggesting that the interventions chosen for the study were beneficial in improving depression among older adults (Sirey et al., 2007).

An article by Duffy and Nolan (2005) explored the results of a detailed survey that was completed by 82 occupational therapists, all of whom had been working in different mental health settings with geriatric clients. The survey questioned different aspects of their professional services, with one main topic focused on the different interventions that therapists used during client treatment sessions. Group work was used by all of the occupational therapists in the study, and it was the most common type of intervention activity found in the mental health settings within the survey (Duffy & Nolan, 2005). Duffy and Nolan also found that 62% of the reporting therapists used one-on-one therapy interventions with clients.

The qualitative data from the study showed that group work was used to help clients develop skills; increase their confidence, concentration, and self-esteem; and provide an opportunity for creativity, practical activities, social interaction, and sensory integration experiences (Duffy & Nolan, 2005). Therapists used individual work to engage clients prior to placing them in groups; for individual assessment; to define and carry out individualized treatment plans; to address vocational needs; and to review goals. The individual work done by the therapists in their mental health settings was more preparatory and purposeful in nature than the group work. Forty-three percent of the survey’s respondents carried out individual sessions in community settings and at clients’ homes to help them integrate into their previous lifestyle after discharge (Duffy & Nolan, 2005). Numerous interventions were used by the therapists for clients to practice and maintain their activities of daily living skills. Psychoeducational group sessions, addressing topics such as anxiety management, were another intervention activity that was common among many of the occupational therapists surveyed. The respondents also valued multidisciplinary teamwork for promoting...
effective practice and as a means to ensuring cohesiveness in working towards a common goal (Duffy & Nolan, 2005).

A randomized control trial conducted by Lam et al. (2010), examined the effects of an individualized functional enhancement program on skills and mood symptoms in older adults with mild to moderate dementia. The intervention plans within the study were client-centered and were developed by having the participants rate their own perceived ability to perform common daily tasks (Lam et al., 2010). The participants then expressed whether they found the tasks meaningful or important for their daily lives. The occupational therapists implemented one-on-one functional skills training interventions into each participant’s therapy sessions, focusing solely on the tasks that participants had previously identified as meaningful and important (Lam et al., 2010). The results of the study indicated that there is a potential benefit of enhanced mood for clients with dementia who receive individualized one-on-one occupational therapy services in mental health settings (Lam et al., 2010). The therapists then provided each client with individualized therapy during the group session; this component of their group design is now considered the standard in most mental health settings.

**Adult Mental Health Treatment Settings**

**Cognitive Behavioral Therapy**

Students found many studies supporting the use of cognitive behavioral therapy (CBT) techniques in mental health occupational therapy interventions for many different types of adult mental health disorders, including a systematic review conducted by Gibson, D’Amico, Jaffe, and Arbesman (2011), an evidence-based review conducted by Stoffel and Movers (2004), and a study by Osilla, Hepner, Muñoz, Woo, & Watkins (2009). The studies found that CBT techniques were useful for treating co-occurring disorders alone and in combination with other types of interventions, such as 12-step programs and neuro-cognitive retraining. The study conducted by Osilla et al. (2009) sought to establish whether CBT was useful and acceptable for clients and staff in dealing with co-occurring disorders. The results indicated that the clients, counselors, and administrators supported the use of integrated CBT for depression and substance use disorders (Osilla et al., 2009). The clients believed that the structure of the treatment helped build their confidence, and they also believed that the group process involved in the treatment sessions provided them with an opportunity to learn from one another. The clients in this study also reported that CBT appeared to offer more practical solutions than their respective 12-step programs.

Another research study examined the integration of cognitive-behavioral intervention and neurocognitive training with skills training. The systematic review conducted by Gibson et al. (2011) specifically noted improved performance outcomes across cognitive and social domains, and a reduction of psychiatric symptoms when cognitive-behavioral intervention and neurocognitive training were integrated with skills training.

**Skills Training**

Systematic reviews by Gibson et al. (2011) and RachBeisel, Scott, and Dixon (1999) found that skills training, including training in social skills, interpersonal skills, and behavioral skills, enhanced patient skills and reduced their psychiatric symptoms. The RachBeisel et al. (1999) study showed that this approach resulted in a decrease in the number of visits to the emergency room and days in which patients were hospitalized, and an increase in patients’ use of outpatient mental health services. The systematic review conducted by Gibson et al. (2011) examined the effect of social skills training on individuals with mental illnesses and found that skills training was moderately to strongly effective in teaching patients assertiveness and interpersonal skills while also reducing their psychiatric symptoms.

Another review of studies conducted by RachBeisel et al. (1999) examined the cost and effectiveness of treatment approaches. Clients who participated in the behavioral skills training group had better social adjustment and role functioning, as well as a greater reduction in substance use than those in a 12-step recovery program (RachBeisel et al., 1999). All three strategies used in the study: cognitive-behavioral skills training, a 12-step recovery program, and case management, resulted in a decrease in the number of visits to the emergency room and the number of days of patient hospitalization, and an increase in patients’ use of outpatient mental health services. These changes are indications of the positive outcomes from the treatment interventions (RachBeisel et al., 1999).

**Cognitive Remediation**

Studies by Tan (2009) and Katz and Keren (2011), and a review by Padilla (2011), all identified many effective techniques being used by therapists to treat cognitive dysfunction for people with serious mental illness. These interventions included, but were not limited to, grading the activity and repetitive actions or an activity with errors method (a form of failure-free programming whereby any effort to complete the task is viewed as successful, regardless of quality of performance), step-by-step instruction, gestural cues, breaking down the task, suggesting activities to the person when unoccupied, reminding the individual to use visual cues, using adaptive equipment, color coding, and rearranging the physical work setting. Helfrich, Chan, and Sabol’s 2011 study examined the use of life skills occupation-based interventions consisting of four modules: room and self-care management, food management, money management, and safe community participation. This study stands out as an example of research in which the interventions were clearly identified as occupation-based. The results indicated a significant difference from baseline to post-intervention at a 6-month follow up for participants’ independence or level of assistance required to complete tasks of self-care, food management, money management, and safe community participation (Helfrich et al., 2011).

**Outpatient Programs/Community Integration**

The research conducted in outpatient settings is consistent with the trend identified in the previous settings outlined. Systematic reviews completed by Gibson et al. (2011), Arbesman and Logsdon (2011), Bullock and Bannigan (2011), Gutman, Kerner, Zombek, Dulek, and Ramsey (2009), and Oka et al. (2004), all support the effectiveness of interventions focusing on recovery in areas of life.
roles and community integration. The results indicated moderate to strong evidence for the effectiveness of social skills training and supported employment using individual placement and support to result in competitive employment. The effectiveness of a more comprehensive approach, however, including life skills, social participation, instrumental activities of daily living (IADLs), neurocognitive training, and supported education to improve performance was limited (Gibson et al., 2011). The evidence suggests that the effectiveness of supported employment is well documented, especially for the individual support plan model and the increased employment of individuals with serious mental illness (Arbesman & Logsdon, 2011). Thus a focused, supported educational approach yielded positive results compared with conventional vocational rehabilitation or those programs that also included IADLs and neurocognitive components. The evidence also indicated that a strong emphasis within education programs on goal setting and skill development resulted in increased participation in vocational and educational pursuits (Arbesman & Logsdon, 2011). A combination of these approaches produced the best outcomes in employing individuals with mental health illness (Arbesman & Logsdon, 2011).

12-Step Programs

An evidence-based review conducted by Stoffel and Moyers (2004) examined the use of both 12-step treatment programs and cognitive-behavioral interventions in mental health care settings. Stoffel and Moyers found that 12-step treatment programs and cognitive-behavioral interventions significantly affected positive expectancy, sense of self-efficacy, and general coping skills. Participants in the 12-step programs also had better outcomes related to substance-specific coping (Stoffel & Moyers, 2004).

Activity-Based Training

Bullock and Bannigan’s (2011) systematic review, Buchain, Vizotta, Neto, and Elkins’s (2003) randomized controlled trial, and Hasson-Ohayon, Kravetz, Roe, Rozenzwieg, and Weiser’s (2006) qualitative study all suggested that activity-based groups were more effective than verbally-based groups. The results indicated that occupational therapy intervention combined with appropriate medications was associated with improvements in patients’ conditions in areas of occupational performance and interpersonal relationships. Psychosocial interventions included both verbal and activity-based interventions (Hasson-Ohayon et al., 2006). Due to the paucity of research in this area, as well as limitations in the strength of the research, it is difficult to make strong conclusions about activity-based training at this time. Researchers in each of these studies asserted that more research must be done to help strengthen the base of evidence used to support these claims.

Conclusion

A common theme throughout the research suggests that the interventions used by occupational therapy practitioners in mental health settings are client-centered as well as activity-based, and that they have a positive effect on clients. Even though there are numerous factors and treatment options to take into consideration as occupational therapy practitioners treating clients who have a mental illness, studies have shown the effectiveness of various forms of occupational therapy interventions. This evidence needs to be considered by occupational therapists when determining the types of interventions to be utilized with their clients in mental health settings.

References


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ABSTRACT

The profession of occupational therapy has firm roots in mental health practice; occupational therapy practitioners have the knowledge and skills to provide psychosocial services to children and adults in order to promote participation in those activities and roles that they need and want in their lives. The profession of occupational therapy at one point in our history was considered “one of the most valued services for people with mental health disorders...an essential component of the treatment arsenal for people with psychiatric disorders” (Gutman, 2011, p. 235). Yet in 2010 only 3% of occupational therapists and 2.4% of occupational therapy assistants reported their primary work setting to be in a mental health practice setting (American Occupational Therapy association [AOTA], 2010a). It is becoming increasingly challenging for new graduates to enter mental health practice positions when they may not have had an opportunity to develop entry-level competencies in a mental health practice setting during Level I or II fieldwork.

This article will discuss mental health competencies and innovative ways in which they can be incorporated into academic and clinical education. It will also emphasize the importance of using those competencies in practice areas other than mental health. With the decrease in the number of occupational therapy practitioners working in mental health practice settings, there are also fewer available fieldwork sites. To support the continued competency of occupational therapy practitioners in mental health practice, this article will identify key skills linked to new AOTA documents and Accreditation Council for Occupational Therapy Education Standards, as well as describe innovative ways in which these documents and Standards can be incorporated into academic and clinical education.

LEARNING OBJECTIVES

1. Recognize the importance of entry-level mental health knowledge and skills that are applicable to all practice areas.
2. Identify competencies related to mental health practice at the occupational therapist and occupational therapy assistant levels.
3. Recognize learning activities that can be used both in academic and fieldwork education in order to develop mental health knowledge and skills.

INTRODUCTION

The profession of occupational therapy began in 1917, emerging from a time referred to as the moral treatment era of psychiatric care, when humane treatment of those with psychiatric disorders was being emphasized. Occupational therapists provided therapy in state psychiatric institutions and private psychiatric facilities that offered long-term care (Gutman, 2011). Following the moral treatment era, the profession of occupational therapy expanded its service provision to soldiers returning from World War I, shifting the focus from mental health care to medical care. Over the last 90 years, the profession of occupational therapy has expanded its horizons to include a wide array of settings that are not only facility based, but also reach into the community. Occupational therapy provides interventions to people across the life course. Today, occupational therapists and occupational therapy assistants can be found practicing in such varied settings as schools, forensic units, community health centers, and hand therapy clinics. While the total number of occupational therapy practitioners working in the United States has increased since its origins, the number of occupational therapy practitioners working in mental health settings has decreased to 3% of all occupational therapists and 2.4% of all occupational therapy assistants, according to the 2010 AOTA Compensation and Workforce Survey (AOTA, 2010a). Compare this with occupational therapy workforce numbers in 1986, when 16% of occupational therapists worked in mental health settings, and in 1987, when 25.5% of occupational therapy assistants reported working in mental health practice (Kleinman, 1992). In some U.S. states, such as Florida and New Jersey, there are fewer than 30 practitioners total in identified mental health sites. Yet, as reflected in the Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (AOTA, 2008), mental health is an important consideration when evaluating and treating a client. The challenge becomes how students can learn and
practice mental health skills without being placed in identified mental health sites, and whether there are mental health skills that are endemic to occupational therapy practice.

The decrease in the number of occupational therapy practitioners working in mental health practice settings has been accompanied by a number of developments in our profession that have in turn affected the academic and fieldwork education of students in occupational therapy (OT) and occupational therapy assistant (OTA) education programs. With fewer occupational therapy practitioners working in mental health practice settings, there are fewer mental health fieldwork placements available to OT and OTA students. Fewer occupational therapy practitioners are available to engage in advocacy efforts, and less outcomes research is being conducted on the effectiveness of occupational therapy interventions in mental health (Gutman, 2011).

In 2004, AOTA’s Representative Assembly charged the Association’s Commission on Education to explore how education for mental health competencies was being addressed in entry-level OT and OTA programs. The final report, issued in 2007, summarized the results of surveys sent out to accredited OT and OTA programs across the United States. The results of the survey indicated that mental health Level I fieldwork was required in 53% of OT programs and 42% of OTA programs reporting data, and mental health Level II fieldwork was required in only 22% of OT programs and 6% of OTA programs (AOTA, 2006). The ramifications of these findings are clear: if students are not given opportunities to apply the knowledge and skills they have learned in the classroom in a clinical setting, they will not develop competencies in mental health that may be applied not only in mental health settings, but in other practice areas as well. This report identified several curricular issues of concern. One, the very wide range of textbooks being used in occupational therapy classrooms (219 publication titles) means that there is a very wide variety of sources for teaching mental health content, creating difficulty in ensuring uniformity in entry-level knowledge and skills. Two, for the OT and OTA programs that responded to this survey, the majority of learning objectives were at the first two levels of Bloom’s taxonomy (knowledge and comprehension), with relatively few objectives being written at the upper levels of the taxonomy (application, analysis, synthesis, and evaluation). Bloom’s taxonomy is a way of categorizing learning activities from easiest to most difficult within three domains or types—cognitive, affective, and psychomotor. The focus on knowledge and comprehension suggests that students are not being engaged in higher order learning that is targeted toward integration and critical analysis (Padilla, Munoz, & DeCleene, 2007).

In 2006, the Representative Assembly asked AOTA’s president to establish an ad hoc workgroup that would address the issue of Qualified Mental Health Provider status for occupational therapists; this classification is tied to reimbursement for mental health services. One of the outcomes of this workgroup was the creation of the AOTA document *Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice* (AOTA, 2010d), which outlines the core entry-level competencies and specialized knowledge and skills at both the OT and OTA levels. This document illuminates the specific skills needed by entry-level practitioners as well as occupational therapy’s unique role in mental health. It offers a guide to practice, as well as information to educate administrators about the role of occupational therapy in mental health, promote advocacy efforts, and aid lobbying efforts promoting occupational therapy for mental health services.

The Knowledge and Skills document is divided into two sections: Core Mental Health Professional Knowledge and Skills; and Specific Occupational Therapy Knowledge and Skills Applied to Mental Health Promotion, Prevention, and Intervention Practice. Within those two broad sections are specific categories such as Foundations, Evaluation and Intervention, Professional Role and Service Outcomes, and Mental Health Systems. The specific role competencies delineated in each category are divided into OT and OTA sections, indicating the required competencies at each level of practice; they are further divided into knowledge, performance, and reasoning skills. An example of a *performance skill* that an OT or OTA practitioner should be competent in at entry level is: “Evaluate the relationship between/among health, well-being, and participation in daily life activities throughout the life course for individuals at risk for or with mental health challenges” (AOTA, 2010d, p. 321). An example of entry-level knowledge OTs and OTAs should possess is: “Common co-morbidities with mental illnesses (e.g., diabetes, COPD, obesity, substance abuse, ADHD, autism spectrum disorders” (AOTA, 2010d, p. 318). A *reasoning skill* that is listed in the Foundations section is:

> Evaluate and select occupational therapy theories, frames or references, and intervention models of practice to design and deliver occupational therapy services in various practice settings to promote mental health, prevent mental illness, and intervene with the presence of diagnosed psychiatric conditions. (AOTA, 2010d, p. 321)

A companion document, *Occupational Therapy Services in the Promotion of Psychological and Social Aspects of Mental Health* (AOTA, 2010c), focuses on the roles of occupational therapy practitioners in delivering mental health services across practice settings, and it contains several case studies that illustrate the application of the specialized knowledge and skills that occupational therapy practitioners possess.

**EDUCATING COLLABORATIVE PRACTITIONERS**

According to Lang and Kneisley (2005), the addition of nontraditional and community-based practice into the Stan-
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dards for OTA education made a significant impact on OTA education. These added practice arenas enable community colleges to partner with community agencies to benefit local populations. This mutually beneficial relationship adds richness to the occupational therapy assistant education experience, enhancing the competency of the clinician in meeting client needs. Innovative community partnerships further increase awareness, often among the underserved, about the profession. As with occupational therapy assistant programs, entry-level occupational therapy programs are required to expand their connections to the community, according to the Accreditation Council for Occupational Therapy Education (ACOTE) Standards of 2006 (ACOTE, 2007a, 2007b, 2007c).

The process of educating students to become competent entry-level practitioners requires a review of what needs to be taught, experienced, understood, and implemented. Acculturating students to mental health care will help ensure that the mental health component of intervention remains a well integrated component of occupational therapy service delivery. Practically, this research supports curriculum design that incorporates reflection and introspection as students develop competencies. Fieldwork educators often create assignments for students such as reflective journaling; academic fieldwork coordinators sometimes post reflective questions on Web-based discussion boards in order to track students' progress during fieldwork. Both of these provide opportunities to monitor and mentor this development of competency in mental health care in all practice arenas.

Role delineation is another competency that is essential for each level of practice. Educational programs need to enable students to understand their role within the scope of the multiple levels of practice in order to ensure effective collaboration. Occupational therapy assistants work "under the supervision of, and in partnership with," occupational therapists (AOTA, 2009, p. 797). For that partnership to lead toward better client outcomes, educational programs at each level must address supervision and collaboration.

Role delineation is especially important in practice areas that have a high demand for practitioner autonomy. Mental health outpatient clinics, day treatment programs, and home-based case management are all arenas that primarily address mental health concerns and have a shortage of skilled occupational therapy supervisors. Occupational therapy assistants often work autonomously, receiving scheduled supervision for a few hours a week. Therefore, role delineation and supervision competencies must be components of educational programs preparing practitioners for this area of practice.

Collaborative OT/OTA fieldwork experiences enhance student competencies in both service delivery and role delineation (Jung, Salvatori, & Martin, 2008). These collaborations can be on site, off site, or virtual. Service learning opportunities give students additional opportunities to develop competencies (Gupta, 2006). The advances in the technology field are making it possible to provide supervision through virtual formats; one educational institution in Texas, for example, provides fieldwork supervision through videoconferencing. Collaborative learning experiences between OTA and OT programs will further enhance the underlying skills needed for effective psychosocial practice. Using technology for interaction is an idea that should be encouraged to enable collaboration among educational programs.

Many occupational therapy practitioners work in skilled nursing facilities. In older adults, diagnosing mental illness can be difficult due to co-morbidities, both mental and physical (Mitchell, 2011). In this population, there is a high rate of under-reported depression, and many practitioners are frustrated that it is often not acknowledged (Chapman & Perry, 2008). Yet addressing mental health issues of clients is bedrock to the profession of occupational therapy (Ikigü, 2010). Occupational therapy practitioners need to develop the competencies through a range of educational experiences to meet this ideal and the needs of the clients they will treat.

Curriculum Design

In designing an occupational therapy curriculum, one of the most critical issues is the interface between the curriculum design and its application in fieldwork. As more content areas are added to OT and OTA curricula, some programs are decreasing content in mental health. Yet the challenge becomes addressing these psychosocial issues in sufficient detail so that the students will develop the key skills and knowledge required to practice within behavioral health environments. An additional issue confronting academic programs is the decreasing number of fieldwork placements available in mental health practice (Pitts et al., 2005).

To prepare students for fieldwork, occupational therapy educators must ensure that students are trained in evaluating and re-evaluating clients, developing occupational therapy profiles, and planning treatments and discharges (ACOTE, 2007b, 2007c; AOTA, 2008). The ACOTE Standards (2007a, 2007b, 2007c) are not specific to mental health, gerontology, pediatrics, or physical rehabilitation; rather, they are global standards that address the depth and breadth of occupational therapy practice. The Standards that directly impact psychosocial practice include an examination of human behavior; the impact of culture and society on lifestyle; places and contexts where individuals engage in occupation; the theoretical lenses through which occupation is viewed; and the implications for evaluation, assessment, and interventions. They call on shareholders to work with individuals toward their self-directed goals, and use evidence that supports occupational therapy practice. The level of detail the Standards address is different for the entry-level
doctoral, master's, and associate degree students, but the Standards address all these areas. All occupational therapy practitioners share a common knowledge base, but their integration of educational materials has different requirements and their ultimate use of the knowledge is different. For example, an associate-level student may need to simply understand certain types of information, such as frames of reference, whereas the master's-level student may have to apply and the doctoral level may be required to integrate this information.

As the Standards are addressed throughout curricula, it is also important to prepare students for the fieldwork learning experiences they will encounter. This is typically initially done through the use of short exposures to practice environments. This may be through volunteer experiences prior to starting a program, visits to outside agencies or sites during courses, and finally Level I fieldwork experiences. These experiences are all designed to link the materials covered in classes and through hands-on learning experiences to the practice environments. Within each course, the objectives are directly linked to the ACOTE Standards in preparation for practice. They are also taught within the context of the curricular design and model of the occupational therapy program.

Psychosocial issues may be addressed in specific courses or interwoven within the entire curriculum. Specific courses directly addressing psychosocial issues include group dynamics, mental health, psychiatric disorders, and community-based practice. Other programs embed psychosocial issues within broader practice courses. Each curricular design method has its strengths and weaknesses.

The recently published AOTA documents that address entry-level knowledge and skills in mental health practice—Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy (AOTA, 2010d), and Occupational Therapy Services in the Promotion of Psychological and Social Aspects of Mental Health (AOTA, 2010c)—provide an opportunity for educators to carry out the ACOTE Standards in preparation for practice. They are also taught within the context of the curricular design and model of the occupational therapy program. The intent is an important one: occupational therapy practitioners must be knowledgeable about those interventions currently being offered in mental health settings that have a strong evidence base.

FIELDWORK EDUCATION

Academic programs are required to meet certain criteria for fieldwork experiences. ACOTE Standard B.10.15 states, “In all [fieldwork] settings, psychosocial factors influencing engagement in occupation must be understood and integrated for the development of client-centered, meaningful, occupation-based outcomes” (ACOTE, 2007b, p. 670; 2007c, p. 661). To meet this Standard, occupational therapy practitioners must be prepared by the academic program to bring their knowledge and skills in this area to fieldwork, and conversely, they should be given opportunities to observe and practice how “occupational therapy practitioners promote mental health and support functioning in people with or at risk of experiencing a range of mental health disorders” (AOTA, 2010d, p. 314). This Standard exists to ensure that students are aware of the importance of applying their knowledge and skills in this area in fieldwork. However, to meet the Standard and to maximize the connection between the curriculum in the academic program and fieldwork, evidence that clinicians and students infuse their practice with an understanding of the effects of disability on mental health must be shown.

Links Between Academic and Fieldwork Education

Because fieldwork education is a continuation of the academic program, fieldwork educators are responsible for understanding the curriculum and for working to mesh the students’ experiences with the theory and the skills they have learned in the classroom. A student’s opportunity to witness and practice those skills during fieldwork may vary depending on the culture and context of the site and the ability of the fieldwork educator to provide learning activities that offer opportunities to practice skills. In some practice areas, occupational therapists do not explicitly evaluate the mental health needs of their clients (Hayner, 1999) but may address these through other means. Payment regulations for some conditions may affect the clinician’s choice of frames of reference for treatment, so that psychosocial factors that affect recovery may not be addressed directly. Some practitioners may attend to their clients’ moods, ideas, verbalizations, and affect, and may make note of them as factors influencing their progress and engagement in occupation, but may not treat these mental health factors directly. Therapeutic use of self may be used in these instances to support a client, prompt self-awareness, or to suggest seeking assistance from another professional. Often, this approach occurs, but not overtly, so that the student may not be aware of it being deliberate. Other professionals, such as psychologists
Mental Health Competencies During Fieldwork

The percentage of occupational therapists employed in mental health settings is relatively low, and traditional placements for students in mental health settings are therefore limited. Many academic programs are able to arrange fieldwork in community settings and emerging practice settings where students are supervised by non–occupational therapists during Level I and on a part-time basis during Level II. In at least 8 out of 50 states whose regulations about student supervision are listed (AOTA, 2010e), practice regulations may prohibit or limit the supervision of occupational therapy students by non–occupational therapists, or they do not allow part-time supervision, which further limits opportunities for students to observe and practice mental health intervention competencies (AOTA, 2010d).

However, several recently published articles underscore the importance of addressing psychosocial concerns in settings other than mental health. One article found that at 12 months postinjury, 31% of clients with a traumatic brain injury reported a psychiatric disorder and 22% had developed a psychiatric disorder not present before the injury; thus, the psychiatric aftermath of injury may be not always be identified as a clinical concern by practitioners in rehabilitation settings (Bryant et al., 2010). Thompson (2007) suggested that individuals with substance abuse disorders are more likely to sustain job-related injuries and file workers’ compensation claims related to those injuries. Further, Thompson suggested that such individuals are more likely to be involved in accidents through which they sustain traumatic brain or spinal cord injuries, and individuals who develop substance abuse disorders after their injuries may be less likely to participate in their rehabilitation.

Thompson’s Web-based questionnaire showed most occupational therapy practitioners outside of mental health settings treated substance abuse indirectly by referring clients to a physician or some other professional. Reasons practitioners cited for not offering direct services were that the services were not within the scope of occupational therapy practice; they lacked the time, met resistance from clients, or lacked knowledge of substance abuse disorders; and that there were limitations on the number of treatment sessions related to reimbursement. Indirect interventions that were offered included education, recommendations about local support groups, listening, discussing the need for a supportive environment, and teaching coping skills.

As another example of why OT and OTA students assigned to fieldwork in rehabilitation settings should review resources available to support their clients’ mental health needs, Foster et al. (2011) found executive functioning deficits and depressive symptoms in their study of persons with severe congestive heart failure and awaiting heart transplant. Both of these conditions appeared to affect levels of participation in occupation for those studied; satisfaction with participation in occupation appeared to be affected by depression. Because depression and reduced cognitive ability may affect participation in treatment, and ultimately create a societal economic burden, the authors called for the development of treatment approaches to assist this population and others with neuropsychological sequellae of disability.

Practitioners in pediatric settings may set behavioral and social goals to be addressed during direct intervention, or they may support the goals of other professionals such as teachers, behaviorists, and counselors. Social skills are often a part of treatment planning, especially in groups in which taking turns, sharing, and communicating is required. Relationship-based interventions may assist children in meeting their developmental needs and promote communication and socialization. Although occupational therapists do not routinely develop behavioral plans for children, they often collaborate in the development of these plans, and they may be called upon to interact with children using behavioral programs. Rosenberg, Jarus, Bart, and Ratson (2011), found that performance skills and self-perception of competence affect the independence levels of children; therefore, interventions with children that focus on developing specific skills and confidence contribute to their psychosocial well-being. Bazyk (2010) noted the importance of direct intervention with children in school-based settings because they have a higher rate of mental health disorders than the general population. She suggested a model throughout pediatric practice focused on principles of positive psychology within a public health framework. OT and OTA students assigned to fieldwork in school-based settings should review resources available to support children’s mental health.

The academic fieldwork coordinator (AFWC) is responsible for ensuring that students and fieldwork educators bring their knowledge and training in the promotion of mental health to the occupational therapy process. Both the fieldwork educator and the student must partner with the AFWC to see that mental health competencies are addressed, by becoming deliberate in providing opportunities to assess and treat the psychosocial needs of their patients and clients.
Fieldwork educators first must be made aware of the ACOTE Standards and the connection of mental health services to the Standards and the curriculum of the academic program. They must also appreciate that they must model how to connect all these aspects of mental health in practice and discuss it openly as part of their reasoning when working with clients in order to assist students to make the connection. This is especially true in contexts and settings where psychosocial factors are not assessed outright, or where frames of reference and payers do not support those goals for clients. Meeting this challenge can be particularly important in settings where addressing the mental health aspect of therapy is implicit versus explicit. A variety of strategies may be employed to show evidence that the Standards are met and that the site is sensitive to the need to educate students in mental health. The academic program coordinator and the fieldwork educator may design learning activities that support students’ understanding, and use learning strategies that support their learning styles. Strategies could include the following:

- Ensure that the topic of using psychosocial intervention in addressing the needs of clients with all disabilities is aligned throughout the curriculum of the academic program and not just in mental health classes.
- Ensure that a goal to meet the mental health entry-level knowledge and skills Standard is included in the fieldwork course syllabi and is addressed formally by each fieldwork site.
- Use college- or university-sponsored fieldwork education events to explain the Standards and enlist fieldwork educators to meet them in collaboration with the academic program.
- Use electronic or traditional mailings to disseminate information about the ACOTE Standards and strategies to address this issue.
- Use advisory groups to learn about and understand trends in clinical practice and adjust curricula and fieldwork expectations accordingly.
- Communicate with students to heighten their awareness of the need to address the Standards, and to increase their own awareness of the links between their academics and clinical practice.
- Disseminate information (e.g., research articles, AOTA-generated Knowledge and Skills papers) about using mental health practice principles in varied practice settings.
- Ensure that sites include statements about meeting clients’ psychosocial needs in site-specific learning objectives.
- Require students, in an assignment, to collaborate with their fieldwork educator and report on the methods used at the fieldwork site to address the psychosocial needs of the clients. Examples of such assignments include using case studies to emphasize how psychosocial factors were addressed; performing a critical appraisal of a research article addressing the psychosocial needs of a client seen in their setting, then presenting the appraisal to their fieldwork educators and other occupational therapy practitioners at the site; using electronic media to discuss or write about a topic; creating a library of resources available to support the mental health needs of clients that could be used in a particular practice setting; and presenting an in-service to staff about psychosocial assessments/interventions that are available and could be used in practice with a particular population, with students to follow up on this topic during telephone calls and meetings with individual clinical supervisors.

The fieldwork requirements for doctoral students are the same for students at the master’s level. However, there is an additional Standard for a doctoral-level experiential component. It states:

- The student must successfully complete all coursework and Level II fieldwork and pass a competency requirement prior to commencement of the doctoral experiential component. The goal of the doctoral experiential component is to develop occupational therapists with advanced skills (those that are beyond a generalist level). (ACOTE, 2007a, p. 651)

In addition:

- The doctoral experiential component shall be an integral part of the program’s curriculum design and shall include an in-depth experience in one or more of the following: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, or theory development. (AOTA, 2007a, p. 651)

Doctoral-level students can help expand or refine mental health practice throughout all practice areas by developing policy and theory, advocating for the provision of improved mental health services, educating constituencies, and doing research.

SUMMARY

This article has reviewed the importance of developing entry-level competencies in mental health for occupational therapists and occupational therapy assistants. In light of decreasing numbers of occupational therapy practitioners working in mental health practice settings, academic and fieldwork educators must identify strategies to meet these competencies. Only in this way will the legacy of our profession’s roots in mental health practice continue to manifest as critical knowledge and skills across practice settings.

REFERENCES


How To Apply for Continuing Education Credit

A. After reading the article Integrating Mental Health Knowledge and Skills Into Academic and Fieldwork Education, register to take the exam online by either going to www.aota.org/cea or calling toll-free (877) 404-2682.

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C. Answer the questions to the final exam that begins below by October 31, 2013.

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Integrating Mental Health Knowledge and Skills Into Academic and Fieldwork Education • October 31, 2011

To receive CE credit, exam must be completed by October 31, 2013.

Learning Level: Intermediate

Target Audience: Occupational therapists and occupational therapy assistants

Content Focus: Category 3: Professional Issues, OT Education

1. Which of the following is not one of the examples of a mental health co-morbidity given in the AOTA document Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice?

A. Hypertension

B. Obesity

C. Chronic obstructive pulmonary disease

D. Substance abuse

continued
2. Historically, which profession has been considered one of the most valued services for people with mental health disorders and an essential component of the treatment arsenal for people with psychiatric disorders?
   A. Nursing  
   B. Social work  
   C. Psychology  
   D. Occupational therapy

3. Overt communication between students and fieldwork educators about how the psychosocial needs of the client are being addressed at the site is important because:
   A. Specialized knowledge and skills in mental health promotion can be developed  
   B. Participation in occupation can be affected by the client's mental health  
   C. Clinicians may be addressing the client's mental health needs in a way that is not explicitly evident to a student  
   D. All of the above

4. In non–mental health settings, the best way to ensure that students and fieldwork educators infuse mental health promotion into practice during fieldwork is to:
   A. Discuss potential mental health issues and co-morbidities related to a client's condition  
   B. Include behavioral objectives for student performance  
   C. Make the students aware of it in preparation for fieldwork  
   D. Send information about mental health promotion to sites

5. When working with students, either in an academic or fieldwork setting, mental health competencies can be developed most by:
   A. Providing students with direct feedback  
   B. Supporting students rights  
   C. Enforcing students' knowledge-based learning  
   D. Evaluating performance based on ACOTE Standards

6. When working jointly with students from OT and OTA levels of occupational therapy education, which of the following best supports facilitation of a partnership that leads toward better patient outcomes?
   A. Giving students separate assignments to complete  
   B. Encouraging students to view the whole person in the evaluation and treatment process  
   C. Supporting clear knowledge of the challenges each client may have  
   D. Modeling clear roles and discussing role delineation for both practice levels

7. According to a survey by Thompson, non–mental health-based occupational therapy practitioners stated all of the following reasons for not treating substance abuse except:
   A. Outside the scope of occupational therapy practice  
   B. Not part of the occupational therapy curricula  
   C. Insufficient time  
   D. Reimbursement issues

8. When developing an occupational therapy curriculum, a major focus is:
   A. Skills training specific to each practice setting  
   B. Occupation-based intervention in the classroom and academic learning environments  
   C. Interface between the curriculum design and application in fieldwork  
   D. Creating a strong sense of personal identity for the students as they prepare for fieldwork

9. Addressing role delineation in supervision within occupational therapy practice is:
   A. Not practical  
   B. Valuable to the facility but not the practitioner  
   C. Only the responsibility of the doctoral level practitioner  
   D. Required by AOTA Guidelines for Supervision

10. Service learning can be used to
    A. Increase knowledge of the mental health practice arena  
    B. Decrease awareness of client needs  
    C. Decrease autonomous decision making  
    D. Increase mental health competencies

11. Which of the following domains represents a lower level of Bloom's taxonomy?
    A. Analysis  
    B. Synthesis  
    C. Evaluation  
    D. Comprehension

12. Which of the following is an example of a group intervention approach that occupational therapy coursework should cover?
    A. Dialectical Behavior Therapy  
    B. Social-Emotional Learning  
    C. Resiliency Models  
    D. All of the above
The Substance Abuse and Mental Health Services Administration (SAMHSA), at www.samhsa.gov, is a U.S. Department of Health and Human Services agency that provides direction and support for national mental health policy and services. SAMHSA’s vision is “A Life in the Community for Everyone,” based on the premise that people of all ages, with or at risk for mental or substance abuse disorders, should have the opportunity for a fulfilling life that includes a job, education, a home, and meaningful personal relationships with friends and family.

Through federal grants and contracts, SAMHSA promotes recovery and resilience of children, youth, adults, and older adults.

SAMHSA recently updated its resources for helping those in mental health provide quality, evidence-based care. One such resource is SAMHSA’s series of Knowledge Informing Transformation publications (KITs) on evidence-based practice (EBP), including such topics as supported employment, permanent supportive housing, family psychoeducation, integrated treatment for co-occurring disorders, illness management recovery, and assertive community treatment, with more topics to come next year. The KITs incorporate information, tools, and resources to help states, communities, and organizations select, implement, and evaluate evidence-based and promising programs and interventions. Included in each KIT is a summary of scientific literature on the effectiveness of the intervention; materials to introduce the practice to a wide variety of stakeholders, including consumers and family members; and training and evaluation tools. To access a KIT from the SAMHSA home page, click on Publications, then Professional & Research Topics, and then Training & Continuing Education. The KITs are available both for immediate download as PDF files or for free on CD/DVD (there may be a charge for shipping).

The second component of SAMHSA’s EBP resources is the National Registry of Evidence-Based Programs and Practices (NREPP), at www.nrepp.samhsa.gov, which is a searchable online database of mental health and substance abuse interventions that have been reviewed and rated by independent experts. The recent update of NREPP makes searching the 167 interventions by keyword easier. Each citation contains a description of the program, information on how the program can be implemented in clinical practice, and contact information for the developers of the intervention. The information in NREPP intervention summaries is provided to help you determine whether a particular intervention may meet your needs. Entries are rated on the quality of the research (with a summary and rating of the strength of the evidence provided) and the intervention’s readiness for dissemination (with a rating of the quality of the resources available to support the use of the intervention). NREPP intervention topics of interest to occupational therapy practitioners include Reconnecting Youth: A Peer Group Approach to Building Skills, Resources for Enhancing Alzheimer Caregiver Health II (REACH II), and Clinician-Based Cognitive Psychoeducational Intervention for Families.

Individuals who develop and research specific interventions may want to consider submitting them to NREPP, which on its Web site posts a link to the Federal Register that describes the criteria and process for screening and selecting interventions. New interventions are being consid-

Continued on page 8
ered for submission to NREPP through February 1, 2011. Once an intervention is accepted for review, the developer of the intervention and NREPP staff together identify the outcomes and materials that will be used in the review process. The number of reviews conducted from year to year varies depending upon the availability of funds.

SAMHSA’s NREPP does not offer a single, authoritative definition of evidence-based practice. Rather, evidence-based practice is operationally defined in the context of NREPP and by the intervention developers. Further, NREPP provides a range of objective information about research conducted on a particular intervention and about the rating criteria and processes used to obtain that information. The purpose of this is to allow users to make their own judgment about which interventions are best suited to their particular needs.

More information on NREPP’s definition of “What Is Evidence-Based?” can be found at NREPP. In addition, author Marian Scheinholtz will be presenting a poster describing SAMHSA’s evidence-based practice tool KITs during AOTA’s 91st Annual Conference and Expo in Philadelphia from April 14 to 17, 2011.

Marian Scheinholtz, OTR/L, is public health advisor at the Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration, where she manages grants, contracts, and activities to support persons with behavioral health needs.

Marian Arbesman, PhD, OTR/L, is president of ArbesIdeas, Inc., and an adjunct assistant professor in the Department of Rehabilitation Science at the State University of New York at Buffalo. She has served as a consultant with AOTA’s Evidence-Based Practice Project since 1999.

Deborah Lieberman, MHSA, OTR/L, FAOTA, is the program director of AOTA’s Evidence-Based Practice Project and staff liaison to AOTA’s Commission on Practice. She can be reached at dlieberman@aota.org.
A colleague and I were discussing the difference between the practice of occupational therapy in the area of mental health, and the psychological and social aspects of occupational therapy. Does AOTA have any documents that could help us understand their similarities and differences?

In the spring of 2010, AOTA’s Representative Assembly adopted two papers from the Commission on Practice that address these issues. Your question is a good one in that some occupational therapy practitioners may think the phrase “psychological and social aspects of occupational therapy practice” applies only to people with mental illness and not to clients receiving occupational therapy services within their areas of practice. Yet, attending to the psychological and social aspects of people’s health and occupational engagement is within the domain of occupational therapy practice and is the responsibility of occupational therapy practitioners working in all practice settings, including those who work with people with mental illness. Attention to the psychological and social factors influencing mental health and occupational performance is grounded in the historical foundation of occupational therapy. Psychological and social well-being contributes to a person’s mental health and transcends a specific diagnosis or practice area. In addition, occupational therapy practitioners have the knowledge and skills to provide services specifically and primarily for persons with mental illness or problems, usually through the mental health service system.

The purpose of the AOTA position paper “Occupational Therapy Services in the Promotion of Psychological and Social Aspects of Mental Health” is “to describe the role of occupational therapy practitioners in addressing the psychological and social aspects of human performance as they influence mental health and participation in occupations” (p. 1). Psychological factors are those mental functions that are internal to the client, such as thought, behavior, emotions, and personality, and allow for interest in and sustained engagement with meaningful occupations and roles. Social factors occurring at the personal level include communication and interaction with others; at the environmental level, they reflect connection to the surrounding world.

The AOTA position paper includes discussion of the historical background and rationale for addressing the importance of psychological and social factors as a primary influence on health and recovery. It also describes the types of occupational therapy interventions that support a client’s ability to resume meaningful occupations.

The second document is “Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice.” It focuses on the specialized knowledge and skills in entry-level occupational therapy practice that support occupational therapy’s role in the provision of services within mental health systems for individuals with mental health diagnoses or problems as well as in prevention and intervention for all individuals throughout life. It describes the knowledge and skills that occupational therapy practitioners have in common with other core mental health system providers, and specifically addresses the unique knowledge, reasoning, and skills necessary for competent and ethical occupational therapy practice in mental health. This document provides support for the inclusion of occupational therapy as a qualified mental health profession as defined by federal or state statute and regulation. It can be used as a resource for health care, education, and community stakeholders.

Practitioners can use these papers to evaluate their own practice and to advocate for the important and unique role of occupational therapy in mental health practice and in promoting the mental health of all clients across practice settings.

References

Kathleen Kannenberg, MA, OTR/L, CCM, is a member of AOTA’s Commission on Practice and is a clinical specialist in occupational therapy for psychiatry at Harborview Medical Center in Seattle, Washington.
Katherine A. Burson, MS, OTR/L, CPRP, is director of rehabilitation services for the Illinois Department of Human Services’ Division of Mental Health. Last year she was selected to represent occupational therapy in the Adult Major Depressive Disorder workgroup of the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI), which develops, tests, and maintains evidence-based clinical performance measures and measurement resources for physicians.

Burson represented AOTA at the most recent PCPI meeting on adult major depressive disorder in Chicago, in December 2010. She recently spoke with OT Practice Editor Ted McKenna about the importance of the workgroup and the growing awareness of how occupational therapy can help those with major depressive disorders.

McKenna: Briefly, what does this group do?
Burson: They set standards and measures for physicians, for quality improvement and accountability to a basic standard of care. There are standards and measures for all kinds of health disorders, and the particular workgroup I’m serving on is focused on major depressive disorders for adults.

In this group there are representatives of all kinds of doctors and physicians, from family medicine and internists through psychiatrists—anyone who might be approached initially regarding treatment for major depressive disorders. They also have representatives from other stakeholders, including psychologists, social workers, and nurses.

McKenna: And OT?
Burson: And OT, yours truly. We’ve had one face-to-face meeting, in December, in which we reviewed all of the measures for existing depressive disorders for adults—the ways of quantifiably measuring adherence to the standard. Our job was to critique those and see where they needed to be changed or upgraded. After some follow-up meetings, the end result is these updated standards, the performance measures for physicians when they treat persons with major depressive disorders.

McKenna: Had occupational therapy previously been represented in PCPI workgroups?
Burson: It’s fairly new for [the AMA] to be including other stakeholders. Certainly it was new for this particular diagnostic group. I would say there was a discussion that might not have gotten going if an OT wasn’t there. When doctors make a diagnosis of a major depressive disorder, one of the things they do is code it based on severity, and their indicators assess the severity of symptoms but not function. So I raised that in the meeting and it got quite a discussion going about how they could begin to look at or measure function. It’s their role to assess whether function is impaired, but not necessarily to treat that. In an ideal world, you take the medication and suddenly you function well again. That may or not actually be what happens.

McKenna: It shows the importance of participating in something like this group, considering how much time it takes to change things.
Burson: Right, and it does begin to shift the mental model of physicians. There gets to be a lot of things involved when you measure function. Function impairments can be affected by all sorts of things—diabetes, major depression, weight gain, heart disease. Physicians don’t want to be held accountable if function is affected by some issue outside their control. But to their credit, they were really struggling with it; they were not dismissing this and its relevance at all.

McKenna: Any other general thoughts on the role of OT?
Burson: I think it’s important for OT to be involved in things like this because I think it keeps OT visible as a member of the team. When we engage with other groups like this, I think it does help us be seen as a member of the team. I think it’s really important in mental health treatment, when it isn’t always seen that way, depending on what health care system you’re in. I also see the upside for me, just as a practitioner and administrator. I get a view of their system and the issues that they’re struggling with. It puts me in a better position to engage with physicians in problem solving because I can understand their challenges better.
Questions and Answers

The World Health Organization has identified mental illness as a growing cause of disability worldwide and predicts that in the future, mental illness—specifically depression—will be the top cause of disability. With that backdrop, AOTA Vice President Virginia Stoffel, PhD, OT, BCMH, professor and chair of the Occupational Therapy Department at the University of Wisconsin–Milwaukee, in October attended the Rosalynn Carter Symposium on Mental Health Policy in Georgia. AOTA has been a regular participant at the annual invitation-only symposia, which since 1985 has brought mental health professionals together for open dialogue. Stoffel discussed her recent experience with OT Practice Associate Editor Andrew Waite.

**Waite:** What was discussed at the 2011 symposium?

**Stoffel:** This year’s focus was on building services and support for child welfare, juvenile justice, and children exposed to domestic violence. I participated in the prevention and resilience group, and we talked about the current programs that have good, strong evidence. We also discussed the dilemma that many of the working professionals may not be aware of the evidence they can use those to inform their care. For example, during the last year I have had a number of opportunities to attend presentations on trauma-informed care, and attending [the mental health symposium] really made me aware that we need to be sure that all OT practitioners understand what trauma-informed care is and how we can integrate it into our working knowledge.

**Waite:** How do you explain trauma-informed care?

**Stoffel:** Trauma-informed care starts with a review of the therapeutic environment to be sure that its programs and practices don’t unintentionally retraumatize or trigger traumatic enactments. Children who have been exposed to psychological or physical violence and overwhelming stress have been shown to have neurobiological changes in areas of the brain that generate thought and memory, often with long-term effects such as ineffective personal control (e.g., addictive behavior, self-harm) or deficits in interpersonal skills. If you think about juvenile justice, you think about a teenager who has broken the law and is now serving the consequences of his or her offenses. Trauma-informed care would suggest that every person in a juvenile justice treatment setting has been exposed to abuse, neglect, or long-term overwhelming stress. Helping them to develop skills to self-regulate and move toward a sense of personal responsibility is one trauma-informed approach. Another point made at the symposium was that when kids are frequently exposed to trauma, they want and need to talk about it. Just little things like asking the question, “Since the last time I saw you, has anything really scary or upsetting happened?” is a way to get a sense of what the exposure has been and then help us meet their needs.

**Waite:** How does trauma-informed care relate back to your contributions to the mental health symposium?

**Stoffel:** Part of what we talked about is, what adults are kids talking to? Who might be able to be in a position to help them? In the absence of a good, positive parental role model, we know that the kids who are resilient and thrive have some caring, significant adult in their life, and that could be an occupational therapist who works with them in a school setting, for example. So it’s important to recognize some of the ways we can better serve this group of young people.

**Waite:** Did you feel like your voice was heard at the symposium?

**Stoffel:** The participants in our resiliency group were interested to know how an occupational therapy practitioner might work with youth in school systems.

However, some know that [occupational therapy practitioners] are in school systems, but because we’ve often been so over connected to things like handwriting, I think a lot of professions don’t have a sense of our broad scope. How we build on strengths and develop interpersonal skills as a part of social participation in everyday occupations. I think we bring new knowledge and understanding about so much, from sensory systems to mental health, and although I briefly mentioned that at the symposium, I think we need to do a lot more to really offer good, strong information to other professions about how to pay attention to what skills we can provide.

**Waite:** So AOTA taking part in this symposium is a way to spread to word?

**Stoffel:** Exactly—it was a great opportunity to build relationships with other professionals focused on mental health and resiliency.

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For more information on the symposium, visit www.cartercenter.org/health/mental_health/symposium/index.html.

For more information on AOTA and mental health, check out www.aota.org/practitioners/practiceareas/mentalhealth.
Additional Evidence and Research

The American Journal of Occupational Therapy features many articles on mental health across the life course, as well as periodically publishes special issues on the topic. Here is a sample from recent issues:

**Assessments**

**Rasch Analysis of the Mental Health Recovery Measure**
Yen-Ching Chang, Sarah H. Alley, Tamar Heller, and Ming-De Chen
July/August 2013
http://dx.doi.org/10.5014/ajot.2013.007492

**Psychometric Properties of the Practical Skills Test (PST)**
Feng-Hang Chang, Christine A. Helfrich, and Wendy J. Coster
March/April 2013
http://dx.doi.org/10.5014/ajot.2013.006627

**Adults**

**Occupational Performance Needs of Young Veterans**
Heidi Lynn Plach and Carol Haertlein Sells
January/February 2013
http://dx.doi.org/10.5014/ajot.2013.003871

**Self-Development Groups Among Women in Recovery: Client Perceptions of Satisfaction and Engagement**
Suzanne M. Peloquin and Carrie A. Ciro
January/February 2013
http://dx.doi.org/10.5014/ajot.2013.004796

**Children and Youth**

**Art-Based Occupation Group Reduces Parent Anxiety in the Neonatal Intensive Care Unit: A Mixed-Methods Study**
Laurie E. Mouradian, Beth W. DeGrace, and David M. Thompson
November/December 2013
http://dx.doi.org/10.5014/ajot.2013.007682

**Systematic Review of Occupational Therapy and Mental Health Promotion, Prevention, and Intervention for Children and Youth**
Marian Arbesman, Susan Bazyk, and Susan M. Nochajski
November/December 2013
http://dx.doi.org/10.5014/ajot.2013.008359


Resources for Evidence-Based Practice & Research may also be found at www.aota.org/en/practice/researchers

Additional evidence resources are available from AOTA Press:

**Occupational Therapy Practice Guidelines for Adults With Serious Mental Illness**
Catana Brown

**Occupational Therapy Practice Guidelines for Mental Health Promotion, Prevention, and Intervention of Children and Youth**
Susan Bazyk and Marian Arbesman
What Is Posttraumatic Stress Disorder?

Posttraumatic stress disorder (PTSD) is a type of anxiety disorder that develops over time after being exposed to or witnessing a traumatic event that is life threatening or that threatens the integrity of one’s self or others, and reacting with intense fear, helplessness, or horror (American Psychiatric Association [APA], 2000). These events can include childhood neglect or emotional, physical, or sexual abuse; hospital procedures (invasive or traumatic procedures across the lifespan); military service or combat exposure; attacks by terrorists; sexual, emotional, or physical assault in adulthood; workplace violence; serious accidents; or natural disasters.

When the onset of symptoms is within the first month after the traumatic experience, individuals meet the criteria for acute stress disorder. If symptoms appear after 4 weeks, or continue beyond 4 weeks, however, a diagnosis of PTSD may also be warranted (APA, 2000). Common symptoms include flashbacks, emotional numbing, hypersensitivities, and hypervigilance.

Sensory processing, cognition, and emotion regulation abilities are often impaired with PTSD, which may negatively impact the person’s ability to create and maintain meaningful relationships, as well as participate in self-care, home care, education, work roles, and social and leisure interests. People with PTSD are also more prone to engage in self-injurious behaviors, and to have other physical and mental health disorders (APA, 2000). When trauma occurs in childhood, the developmental trajectory is affected, creating some differences between adult and childhood onset PTSD. Therefore, a new diagnosis, developmental trauma disorder, is being developed to better clarify the differences (van der Kolk, 2005).

The Role of Occupational Therapy With Persons With PTSD

Occupational therapy practitioners are uniquely skilled to assist people with PTSD in all phases of recovery by using engagement in meaningful occupations to meet recovery goals (American Occupational Therapy Association, 2008). The term *occupations* refers broadly to everyday activities and roles that are meaningful and/or necessary for an individual (e.g., activities of daily living; roles such as parent, worker, and spouse). Occupational therapists conduct a comprehensive evaluation to identify strengths and deficits in functional performance and their cause (e.g., limited skills, environmental barriers, etc.). The occupational therapist and client then collaboratively create goals and develop a plan to meet these goals by addressing the deficits.

Occupational therapy interventions focus on functional outcomes that are meaningful to each individual. Some examples of interventions include:

- Providing individual sessions focusing on stabilizing symptoms and learning new coping strategies (e.g., sensory-supportive interventions).
- Training clients and caregivers in adaptive or modified self-care strategies, so as not to inadvertently trigger hypersensitivity patterns, dissociation, flooding, or flashbacks.
Occupational therapy enables people of all ages to live life to its fullest by helping them to promote health, make lifestyle or environmental changes, and prevent—or live better with—injury, illness, or disability. By looking at the whole picture—a client’s psychological, physical, emotional, and social make-up—occupational therapy assists people to achieve their goals, function at the highest possible level, maintain or rebuild their independence, and participate in the everyday activities of life.

- Assisting individuals to increase their ability to participate in meaningful roles and activities by helping them plan and initiate the use of a daily routine (schedule), considering the amount and type of supports necessary for follow through.
- Assisting clients and caregivers in determining the needs and requirements for home modifications for individuals with PTSD and physical impairment(s).
- Providing individual or group sessions on relapse prevention to assist individuals in their recovery process.

In addition, many occupational therapists are skilled in implementing a variety of complementary, alternative, and other therapeutic methods that target an individual’s needs, as an adjunct to occupational therapy.

**Where Are Occupational Therapy Services Provided?**

Individuals with PTSD may receive services across a large variety of settings, including acute care hospitals, short- and long-term-care rehabilitation centers, state hospitals, partial hospital programs, outpatient clinics, club houses, day programs, supported work environments, community-based programs, home care, independent living and skilled nursing facilities, and military-based settings, such as Veterans Administration (VA) hospitals.

Services can be provided one-on-one, in group settings, or in collaboration with other professionals (e.g., primary care physicians, psychiatrists, neuropsychiatrists, psychologists, nurses, social workers, direct care staff, teachers, other therapists). Occupational therapy practitioners also provide consultation to organizations, and collaborate with the client’s caregivers and colleagues to provide education and additional resources.

**Conclusion**

Occupational therapy practitioners believe in the value of engaging in meaningful roles and daily activities to maintain and/or regain health and well-being. They are able to help identify and address coping skill needs and strategies within the context of real-life demands. Given their unique educational background in client, activity, and environmental analysis, and a rich understanding of neuroscience, anatomy, physiology, and mental health, occupational therapy practitioners are a vital part of the interdisciplinary team working with people with PTSD.

**References**


Occupational Therapy’s Role in Mental Health Recovery

According to the National Consensus Statement on Mental Health Recovery,1 mental recovery is defined as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to reach his or her potential.”

The recovery model requires a shared decision-making process that is person centered and client driven. The client–provider partnership supports shared decision making from the time the individual first engages in services, through developing intervention plans, and in all other aspects of the therapeutic process. A primary goal of the recovery model is to facilitate resiliency, health, and wellness in the community of the individual’s choice, rather than to manage symptoms. The National Consensus Statement identified 10 fundamental components of recovery: (1) self-directed, (2) individualized and person centered, (3) empowered, (4) holistic, (5) nonlinear, (6) strengths based, (7) peer supported, (8) respect, (9) consumer responsibility, and, “the catalyst of the recovery process,” (10) hope.1 These fundamental recovery principles are in full alignment with the philosophy of occupational therapy practice, which is inherently client centered, collaborative, and focused on supporting resiliency, full participation, health promotion, and a wellness lifestyle.

Occupational therapy practitioners work collaboratively with people in a manner that helps to foster hope, motivation, and empowerment, as well as system change. Educated in the scientific understanding of neurophysiology, psychosocial development, activity and environmental analysis, and group dynamics, occupational therapy practitioners work to empower each individual to fully participate and be successful and satisfied in his or her self-selected occupations. Occupational therapy practitioners assume a variety of roles such as direct care therapists, consultants, academic educators, managers, and administrators. They may also work in state and national mental health organizations to help assist in local, state, and national transformation efforts.

The following are examples of how the knowledge and skill base of occupational therapy is used in the process of assisting individuals in all phases of mental health recovery:

- Teach and support the active use of coping strategies to help manage the effect of symptoms of illness on one’s life, including being more organized and able to engage in activities of choice.
- Help to identify and implement healthy habits, rituals, and routines to support a wellness lifestyle.
- Support the identification of personal values, needs, and goals to enable informed decision making, such as when considering housing and employment options.
- Support the creation and use of a wellness recovery action plan in group or individual sessions.
- Provide information to increase awareness of community-based resources, such as peer-facilitated groups and other support options.
- Provide information on how to monitor physical health concerns (e.g., diabetes management, smoking cessation), develop strategies to control chronic symptoms, and recognize and respond to acute changes.
- Support the ability to engage in long-term planning (e.g., budget for major purchases, prepare advance medical and mental health directives) that leads to meeting personal recovery goals.
Occupational therapy practitioners are also teaming with individuals, families and caregivers, interdisciplinary professionals, and other mental health stakeholders, including behavioral health organizations, payers, and communities, to help transform the culture of mental health care through the promotion and active implementation of recovery-based principles and practices. Together, these teams are designing innovative agency and community based supportive programming based on recovery principles. The recent “Recovery to Practice” federal initiative has been set in motion to provide the assistance and resources necessary to “foster a better understanding of recovery, recovery-oriented practices, and the roles of the various professionals involved in promoting recovery” (p. 2).

Where Are Occupational Therapy Mental Health Recovery Services Provided?
Occupational therapy practitioners provide mental health services in the following settings:

- acute and long-term-care facilities
- private and public hospitals
- forensic and juvenile justice centers
- residential and day programs
- skilled nursing facilities
- community-based mental health centers
- schools
- military installations
- employment programs
- private practice
- outpatient clinics

Conclusion
The practice of occupational therapy, like the recovery model, is based on the philosophy and evidence that individuals diagnosed with mental health conditions can and do recover and lead meaningful, satisfying, and productive lives. It is the profession’s emphasis on holism, function, participation, and partnership, that is used to help support people with mental illness to develop skills, engage in activities of interest, and meet individual recovery goals.

References

The origins of occupational therapy are rooted in mental health, as the creation of the profession dovetailed with the early 20th century's mental hygiene movement. With the call for deinstitutionalization of individuals with mental illness, which culminated in the 1963 Community Mental Health Act, occupational therapists and occupational therapy assistants began working in community mental health (Scheinholtz, 2010). Today, occupational therapy practitioners provide services in community settings including, but not limited to:

- Community mental health centers
- Assertiveness community treatment (ACT) teams
- Psychosocial clubhouses
- Homeless and women’s shelters
- Correctional facilities
- Senior centers
- Consumer-operated programs
- After-school programs
- Homes
- Worksites

As services for individuals with mental illness have shifted from the hospital to the community, there has also been a shift in the philosophy of service delivery. In the past, there was an adherence to the medical model; now the focus is on incorporating the recovery model. This model acknowledges that recovery is a long-term process, with the ultimate goal being full participation in community activities. These activities may include obtaining and maintaining employment, going to school, and living independently. The philosophical base of the recovery model is a good fit with occupational therapy because the purpose of occupational therapy in community mental health is to increase an individual's ability to live as independently as possible in the community while engaging in meaningful and productive life roles. Because occupational therapy facilitates participation and is client-centered, it plays an important role in the success of those recovering in the community (American Occupational Therapy Association [AOTA], 2010; Scheinholtz, 2010).

Both occupational therapists and occupational therapy assistants are educated to provide services that support mental and physical health and wellness, rehabilitation, habilitation, and recovery-oriented approaches. Such education includes at least one clinical fieldwork experience in a setting focused on psychosocial issues (AOTA, 2010).

There is evidence that occupational therapy interventions improve outcomes for those living in the community with serious mental illness (AOTA, 2012). Such interventions can be found in the areas of education, work, skills training, health and wellness, and cognitive remediation and adaptation. Examples of occupational therapy interventions in community mental health include:

- Evaluating and adapting the environment at home, work, school, and other environments to promote an individual's optimal functioning
- Providing educational programs, experiential learning, and treatment groups or classes to address assertiveness, self-awareness, interpersonal and social skills, stress management, and role development (e.g., parenting)
- Working with clients to develop leisure or avocational interests and pursuits
Facilitating the development of skills needed for independent living such as using community resources, managing one’s home, managing time, managing medication, and being safe at home and in the community

Providing training in activities of daily living (e.g., hygiene and grooming)

Consulting with employers regarding appropriate accommodations as required by the Americans with Disabilities Act

Conducting functional evaluations and ongoing monitoring for successful job placement

Providing guidance and consultation to persons in all employment settings, including supportive employment

Providing evaluation and treatment for sensory processing deficits

Individuals of all ages who are diagnosed with a mental illness can benefit from occupational therapy. Furthermore, friends and family members can also benefit from these services to learn ways to deal with the stress of caregiving and how to balance their daily responsibilities to allow them to continue to lead productive and meaningful lives.

**Addressing Barriers to Mental Health in the Community**

Occupational therapy practitioners address barriers to optimal functioning through interventions that focus on enhancing existing skills, creating opportunities, promoting wellness, remediating or restoring skills, modifying or adapting the environment or activity, and preventing relapse. The following is a list of typical community barriers and occupational therapy interventions.

- **Stigma:** Occupational therapy addresses self-efficacy by providing opportunities for mastery and promoting advocacy in civic arenas as well as individual interpersonal relationships.

- **Safety:** Occupational therapy interventions include self-care, accessing services and supports, and preventing victimization through healthy and meaningful daily activity.

- **Low socioeconomic status:** Occupational therapy interventions address educational, prevocational, and vocational performance. Occupational therapy practitioners collaborate with clients, educators, employers, and other agencies to help the person achieve success in the working world.

- **Lack of long-term housing:** Occupational therapy practitioners can analyze performance skills and needs for living in the community (e.g., identifying the benefits of supported housing and developing routines and habits to maintain one’s living space effectively) (Brown & Stoffel, 2011).

Mental illness is the leading cause of disability in the world (Scheinholtz, 2010). It can significantly impact an individual’s ability to engage in daily life activities that are meaningful and lead to productive daily routines. Occupational therapy is a profession vital to helping individuals with mental illness develop the skills needed to live life to its fullest.

**References**


Participation in meaningful roles (e.g., student, friend, family member) and activities (e.g., sports or hobbies) leads to enhancement of emotional well-being, mental health, and social competence. Social competence for children and adolescents includes doing what is necessary to get along with others, making and keeping friends, coping with frustration and anger, solving problems, understanding social etiquette, and following school rules. Recent studies indicate that behavior and social interaction skills (i.e., social competence) are stronger indicators of academic and lifelong success than academic skills. Therefore, failure to support appropriate behavior and social competence can have long-lasting negative effects on a significant number of persons as they transition from childhood into adulthood.

Occupational therapists evaluate all the components of social competence and determine whether a child’s motor, social-emotional, and cognitive skills; ability to interpret sensory information; and the influence from home, school, and community environments have an impact on his or her ability to meet the demands of everyday life. Occupational therapy practitioners also facilitate supportive environments to promote mental health among all children.

**How Do Occupational Therapy Practitioners Support Children With Mental Health Issues?**

Occupational therapy practitioners can assist with identifying the early signs of mental illness. They can also intervene with children who are at risk for failure, such as those whose families move frequently or those from families with economic or social disadvantages. They can offer services to children who are diagnosed with bipolar disorder, depression, autism, and other disorders that may affect a child’s mental health. Occupational therapists use a client-centered evaluation process to develop an understanding of the child’s primary roles and occupations (activities), such as play, schoolwork, and age-appropriate self-care. A client-centered assessment for children also requires interaction with school staff, parents, care providers, and community members. Therapists then seek to determine what factors affect the child’s ability to meet the demands of these roles and activities and fully participate in them.

Interventions are used to promote social–emotional learning; regulate overactive or underactive sensory systems; collate with families and medical or educational personnel; and more. For example, occupational therapy practitioners can help the child incorporate sensory and movement breaks into the day to enhance attention and learning; and provide support to teachers and other school staff by breaking down study tasks, organizing supplies, and altering the environment to improve attention and decrease the effect of sensory overload in the classroom. Occupational therapy practitioners can also provide programming to establish social competence through planning and development of playground skill groups, bullying prevention, social stories, and after-school activities.

Occupational therapists and occupational therapy assistants also collaborate with adults in the child’s life:

- **Parents or care providers**—to provide education about the social-emotional, sensory, and cognitive difficulties that interfere with a child’s participation in play, activities of daily living, and social activities; and to help develop emotional supports, structure, and effective disciplinary systems.

- **Educators and other school staff**—to develop strategies for a child to successfully complete classroom, recess, and lunchroom activities and to interact effectively with peers and adults.
Occupational therapy enables people of all ages to live life to its fullest by helping them to promote health, make lifestyle or environmental changes, and prevent—or live better with—injury, illness, or disability. By looking at the whole picture—a client’s psychological, physical, emotional, and social make-up—occupational therapy assists people to achieve their goals, function at the highest possible level, maintain or rebuild their independence, and participate in the everyday activities of life.

- **Counselors, social workers, and psychologists**—to provide insights into the interpersonal, communication, sensory processing, and cognitive remediation methods that aid emotional and social development.
- **Pediatricians, family physicians, and psychiatrists**—to support medical intervention for persistent mental illness and to provide a psychosocial and sensory component to supplement medical intervention.
- **Administrators**—to develop programs that promote social competence and to train staff and families to help kids learn and maintain sensory self-regulation strategies.
- **Communities**—to support participation in community leisure and sports programs; encourage education, understanding, and early intervention for children with mental health problems; and develop advocacy and community programs for promoting understanding of the mental health diagnosis and decreasing stigma.

**Where do Occupational Therapy Practitioners Provide Mental Health Services for Children?**

Occupational therapy practitioners promote mental health in all the environments where children are playing, growing, and learning. Children with mental health issues receive occupational therapy services in hospitals, community mental health treatment settings, private therapy clinics, domestic violence and homeless shelters, schools, day care centers, and other early education programs.

Ultimately, the goal of intervention is to promote successful participation in the occupations that characterize a healthy childhood and set up the child for success throughout his or her life. Occupational therapy practitioners help to promote safe and healthy environments for learning, growth, and development by addressing both physical and mental health.

**References**


Originally developed by Lisa M. Mahaffey, MS, OTR/L, for the American Occupational Therapy Association. Revised and copyright © 2011 by the American Occupational Therapy Association. This material may be copied and distributed for personal or educational uses without written consent. For all other uses, contact copyright@aota.org.
The primary purpose of this statement is to define the role of occupational therapy and the scope of services available for survivors and families who have experienced domestic violence. The American Occupational Therapy Association (AOTA) supports and promotes the use of this document by occupational therapists, occupational therapy assistants, and individuals interested in this topic as it relates to the profession of occupational therapy.

Domestic Violence

Prevalence

Domestic violence is a societal problem in the United States and internationally that affects not only the survivor of the violence but also the children witnessing it, the family and friends of the survivor, and the communities in which it occurs. In 2008, there were approximately 552,000 reported cases of nonfatal domestic violence against females and approximately 101,000 reported cases against males (United States Department of Justice [USDOJ], 2011). These are the reported cases; it is estimated that the numbers are much higher because many cases of abuse are unreported (National Coalition Against Domestic Violence [NCADV], 2007; Centers for the Disease Control and Prevention [CDC], 2010).

Definitions

The term victim is sometimes used to describe individuals who are or have been in an abusive relationship. The term survivor is used to describe individuals who are currently in the abusive relationship or who have overcome the abuse. We choose to use the term survivor as it is more empowering and denotes the strength and courage needed to endure as well as leave the abusive relationship.

There are numerous definitions of domestic violence depending on the state and organization. This document defines domestic violence as a pattern of “coercive behavior designed to exert power and control over a person in an intimate relationship through the use of intimidating, threatening, harmful, or harassing behavior” (Office for Victims of Crime [OVC], 2002). The emphasis is on a pattern of abuse and violence that becomes part of their lives, leaving lasting effects on the survivor and children. Domestic violence often is used more globally to account for the broad impact it has on the family, whereas the term intimate partner violence (IPV) specifically refers to the violence between a former or current partner or spouse (National Institute of Justice [NIJ], 2007).

For the purposes of this paper, the term domestic violence will be used because of its broader connotation. Although women are abused in 85% to 95% of the reported domestic violence cases (Fisher & Shelton, 2006), men also are abused and face an additional stigma of gender
roles, which often prevents them from coming forward (OVC, 2002). Therefore, it is important to view domestic violence as an issue of obtaining power and control over a partner without assuming that the partner is female.

**Survivor Characteristics**

Domestic violence occurs in both heterosexual and homosexual relationships at nearly the same rate (National Coalition of Anti-Violence Programs, 1998). In a national study, Tjaden & Thoennes (2000a) indicated that 11% of lesbians reported violence by their female partner and 15% of gay men who had lived with a male partner reported being victimized by that partner. Survivors of domestic violence in a homosexual relationship may have more difficulty accessing services and may face further stigma and marginalization due to their sexual orientation.

Domestic violence knows no boundaries; it crosses into all socioeconomic classes, races, societies, and ages, regardless of the sexual orientation that defines the relationships. The key issue in domestic violence is the use of a pattern of abusive behavior by the abuser to establish fear, power, and control over an intimate or formerly intimate partner.

Women with disabilities who are abused may face additional barriers that make it more difficult to leave the abusive relationship and access services. Although there are inconsistent findings regarding the incidence of abuse of women with disabilities, several sources indicate that women with disabilities are assaulted, raped, and abused at a rate twice that of women without disabilities (Brownridge, 2006; Helfrich, Lafata, MacDonald, Aviles, & Collins, 2001; Milberger et al., 2002; NIJ, 2000; Nosek, Hughes, Taylor, & Taylor, 2006). Analysis of data from the 2007 National Crime Victimization Survey indicated that the rates of violence against women with disabilities was highest among women with cognitive disabilities (Rand & Harrell, 2009).

Women with disabilities may be dependent on their partners for financial, physical, and/or medical support and thus may stay in abusive relationships for longer periods of time (Helfrich et al., 2001; NIJ, 2000). Their abusers may withhold necessary equipment such as wheelchairs, braces, medications, and transportation as a means to control them (NIJ, 2000).

Domestic violence also affects older adults. Domestic violence in older adults has unique considerations due to the chronic exposure to abuse over a lifetime (Jacobson, Pabst, Regan, & Fisher, 2006; Zink, Regan, Jacobson, & Pabst, 2003). The couple may experience feelings of guilt mixed with responsibility, particularly when the abuser is also the caregiver or when the caregiver needs to care for the abuser. As the couple gets older and experiences changes in their health, the violence may be masked by conditions such as Alzheimer’s disease, or it may be heightened by the added stress that caregiving brings to the relationship (National Coalition Against Domestic Violence, n.d.; Zink et al., 2003).
Causes and Contributing Factors

Factors that cause or contribute to domestic violence have been discussed and contested by social scientists for decades, with little agreement about the commonalities (Jewkes, 2005). The exception is poverty, which is the only factor that consistently has been found to be a key contributor to domestic violence (Davies, 2002; Jewkes, 2005; Josephson, 2005; Lyon, 2000, 2002; Sokoloff & Dupont, 2005). The most recent U.S. Department of Justice (2007) statistics from an analysis of reported and unreported family violence indicate that persons in households with annual incomes less than $7,500 (below the U.S. poverty threshold) have higher rates of assault than do persons in households with higher income levels. Furthermore, the data also indicate that social class appears to be inversely related to the severity of the violence; more severe domestic violence occurs against women within the lowest socioeconomic group (Bograd, 2005; Browne & Bassuk, 1997; Davies, 2002; Lyon, 2000, 2002; Rank, 2004; Rice, 2001).

Limited education and being a victim of child maltreatment, especially sexual abuse, also have been found to be strong links to subsequent victimization (Browne & Bassuk, 1997; Tjaden & Thoennes, 2000b). Being verbally abused has been found to be a highly predictive variable for abuse by an intimate partner (Tjaden & Thoennes, 2000b).

Being economically poor also has serious implications in terms of whether a woman stays in an abusive relationship. Studies of female survivors of domestic violence have consistently indicated that a survivor’s ability to earn an independent source of income that allows her to successfully sustain her family is the most significant indicator that she will be able to permanently leave the abusive relationship (Economic Stability Working Group, 2002; Waldner, 2003). It makes sense, then, that the lack of a sustainable income is a significant reason why, on average, survivors return to abusive relationships 5–7 times (Adair, 2003; Brush, 2003; Harris, 2003; Louisiana Coalition Against Domestic Violence, 2007).

Childhood Exposure

Between 7 and 14 million children and youth are exposed to adult domestic violence each year (Edleson et al., 2007). In addition to witnessing the violence between their parents or a parent and partner, it is estimated that child abuse occurs in 30% to 60% of domestic violence cases (Appel & Holden, 1998; McKibben, DeVos, & Newberger, 1998). Children who grow up in a domestic violence household often have low self-esteem, psychosomatic complaints, nightmares, impaired social skills, and poor academic performance. As a result, they may be aggressive, withdrawn, anxious, depressed, and even suicidal (Israel & Stover, 2009; OVC, 2002). In families where there is domestic violence, young boys may model their father’s behavior, while girls may model their mother’s behavior and show more signs of withdrawal and isolation (Cummings, Peplar, & Moore, 1999; Holt, Buckley, & Whelan, 2008; Huth-Beck, Levendosky, & Semel, 2001; Stiles, 2002).

Some children may have difficulty expressing their feelings and stress and may exhibit aggressive behaviors as a way to try to communicate with their mother. Studies of children...
exposed to domestic violence indicate that they also may have difficulty with self-calming, sleeping, and eating activities; may demonstrate developmental delays or maladaptive behaviors; and may have poor verbal and social skills that negatively affect their academic performance. They may have higher rates of somatic complaints and interpersonal problems (Cummings et al., 1999; Huth-Beck et al., 2001; Norwood, Swank, Stephens, Ware, & Buzy, 2001; Sternberg et al., 1993; Stiles, 2002).

**Types of Violence**

Abuse in domestic violence comes in many forms; it may be physical, psychological, sexual, or economic. *Physical violence* may include such behaviors as hitting, slapping, punching, or stabbing. *Psychological violence* may take the form of verbal abuse, harassment, possessiveness, destruction of personal property, cruelty to pets, and isolation (OVC, 2002; U.S. Department of Justice, n.d.). The abuser often isolates the victim from family and friends, thus limiting access to support systems. *Sexual abuse* can occur between two intimate partners when the abuser forces or coerces the victim into a sexual act. Survivors also may experience *economic abuse* in which the abuser controls the finances, leaving the victim with no money or a limited allowance.

**Challenges With Occupation or Activities**

Research indicates that women who are survivors of domestic violence may struggle when performing several of their daily life occupations or activities, particularly work performance, educational participation, home management, parenting, and leisure participation (Gorde, Helfrich, & Finlayson, 2004; Helfrich & Rivera, 2006; Javaherian, Krabacher, Andriacco, & German, 2007). They may experience problems with money management, task initiation, self-confidence, coping skills, stress management, and interpersonal relationships (Carlson, 1997; D’Ardenne & Balakrishna, 2001; Helfrich, Aviles, Badiani, Walens, & Sabol, 2006; Levendosky & Graham-Bermann, 2001; Monahan & O’Leary, 1999). They may have difficulty with higher level mental functions, including decision making, judgment, problem solving, and direction following.

Survivors of domestic violence often face challenges sustaining employment (Josephson, 2005; Riger & Staggs, 2004; Tolman & Raphael, 2000). One common reason is that abuse, including stalking and excessive phone calls or other forms of contact, often happens at the workplace (Corporate Alliance to End Partner Violence, 2002–2008). Survivors’ inconsistent work histories can cause difficulties with finding a job once they have left the abusive relationship.

In addition, leaving an abusive relationship and becoming a single parent can increase the risk of being unemployed or among the working poor in the United States. The jobless rate for unmarried mothers is almost 3 times that of married mothers, 8.5% as compared to 3.1% (U.S. Department of Labor, 2007).
Occupational Therapy and Domestic Violence

In its broadest sense, the domain of occupational therapy is the facilitation of people’s ability to engage in meaningful, daily life activities, or occupations in a manner that supports their full participation in various contexts and positively affects health, well-being, and life satisfaction (AOTA, 2008). Occupational therapists and occupational therapy assistants view occupations as central to a person’s identity and competence, influencing how a person spends time and makes decisions (AOTA, 2008). Domestic violence negatively affects the ability of the survivors and their families to engage in their daily life occupations in a competent, healthy, and satisfying manner. Consequently, in the spirit of social and occupational justice, occupational therapy practitioners focus on developing or restoring these abilities. Specifically, occupational therapy practitioners focus on enhancing the ability of the survivors and their families to participate in activities of daily living (ADLs), instrumental activities of daily living (IADLs), rest and sleep, education, work, leisure, play, and social participation for the purpose of gaining skills and abilities needed to take control of their lives, find purpose, and develop a healthy independent lifestyle.

Occupational therapy practitioners work directly and indirectly with survivors of domestic violence and their families in a variety of settings such as hospitals, rehabilitation centers, skilled nursing facilities, outpatient therapy clinics, mental health facilities, school systems, shelters, home health care, and other community programs. Occupational therapy practitioners may work with survivors and family members who have

- Sustained injuries or disabilities as a result of domestic violence,
- Chosen to remain in and rebuild a relationship in which abuse has occurred, or
- Decided to leave the abusive relationship and reconstruct their lives.

In the course of their practice, occupational therapy practitioners also may work with individuals whom they suspect or discover are victims or survivors of domestic violence but who have not reported the domestic violence. In such cases, occupational therapy practitioners have a professional and ethical responsibility to take action that promotes the health and safety of these individuals. As health care professionals, occupational therapy practitioners are mandated to report suspected child abuse. Some states also mandate that they report suspected abuse in adults, particularly in older adults or adults who have intellectual disabilities.

Occupational therapy practitioners need to consult their state regulations and facility guidelines regarding procedures to follow when they suspect or know that domestic violence has occurred. Actions that practitioners may take include

- Filing a report to the local law enforcement agency or children’s protective services;
- Interviewing, evaluating, and providing interventions without the abuser present to allow the client the opportunity to discuss the situation in relative safety;
- Identifying and assessing injuries and their potential cause;

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When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).
• Talking to the client about healthy relationships and addressing areas of occupation and performance patterns and skills that may have been affected by the abusive relationship, such as leisure, IADLs, work, and ADLs;
• Respecting the client’s perception of the relative danger of the situation to his or her life and the well-being of other family members and remaining empathetic and nonjudgmental about the client’s decision to remain in or leave the abusive situation;
• Providing the client with contact information for the local domestic violence hotline; and
• Following safety precautions to determine if it is appropriate to conduct home visits.

**Occupational Therapy Evaluation and Intervention**

The occupational therapy service delivery process occurs in collaboration with the survivors of domestic violence, their family members, and other service providers. Throughout the occupational therapy evaluation, intervention, and assessment of outcomes, occupational therapy practitioners value and consider the desires, choices, needs, personal and spiritual values, and sociocultural backgrounds of the survivors and their family members. Practitioners also consider the service delivery context. Important outcomes of occupational therapy service provision include, but are not limited to, facilitating the ability of the survivors and their family members to consistently engage in and perform their daily activities, achieving personal satisfaction and role competence, developing healthy performance patterns, and improving their quality of life.

The occupational therapy evaluation is focused on determining what the survivors and their family members want and need to do and identifying the factors that act as supports or barriers to performance of the desired occupations (AOTA, 2008). Occupational performance; routines, roles, and habits; activity demands; sociocultural beliefs/expectations; spirituality; and physical, cognitive, and psychosocial factors are addressed during the evaluation process. Evaluations and assessments that are client-centered and occupation-based are effective for this population.

Occupational therapy service delivery is based on findings from the evaluation and the survivors’ and the family members’ stated priorities. Interventions with adults who are survivors of domestic violence focus on empowerment and active participation in healthy occupations or daily life activities. Findings from several studies of survivors have indicated that during the early period after leaving the abusive situation, survivors continue to devote themselves to the care of others, especially their children, while often not taking care of themselves (Giles & Curreen, 2007; Underwood, 2009; Wuest & Merritt-Gray, 1999).

Occupational therapy interventions with adult women survivors may include working on the development of a realistic budget; facilitating the use of effective decision-making skills regarding employment opportunities; learning parenting skills and calming techniques to use with their children; encouraging and supporting efforts to attain further education; learning assertiveness skills; and teaching stress management and relaxation techniques to improve sleep patterns (Gorde et al., 2004; Helfrich et al., 2006; Helfrich & Rivera, 2006; Javaherian
Occupational Therapy Services for Individuals Who Have Experienced Domestic Violence

et al., 2010). Therapy sessions focused on performance patterns may be helpful, because findings from several studies have indicated that survivors are constantly juggling family, work, and possibly school responsibilities without a significant other to assist them with their obligations (Butler & Deprez, 2002; Jones-DeWeever & Gault, 2006; Underwood, 2009).

Interventions with children who have witnessed domestic violence may include facilitation of developmentally appropriate play skills, social skills training, the use of techniques for improving concentration and attention span during school activities, and assistance with the organization of study habits and school materials. Adolescents may benefit from interventions addressing relationship skills, life skills, stress management, and coping strategies (Javaherian-Dysinger et al., 2011).

Occupational therapy practitioners focus on outcomes throughout the occupational therapy service delivery process. Assessing outcome results assists occupational therapy practitioners with making decisions about future directions of interventions at the individual as well as at the organizational or population level (AOTA, 2008). At the individual level, the selection of outcomes is based on the survivors’ priorities and may be modified based on changing needs, contexts, and performance abilities (AOTA, 2008). For example, an occupational therapy practitioner may work with a woman who is a survivor of domestic violence on her goal of obtaining housing. After the woman moves into the new living situation, the practitioner may help the woman work on her goal of maintaining a healthy home environment for herself and her children.

At the organizational or population level, data about targeted outcomes can be aggregated and reported to boards of directors of community agencies, state and federal regulators, and funding agencies. An example of this type of outcome assessment would be the reporting of the number of children who demonstrated difficulty participating in their daily life activities at home, at school, and in their communities because of exposure to domestic violence and the progress they have made during the occupational therapy intervention to increase their level of healthy participation.

Occupational therapy practitioners also may work with the abusers in collaboration with other professionals such as psychologists, social workers, and pastoral counselors. Sometimes the judicial system issues a court order for the abuser to participate in a formal program to address the violent behaviors. These programs are generally based on six principles: (1) the abuser is responsible for the behavior; (2) provocation does not justify violence; (3) violent behavior is a choice; (4) there are nonviolent alternatives; (5) violence is a learned behavior; and (6) domestic violence affects the entire family, whether it is directly or indirectly witnessed (OVC, 2002). Occupational therapy interventions with the abuser may include training in social skills, assertiveness, anger management, stress management, parenting, and spiritual exploration as related to daily occupations.
Education, Training, and Competencies

Occupational therapists and occupational therapy assistants are educationally prepared to address the various occupation-related concerns of survivors of domestic violence. The Accreditation Council for Occupational Therapy Education (ACOTE) standards for educational programs require content related to daily life occupations, human development, human behavior, sociocultural issues, diversity factors, medical conditions, theory, models of practice, evaluation, and techniques for the development and implementation of intervention plans under the scope of occupational therapy (ACOTE, 2010). Occupational therapy practitioners are competent to address life skills, lifestyle management, adaptive coping strategies, adaptation, time management, and values clarification that affect the ability of survivors of domestic violence to participate in their ADLs, IADLs, education, work, play, leisure, and social participation activities. In addition, occupational therapy practitioners have the expertise to work with individuals, organizations, and populations.

Occupational therapists and occupational therapy assistants who are supervised by an occupational therapist are competent in the following areas:

- Establishing and maintaining therapeutic relationships;
- Conducting interviews;
- Administering functional assessments to determine occupational performance needs and to develop an intervention plan;
- Utilizing interpersonal communication skills;
- Designing and facilitating therapeutic groups;
- Developing individualized teaching and learning processes with clients, family, and significant others;
- Coordinating program interventions in collaboration with clients, caregivers, families, and communities grounded in evidence-based practice;
- Developing therapeutic programs;
- Promoting health and wellness through engagement in meaningful occupations; and
- Understanding the effects of health, disability, and social conditions on the individual within the context of family and society (ACOTE, 2010).

Participating in continuing education initiatives advances occupational therapy practitioners’ understanding of and capacity to provide interventions that address domestic violence.

Supervision of Other Personnel

When provided as part of an occupational therapy program, the occupational therapist is responsible for all aspects of the service delivery and is accountable for the safety and effectiveness of the service delivery process. The occupational therapy assistant delivers occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2009). The education and knowledge of occupational therapy practitioners also prepare them for employment in arenas other than those related to traditional delivery of occupational therapy. In these circumstances, the occupational therapy practitioner should determine whether the services they provide are related to the delivery of occupational therapy by referring to their state practice acts, regulatory agency standards and
rules, domain of occupational therapy practice, and written or verbal agreement with the agency or payer about the services provided (AOTA, 2009). Occupational therapy practitioners should obtain and use credentials and a job title commensurate with their roles in the specific arena. In such arenas, non–occupational therapy professionals may provide the supervision of occupational therapy assistants.

Case Studies

The following case studies provide examples of the role of occupational therapy in domestic violence.

Adult Case Study: Maria

An occupational therapist working in a shelter for survivors of domestic violence was asked to assess Maria, a 28-year-old mother of two children.

Evaluation

Using the Canadian Occupational Performance Measure (Law et al., 2005), Maria identifies the occupational performance areas are the most important to her. She would like to feel competent in her ability to take care of a house, parent her children, and keep them safe. She also wants to work with the occupational therapist on finding and maintaining a job, budgeting, and completing her GED. Maria rates her performance as 1—unable to do it and her satisfaction levels as 1—not satisfied at all for these performance areas.

When budgeting is discussed, Maria states that she had never been responsible for money management. She went straight from her parent’s home into her marriage at age 17, and her husband would not allow her to have anything to do with the money. He constantly told her that she was “too stupid” to take care of money. She was not allowed to work outside the home, so she was dependent on her husband for money.

Intervention

The occupational therapist helps Maria procure and complete job applications and practice job interviewing skills. After Maria finds a steady job, she and her children move into the shelter’s transitional living program. To stay in this program, Maria needs to put a certain amount of money into a savings account on a monthly basis to secure a home for her and her children. Following her first paycheck, the occupational therapist meets with Maria to project a budget for her expenses and savings. Maria asks the occupational therapist to develop her budget for her because she “isn’t smart enough to do it herself.” She states that math was her worst subject in school. The occupational therapist grades the complexity of the task to enable Maria to develop problem-solving skills and reasoning abilities for budgeting.

The occupational therapist then models for Maria how to contact community agencies to obtain information about GED programs. They determine a daily schedule and identify support networks so that Maria can work, complete her studies, and care for her children.
**Older Adult Case Study: Mr. Lee**

An occupational therapist in an outpatient clinic receives a referral to provide occupational therapy services to Mr. Lee, a 72-year-old man with a right distal radius fracture and a boxer’s fracture. Mr. Lee has chronic obstructive pulmonary disease (COPD) and uses a wheelchair for mobility. He has been living with his current partner for the past 10 years.

**Evaluation**

During the evaluation the occupational therapist asks Mr. Lee to explain how the injury occurred. He is vague in his responses and simply states that he became weak and fell out of his wheelchair. Over the next few sessions, while providing interventions to address Mr. Lee’s hand injuries and COPD, the occupational therapist notices additional bruises on his arms and suspects that he is involved in an abusive relationship.

**Intervention**

Because the occupational therapist lives in a state that mandates reporting of abuse in adults, she files a report to the appropriate law enforcement agency. She lets Mr. Lee know that law requires such action. The therapist then initiates conversation about domestic violence.

Research (Bacchus, 2003; McCauley, 1998) has shown that victims of domestic violence want their health care provider to ask them about domestic violence, thereby creating a venue for them to open up as they feel able.

While continuing to provide interventions related to hand function and energy management, the occupational therapist also reassesses Mr. Lee’s areas of occupation, performance skills, and performance patterns to identify additional home and community supports he may need because of the domestic violence. She provides Mr. Lee with resources on domestic violence and the local crisis center’s contact information. She includes interventions to focus on building self-esteem and empowerment.

**Adolescent Case Study: Heang**

Heang is a 16-year-old girl in 10th grade. For the past 2 months she has dated a popular young man who is in the 11th grade. Heang initially thought that his frequent phone calls and text messages throughout the day were very romantic. He started telling her that he did not want her to go out with her friends and got into several fights with Heang’s male classmates. After dating for about 1 month, he began to slap and punch her. The next day he would bring her flowers. Rather than tell anyone, Heang withdrew from her friends and after-school activities; she did not socialize with other boys at school or work.

A representative from the local women’s shelter spoke to Heang’s 10th-grade class about teen dating violence. Realizing that she was a victim of this violence, Heang spoke to her guidance counselor. The counselor referred her to a teen dating violence group run by the school occupational therapist.
Evaluation
The occupational therapist conducts an initial evaluation to assess Heang’s occupational needs, problems, and concerns. The therapist analyzes Heang’s occupational performance skills, performance patterns, context, and activity demands (AOTA, 2008). After reviewing the results of the evaluation, the therapist develops collaborative goals with Heang related to her school and after-school activities, social participation, leisure activities, and job.

Intervention
Using a cognitive–behavioral approach, the occupational therapist helps Heang explore the impact that the dating violence has had on her school and work performance, social participation, and sense of identity. She encourages Heang to identify the importance of social participation in the development of self-esteem, friendships, health, and identity. Together they develop a plan for Heang to participate again in familiar leisure occupations as well as in new ones.

Infant Case Study: Jonella and Kia

Jonella brought her 4-month-old daughter Kia to an occupational therapist as part of an early intervention service for infants and toddlers. Jonella tells the occupational therapist that she is concerned about Kia, who sleeps only 30 minutes at a time and consistently wakes up screaming. Jonella explains that she and Kia have just left an abusive relationship and now live with friends. Since infancy, Kia has been awakened many times because of the shouting and physical violence. In addition, Jonella could not establish a daily nap and sleep routine for Kia because she frequently had to rush Kia out of the house to keep her safe.

Evaluation
The occupational therapist administers the Test of Sensory Functions in Infants (DeGangi & Greenspan, 1989) and the Transdisciplinary Play-Based Assessment (Linder, 2008) to Kia to assess for sensory issues focusing on self-regulation and for potential developmental complications.

Intervention
The occupational therapist and Jonella collaborate to identify strategies for establishing a consistent nap and sleep routine for Kia. The occupational therapist models strategies that Jonella can use to help calm Kia and modulate the amount of sensory input she receives. They also identify strategies for modifying the environment in the room where Kia sleeps and for helping Jonella relax with Kia before putting her to bed.

Child Case Study: Daniel

A school system occupational therapist is asked to assess Daniel, a 5-year-old student who has an individual education program (IEP), to address learning challenges. His teacher states that Daniel is having extreme problems with manipulating crayons and performing gross motor activities. The teacher informs the therapist that his mother has just left an abusive situation. His mother has stated that Daniel’s father would not let her place Daniel in a preschool or in a
Mother’s Morning Out program. She was not allowed to take Daniel outside to play. In addition, when his father was home, Daniel was expected to sit quietly and not play with toys. In spite of these restrictions, Daniel’s mother did her best to expose her son to books and songs and teach him ways to play with household materials.

**Evaluation**

The occupational therapist performs the Quick Neurological Screening Test II (QNST–II; Mutti, Sterling, Spalding, & Spalding, 1998) and sends the Sensory Profile (Dunn, 1999) home with Daniel for his mother to complete. Daniel scores within the “Definite Difference” range on the following factors on the Sensory Profile: Emotionally Reactive, Oral Sensory Sensitivity, Inattention/Distractibility, Auditory Processing, Vestibular Processing, and Multisensory Processing. As measured by the QNST–II, Daniel also has difficulty with gross motor skills, balance, tactile processing, visual tracking, motor planning, impulsivity, and anxiety.

**Intervention**

The occupational therapist observes Daniel in the classroom and makes recommendations for strategies that the teacher can use to decrease Daniel’s distractibility and to increase his attention and participation at school. The occupational therapy assistant works with Daniel for 45 minutes twice a week, with time divided between intervention in the classroom to address cutting and drawing activities and outside the classroom to increase motor control, sensory awareness, and problem-solving skills.

**Family Case Study: Herminie’s Family**

An occupational therapist is part of a treatment team for individuals who have diabetes. The physician wants the therapist to assess and provide services to Herminie, a 34-year-old woman who is not routinely checking her glucose levels or taking her insulin. Because Herminie speaks limited English, her sister accompanies her to the session and translates for her.

**Evaluation**

During the interview, Herminie shares that her 13-year-old daughter has taken on the responsibility for prompting Herminie to perform the techniques necessary to keep the diabetes under control. The 13-year-old daughter also takes care of her 7-year-old brother while Herminie works. Herminie left home with her children a year ago because her husband was physically and emotionally abusive to her. According to Herminie’s sister, as a result of witnessing the abuse, the daughter is continually afraid that something is going to happen to her mother and brother. She is afraid to leave the house, except to go to school, and does not socialize with friends.

**Intervention**

With the aid of Herminie’s sister, who provides verbal and written translation, the occupational therapist develops a daily checklist that Herminie can use to prompt herself to independently check her glucose levels and take her insulin. She discusses with Herminie how important it is for her, rather than her daughter, to be responsible for managing her diabetes.
The occupational therapist meets with Herminie and her daughter weekly for several weeks to reinforce and monitor the progress that Herminie is making and to assist the daughter with reducing her anxiety. With Herminie’s and her daughter’s permission, the therapist called the daughter’s school guidance counselor to discuss the situation and request help with decreasing the daughter’s anxiety while facilitating increased socialization. In addition, the occupational therapist recommends that Herminie participate in a domestic violence counseling program.

References


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To be published and copyrighted in 2011 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy, 65*(6 Suppl.)
AOTA’s Societal Statement on Combat-Related Posttraumatic Stress

Self-report of symptoms of post-traumatic stress disorder (PTSD) have tripled among combat-exposed military personnel, compared to those who have not deployed, since 2001 (Smith et al., 2008). Tanielian and Jaycox (2008) have estimated that approximately 300,000 military personnel previously deployed to Iraq or Afghanistan currently experience PTSD or major depression. Military personnel are returning home and demonstrating signs and symptoms of combat-related PTSD, such as nightmares, flashbacks, memory loss, insomnia, depression, avoidance of social interaction, fear, decreased energy, drug and alcohol use, and the inability to concentrate. These signs and symptoms could affect these individuals’ ability to effectively negotiate their personal lives and work roles. Specifically during work, the avoidance of social interactions and avoidance of situations that resemble the traumatic event may interfere with coworker relationships or may be perceived as the lack of motivation or ability to be successful in a work setting (Penk, Drebing, & Schutt, 2002).

Combat-related PTSD not only affects military personnel but also the family and the community in which military personnel interact. If unidentified and untreated, the effects of combat-related PTSD may have a delayed onset and cause problems such as depression, social alienation, marital communication problems, difficulty with parenting, and alcohol and drug abuse, and each can cause a disruption in military personnel’s personal lives, professional abilities, and overall physical and mental health (Baum, 2008). It is vital for military personnel and health care providers to be educated on these signs and symptoms and detect them early to ensure that military personnel receive adequate opportunities for prompt intervention services and to access support. This is something that occupational therapists and occupational therapy assistants can do.

The overarching goal of occupational therapy for military personnel coping with combat-related PTSD is to use strategies to help them recover, compensate, or adapt so they can reengage with activities that are necessary for their daily life. Occupational therapists and occupational therapy assistants also help military personnel coping with combat-related PTSD to develop strategies to self-manage the long-term consequences of the condition. These strategies are important to promote their health and participation in family, community, and military life because these strategies support their ability to engage or re-engage in daily life activities and occupations that are necessary and meaningful to them. Because of their knowledge and skills in addressing the physical, cognitive, and psychosocial factors associated with combat-related PTSD, occupational therapists and occupational therapy assistants bring broad expertise to help personnel identify the barriers that are limiting their recovery and participation in meaningful activities (American Occupational Therapy Association [AOTA], 2005). AOTA supports recognition of and intervention services for military personnel coping with combat-related PTSD, including research, advocacy, education, and resource allocation consistent with professional standards and ethics.

References


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The views expressed in this article are those of the authors and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government.

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AOTA’S Societal Statement on Stress and Stress Disorders

Stress is a pervasive societal challenge that affects the social participation of people of varying ages, ethnicity, gender, and socioeconomic status (U.S. Department of Health and Human Services [USDHHS], 2000). It is a significant risk factor in a number of health problems, including mental illness, cognitive decline, cardiovascular disease, musculoskeletal disorders, and workplace injuries. Individuals with disabilities are disproportionately affected, with 49 percent of these people reporting adverse health effects from stress, compared with 34 percent of the general population (USDHHS, 2000).

Individuals, families, organizations, and communities differ significantly in their perceptions of and vulnerability to stressful events, as well as in their coping strategies. Organizational stressors, such as relocation or restructuring, may result in financial strain and loss of personnel. Community or population catastrophes, such as natural disasters or wars, result in stress from overwhelming personal loss, forced displacement, and a disruption of massive proportions in familiar daily routines and occupations (Wein, 2000).

The occupational therapy profession promotes the establishment of healthy habit patterns; familiar, predictable routines; and increased engagement in meaningful occupations that serve both as protective and healing factors in combating the negative effects of stress. Occupational therapy practitioners develop evidence-based interventions based on this philosophy, and conduct research to establish their efficacy for coping with stress (Jackson, Carlson, Mandel, Zemke, & Clark, 1998; Nelson, 1996; Oaten & Chen, 2006; Wein, 2000).

References


1When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

**Related Reading**


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AOTA’S Societal Statement on Youth Violence

A nationwide crisis related to youth violence has resulted in this being the second-leading cause of death among all youth aged 15 to 24 years and the leading cause of death among African American youth of the same age (U.S. Department of Health and Human Services, 2000). Acts of violence include bullying, verbal threats, physical assault, domestic abuse, and gunfire. Premature death, disability, and academic failure occur due to violent activity that surrounds youth. Risk factors that lead to youth violence include history of being abused or abusing others, school truancy, poor time use, exposure to crime, mental illness, drug and alcohol use, gang involvement, access to guns, and absence of familial and social support structures. Rising health care costs, decreased property values, and social services disruption are indicators of the impact that violence has on the health of communities, as well as on individual participation in society (Centers for Disease Control & Prevention, 2006). Individual participation can be limited by reduced access to services, fear of harm to self or others, and the inability to perform valued roles. The severity of this issue has forced policymakers, health care providers, teachers, parents, and students to recognize, examine, and alter social conditions, cultural influences, and relationships.

The profession of occupational therapy has the societal duty and expertise to respond to youth violence by promoting overall health and well-being among youth (American Occupational Therapy Association, 2006). Occupational therapy practitioners work toward understanding the occupational nature of violence, researching effective interventions, creating collaborations, and advocating for public health and social services for youth. Violence and its antecedents can deprive this growing segment of youth of necessary and meaningful occupations (Whiteford, 2000), leaving them insufficiently prepared for their future. Positive change can occur by providing youth with opportunities to replace poor occupational choices with healthy, safe, productive, and socially acceptable activities (Snyder, Clark, Masunaka-Noriega, & Young, 1998). Ultimately, occupational therapy practitioners provide services that support a vision of social justice, dignity, and social action throughout the life span by addressing the engagement patterns and lifestyle choices of at-risk youth through methods such as effective transition services and life skills remediation.

References


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*Adopted by the Representative Assembly 2007CO144*

Dear Chairman Baucus and Ranking Member Hatch:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live a full and productive life by promoting health and well-being while also minimizing the functional effects of illness, injury, disability, and other conditions.

We are writing in response to your request for comments on ways to improve the mental health system in the United States. We would first like to provide some information about the role of occupational therapy in helping those with mental illness, and then provide feedback on the questions posed in your letter.

The scope of occupational therapy practice includes the provision of mental health services, and occupational therapy providers play an important role in the provision of comprehensive, integrated mental health services. Our history in this field traces back to the institutional settings in the early Twentieth Century and has since evolved to include multiple settings, including community behavioral health settings, hospitals, and school settings. Occupational therapists and occupational therapy assistants are educated, trained, and experienced in providing services that support mental and physical health, rehabilitation, and recovery-oriented approaches. Entry-level occupational therapists must have at least a master’s degree but may also enter the profession with a clinical doctorate degree. Occupational therapy practitioners are able to provide mental health services under both Medicare and Medicaid. In Medicare, occupational therapy is included under the partial hospitalization benefit as well as outpatient therapy. In Medicaid, occupational therapy is often a directly covered service for adults; it is covered fully for children under the Early and Periodic Screening, Diagnosis, and Treatment mandate, and can be included in bundled payment approaches that states may utilize for community mental health services.

Serious mental illness can have a devastating impact on the basic skills that are needed for day-to-day, independent functioning. The purpose of occupational therapy in mental health is
to increase an individual’s ability to live as independently as possible while engaging in meaningful and productive life roles. Occupational therapy practitioners work with Medicare/Medicaid beneficiaries and other health care consumers to establish goals related to improving participation in one’s home, school, workplace, and community. They provide consumer-centered, goal-oriented interventions that teach and facilitate skills in the areas of problem solving, medication management, home and community safety, social skills, activities of daily living, vocational and leisure interests, stress management, and more. The profession’s core focus of increasing an individual’s ability to participate fully in their home and community is well-aligned with the recovery perspective for mental health interventions.

Occupational therapy interventions have been shown to result in improved symptom and medication management as well as increased social skills, social participation, and personal well-being. These interventions have also been shown to decrease negative psychological symptoms, hospital admissions and readmissions, poor treatment compliance, and social exclusion.

AOTA has created evidence-based practice guidelines, accepted into the Agency for Healthcare Research Quality (AHRQ) National Guideline Clearinghouse, to support and define the role of occupational therapy practitioners in mental health promotion, prevention, and intervention with children and youth as well as the role of occupational therapy practitioners in serving adults with serious mental illness.

What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?

In order for occupational therapists to fully address the needs of persons with mental illness, the profession’s status as mental health providers must be clear and unambiguous. While mental health services provided by occupational therapists are covered and reimbursed by Medicare and Medicaid, there are states and contractors who restrict provision for mental health diagnoses. An underlying concern is that occupational therapists are not identified as “core mental health professionals” in federal statute. This list is in the National Health Service Corps language but it is often used by policymakers as a reference point for other programs or for state programs. The exclusion of occupational therapists from this list is an outdated remnant from the time when occupational therapists were not required to obtain at least a master’s degree, as they are today. Lack of definition as a “core mental health profession” has led to a wide variation in coverage for occupational therapy services under Medicaid for people with mental illness, limiting consumer access to these services for mental health promotion and recovery. Additionally, in many cases the omission as a “core mental health profession” has led to the exclusion of occupational therapists from higher paying positions typically held by master’s level professional, such as team leader, and program head. Instead those master’s level occupational therapists that chose to work in mental health are often only eligible to fill positions that are paid at a bachelor’s level or lower.

The Center for Medicare and Medicaid Services (CMS) recognized the vital role that occupational therapy plays on the interdisciplinary team for treatment of “physical, medical, psychosocial, emotional, and therapeutic needs” of patients, by specifically listing occupational therapy as team member in the CMS Proposed Rule for Conditions of Participation for
Community Mental Health Centers. We applaud CMS’s inclusion of occupational therapy in this rule and strongly support its inclusion in the forthcoming final rule.

There must not be restrictions on occupational therapists’ capacity to provide and be reimbursed for the full range of services that fall within their scope of practice, when provided to people with mental and behavioral health issues. Any new, non-fee-for-service models of payment must recognize the importance of occupational therapy in physical, behavioral and mental health, and should explicitly include occupational therapy as eligible for reimbursement under any system of bundled payments. Finally, should an integrated model of care be implemented that continues to pay for medical services through a fee-for-service model, there must be parity between reimbursement for physical and mental health services, to ensure a seamless flow of services without arbitrary distinctions in care.

**What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?**

We strongly believe that occupational therapy plays an essential role in integrated primary care settings. Occupational therapy utilizes a holistic lens to look at patients of all ages and diagnoses, which encompasses both physical and psychological aspects of the person, and how that affects daily functioning. Utilizing this approach, occupational therapy provides the solution to the key elements that are sought to be addressed by the integration of behavioral health services with primary care.

In the integration and collaboration of primary care and behavioral health settings, it is critical that professionals who are trained in both areas of practice are pivotal parts of the integrated model. Both occupational therapists and occupational therapy assistants are trained to provide services that support mental and physical health, rehabilitation, and recovery-oriented approaches, which can be applied in a wide array of settings including primary care clinics. Occupational therapy practitioners are currently practicing in primary care settings and have a role in various mental health settings, which ideally situates the profession of occupational therapy to play a crucial role in the integration of the two areas of health care delivery.

Occupational therapy contributes dynamic, function-based evaluations, interventions, and maintenance programs that directly result in overall improved patient outcomes – a key goal of uniting mental services with other health care. Occupational therapy contributes to outcomes in a twofold manner: first, by promoting mental health and well-being in all persons with and without disabilities and, second, by restoring, maintaining, and improving function and quality of life for individuals at risk for or affected by mental illness as well as various other conditions.

Furthermore, occupational therapy has an established role in a collaborative model of health care. The Canadian Collaborative Mental Health Initiative (CCMHI), which seeks to enhance the ability of primary health care providers to meet the mental health care needs of consumers through collaboration among health care partners, not only recognizes the need for occupational therapy expertise on the primary mental health care interdisciplinary team, but has also included occupational therapy on the CCMHI Steering Committee.
Finally, there are multiple examples of occupational therapists providing integrated care throughout the United States. Examples include:

- Providing in-home therapy services for individuals with serious mental illnesses to assist with personal care, activities of daily living (ADLs), and instrumental activities of daily living (IADLs) including medication management and chronic disease management;
- Addressing patients with diagnoses of dysthymia, depression, anxiety, panic disorder, and chronic pain through embedded occupational therapy positions in family medical clinics (interventions focus on symptom management, development of coping skills, ADLs, and progressive goal setting); and
- Implementing an evidence-based lifestyle redesign program that has been proven to improve health and wellness by preventing or managing chronic conditions, including mental health conditions, through building healthier lifestyles.

**How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?**

Access to occupational therapy can help prevent the revolving door of hospital admissions, promote consumer centered outcomes for participation, and ultimately reduce long term costs and improve positive outcomes. Occupational therapy practitioners have the skills and training to both promote mental health and well-being and to restore, maintain, and improve function and quality of life for individuals affected by mental illness.

Occupational therapy can play a key role in the early identification of mental illness. Practitioners are trained to identify functional deficits, which allows them to provide early identification of mental health and substance abuse issues through initial recognition of otherwise unexplained functional declines or comorbidities. Once a functional decline has been identified, occupational therapy can be utilized to implement brief, intervention strategies to mitigate the need for further, costly mental health intervention.

Finally, as a nation we are committed to ensuring that people with mental health issues are able to live and thrive in their communities. Ensuring that consumers have the skills and abilities to carry out activities of daily living is a key part of the successful transition from an Institute for Mental Disease or a skilled-nursing facility to independent living. This is what occupational therapy can provide.

Current barriers to access to occupational therapy services include the lack of inclusion in federal statute as a “core mental health professional”, variation from state to state on the inclusion of occupational therapy services for those with mental health issues under Medicaid, and overall low reimbursement rates for occupational therapy practitioners working in the area mental health. Remediation of these issues would greatly help in improving access to occupational therapy services. Additionally, we strongly recommend that new, integrated treatment models include occupational therapy services.
Thank you for the opportunity to provide input on strategies for improving mental and behavioral health services. AOTA looks forward to providing additional information and assistance as needed. Please contact Heather Parsons at 301-652-2682 ext 2112 if you have questions or need additional information.

Sincerely,

Christina Metzler
Chief Public Affairs Officer
February 6, 2013

Senator Tom Harkin, Chairman
U.S. Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington DC, 20510

Senator Lamar Alexander, Ranking Member
U.S. Senate Committee on Health, Education, Labor and Pensions
835 Hart Senate Office Building
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Dear Chairman Harkin and Ranking Member Alexander,

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and well-being while also minimizing the functional effects of illness, injury, disability, and other conditions.

AOTA greatly appreciates the recent Senate Health, Education, Labor and Pensions (HELP) Committee hearing, “Assessing the State of America’s Mental Health System” and would like to take this opportunity to provide comments regarding this issue. As the Committee proceeds in forming recommendations to improve mental health services, AOTA would like to offer support for your efforts and provide a brief explanation of the critical role occupational therapy practitioners can play in providing mental health services within the school system and the community.

Occupational therapy practitioners have long recognized the glaring need to improve the availability of timely, effective care within America’s mental health system. The profession was founded in mental health, sprouting from its roots in the early Twentieth Century mental health institutions and growing into a widely-ranging profession while maintaining a role in community-based mental health. Occupational therapy emphasizes the provision of supports and services that enable a person to carry out their everyday activities, so that they can be productive, engaged, and safe in the environments in which they live, work, and play.

Within the realm of mental health, occupational therapy utilizes this unique perspective to provide client-centered, occupation-based intervention that enables individuals with a mental illness to maximize their potential and lead productive, full lives. Occupational therapy practitioners are among the qualified mental health professionals who can identify and treat individuals with psychiatric disabilities.

Within schools, occupational therapy practitioners are present throughout all aspects of the school system, working to ensure that every student has the necessary supports to succeed in the educational process. Outside of the school setting, children with mental health issues can also receive occupational therapy services in hospitals, community mental health treatment settings, private therapy clinics, domestic violence and homeless shelters, day care centers, Head Start, and other early education programs.1

Occupational therapy practitioners are thereby well-positioned in the school environment and in the community to contribute to early identification, prevention, and intervention of mental illness among children.

AOTA has created an evidence-based practice guideline, accepted into the Agency for Healthcare Research Quality National Guideline Clearinghouse, to support and define the role of occupational therapy practitioners in mental health promotion, prevention, and intervention with children and youth. Occupational therapy practitioners’ role in mental health within the school setting reaches all three tiers of intervention:

- Occupational therapy can provide informal observation of students for behaviors that might suggest mental health concerns or limitations in social-emotional or educational development;
- Occupational therapy can conduct early identification of mental health problems by providing formal screenings and testing of psychosocial function to at-risk students;
- Occupational therapy can analyze the sensory, social, and cognitive demands of all school tasks and recommend adaptations to support functioning of students to promote positive mental health, prevent psychological decline, and support children with mental illness;
- Occupational therapy can assist other professional personnel in developing and implementing structures to create conducive learning environments supportive of a student’s development of specific social-emotional skills;
- Occupational therapy can be part of the team and provide in-service training to educate teachers, staff, and parents about mental illness recognition, behavioral regulation, and methods of promoting successful functioning throughout the child’s day.

Although mental health services within the school system are crucial, it is also vital to ensure collaboration of schools with community-based mental health programs to provide services not only to children with mental illnesses, but also provide support and services for their families. Occupational therapy practitioners can make significant and broad contributions in the school and in the community because the profession focuses on the development of true life skills in order to promote optimum participation and productivity in education, community living, work, health and wellness, and cognition. As part of the team concerned with the mental health of children and communities, occupational therapy practitioners are committed to providing the tools and supports necessary to assist individuals with mental illness live their lives to the fullest.

During the HELP Committees consideration of the current issues within America’s mental health system, we suggest that the Committee:

- **Ensure that any language in legislation relating to school-based mental health professionals, or mental health professionals, includes occupational therapy practitioners in recognition of its history, research base and skills.**

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• Pass legislation to expand the definition of behavioral and mental health professionals under the National Health Service Corps to include occupation therapy practitioners.

A highly qualified and skilled workforce is essential to meeting the myriad needs of individuals with severe and persistent mental illness disorders as well as those with lesser mental health needs. Access to occupational therapy is critical to enabling these individuals to live as fully as possible in society, which is the focus of the prevalent recovery model in mental health.

Furthermore, we strongly encourage the committee to continue to providing strong oversight of the implementation of the Mental Health Parity and Addiction Equity Act, essential health benefits under the Affordable Care Act (ACA) and Medicaid expansion under ACA. Treatment for mental health conditions must be a fully integrated part of health care.

Thank you for the opportunity to express our views to the Committee. Should you have any questions or need additional information about the role occupational therapy practitioners can play in supporting mental health and individuals with a mental illness diagnosis, please contact Heather Parsons at hparsons@aota.org.

Sincerely,

Christina Metzler
AOTA Chief Public Affairs Officer
American Occupational Therapy Association, Inc.