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Mental Health and OT

Introduction

Although occupational therapy (OT) is such a foundational part of mental health treatment, many people still don't know the role that occupational therapists play in psychiatric settings. Sadly, this also goes for occupational therapists themselves. Interestingly, many OT schools don't emphasize this subject enough, so many therapists enter the field without a solid understanding of how they can help people with behavioral health concerns. Even if a therapist never works in a mental health setting during their career, being aware of mental health topics is crucial to addressing the entire person during occupational therapy treatment.

Section 1: History and Background [1,2]

Occupational therapy has its roots in mental health practice dating as far back as the early 1900s. The first recorded duties of an occupational therapist were in 1918 when four individuals were sent to France to serve as neuropsychiatry reconstruction aides for soldiers in World War I. They aided with some physical injuries but were mainly intended to assist with shell shock and what was termed war neurosis, now more commonly known as posttraumatic stress disorder (PTSD). The 1920s and 1930s were mainly dedicated to the establishment of the field of occupational therapy, including setting forth standards for education and creating a mission statement.

In 1938, five universities developed accredited occupational therapy programs. Some of the first courses within these programs consisted of war emergency training, since this was the initial setting where OTs made an impact and continued to be a major practice area for some time. In the 1960s, certified occupational therapy assistants (COTAs) became a formal discipline. During this time, occupational therapy providers began expanding their reach outside of war-based settings, such as psychiatric hospitals. Their work mainly focused on activities such as arts and crafts, which differs quite a bit from the role of OT today. However, this was the very beginning of what we now know as meaningful occupations, which are the crux of the profession and what separates OTs from other rehabilitation providers.

Interestingly enough, it wasn't until 1965 that OT program curriculums were officially revised to include education and fieldwork opportunities focused on the rehabilitation of physical injuries and disabilities. This is also when OTs were first mentioned under the Social Security Administration Act under the category of home and prolonged care

services and began treating patients within their homes.

Since that time, OTs have entered nearly every mental health setting and expanded their reach to a wide range of skill training and educational groups. However, OT's focus in the realm of mental health has centered around recovery.

According to the American Occupational Therapy Association (AOTA), occupational therapists play a large part in mental health treatment through use of the recovery model. This framework for intervention allows OTs to provide encouragement, motivation, and hope to individuals with mental health concerns through a shared decision-making process. This also aligns with recovery goals set forth by the Substance Abuse and Mental Health Administration (SAMHSA), which states that therapists using the recovery model can instill change and promote wellness by encouraging others toward a more self-directed life.

Section 1 Personal Reflection

How can the recovery model be applied to OT's work with other populations?

Section 1 Key Words

- **Reconstruction aides -** The earliest OT providers who worked with World War I soldiers to alleviate symptoms of war neurosis (now known as PTSD) and shell shock
- **Recovery model for mental health -** The basis of mental health treatment that focuses on offering a sense of self-direction to improve health and wellness

Section 2: Population Health [3,4]

Population health refers to the large-scale health outcomes of a group of people. This concept can be used to assist patients as well as community-dwelling individuals without health concerns in achieving an improved health status and a greater sense of well-being. Many healthcare providers assist with population health. However, occupational therapists play a particularly large part in the health of communities and society as a whole due to their role in prevention.

Among all the ways that occupational therapists can make an impact, one of the lesser-

known areas is prevention. This is also a place where OT's influence can go relatively unnoticed, since what may appear to be decreased incidence for a certain condition can actually be due to aggressive preventive measures. Prevention can be broken down into three parts, all of which are closely related. These three levels of prevention are intended to reduce incidence, relapse, and prevalence of mental health concerns. There are many prevention efforts that can fall under all three categories depending on the population/audience they target.

Primary Prevention

Efforts aimed at primary prevention intend to prevent any sort of injury or health condition before it happens. These are sometimes also referred to as universal preventive interventions. Some good examples of primary prevention efforts focused on mental health include:

- 'Stop the stigma' propaganda
- School-wide anti-bullying and violence prevention assemblies at the beginning of the year
- Programs targeting marginalized populations such as the homeless, LGBTQIA+, migrants, minority groups, indigenous people, those affected by natural disasters or major violence, and more
- Identifying and attempting to remediate (or coordinate for the remediation of) family dynamics that may be impacting children's development or quality of life
- Teaching elementary school children about coping skills, emotion regulation, and healthy habits such as eating a balanced diet and regularly exercising
- Anti-drug programs within the school system
- Providing education to new parents about how to deal with stress, the availability of respite care, and the warning signs of child abuse and neglect
- The systematic development of programs and policies that address mental health concerns in healthcare facilities
- Developing seminars to engage older adults in activities that support brain health and help with Alzheimer's prevention

- Follow-up visits with new parents after they have been discharged from the hospital
- Screening at-risk youth within the community

Many community-based organizations acquire grants and other forms of funding to create and implement programs intended to prevent mental health concerns from developing. This is not only an excellent way to increase the health of the community overall, but it also heightens awareness that has a ripple effect throughout the community. If more people know about the symptoms and warning signs of mental illness, they are in a better position to help their loved ones potentially avoid a crisis altogether. In some instances, people are not able to prevent issues from occurring, but primary prevention can improve society's health literacy so people are more informed about what to look for.

Secondary Prevention

Many therapists may recognize secondary prevention because this is the category that much of occupational therapy mental health interventions fall under. Secondary prevention measures (also known as selective preventive interventions) as they pertain to mental health intend to slow the progression of an existing mental health concern. Secondary prevention is implemented through screenings, referrals, treatments, evaluations, and any other early identification measures. Some of the following are considered secondary prevention for mental health concerns:

- Attending or leading training on de-escalation strategies to prevent physical aggression or confrontations
- Encouraging or coordinating a patient's regular psychiatry check-ups and counseling visits
- Using critical analysis and a person-centered view to identify barriers that may impact the patient's future safety
- Holding team meetings to discuss a status change in a patient who is at risk
- Symptom management of chronic conditions, which helps prevent acute exacerbations (or crises)
- Assisting with the coordination of stable, affordable housing and community

navigation for personal safety, healthy socialization, and disease maintenance

- Monitoring a child or adult's disposition, affect, behaviors, and level of functioning after a major life event such as a move, death of a friend or family member, divorce, change in jobs, or other transition
- Planning, leading, or instructing others in the implementation of a skill maintenance group to preserve the abilities of individuals with existing mental health concerns
- Support groups for individuals with shared experiences, such as caregivers, spouses of someone with an acute illness, or individuals who have recently been diagnosed with a chronic condition

As you can see, many of these secondary prevention efforts are simply part of an occupational therapist's role in clinical mental health settings. But occupational therapists can also make an impact using secondary prevention measures in nontraditional settings. Therapists can even collaborate with other professionals in community settings where OTs are not usually found, such as recreation facilities, assisted living facilities, adult day cares, and more. This connects individuals who may not otherwise have access to prevention from a professional who is trained in this area.

Tertiary Prevention

This tier of prevention is another place where occupational therapists play a big role. Tertiary prevention measures (also called indicated preventive interventions) involve lessening the impact that a chronic condition or illness has on someone's life. This can often be more complex than the other levels, since it may involve working with people who have complex, co-occurring conditions that interact with each other in varying ways. Some of the following are examples of tertiary prevention:

- Educating CNAs and other floor staff on positioning schedules to prevent pressure sores in individuals who are bedbound or minimally-mobile
- Recommending a pureed diet for someone who has moderate but progressive swallowing problems
- Vocational programs to improve the quality of life and IADL function of individuals with mental illness

- Giving someone a customized, pressure-relieving wheelchair to prevent lower body contractures
- Cardiac rehabilitation programs for individuals who are recovering from bypass surgery or a heart attack
- Screening patients with diabetes for issues such as major skin or circulation changes, retinopathy, or kidney damage
- Consistently monitoring lithium levels of patients with bipolar disorder who take that medication

As you can see, there are many places where occupational therapists can assist in the mental health field in the area of prevention. Though occupational therapists more often help with secondary and tertiary prevention as part of traditional OT treatment, primary prevention can (and should) make its way into every treatment session. This can take the form of generalized education or it can be through more concentrated training, role-playing, and other mediums.

Section 2 Personal Reflection

How might an OT help with primary, secondary, and tertiary prevention for a child who has a family history of depression?

Section 2 Key Words

- **Population health -** The large-scale health outcomes of a group of people, such as a community or the people in a certain geographic location
- **Primary prevention -** Efforts that prevent a health condition from developing in the first place; this may come in the form of widespread campaigns, public service announcements (PSAs), education, and training that is suitable for people who are at-risk within the general population; also known as universal preventive interventions
- **Secondary prevention -** Efforts that prevent the progression or worsening of a health condition or temporary illness; this may come in the form of evaluation, screening, traditional treatment, collaborative meetings, and coordination to assist individuals already living with a health concern; also known as selective

preventive interventions

- **Tertiary prevention -** Efforts that prevent complications or co-occurring conditions from developing as a result of chronic conditions; this may also come in the form of evaluation, screening, and traditional treatment, but it also encompasses adaptive equipment, activity modifications, durable medical equipment, and other materials for individuals who are more high-need; also called indicated preventive interventions

Section 3: Group and Individual Treatment [6]

The main format of occupational therapy intervention for individuals with mental health concerns is group therapy. Group interventions usually follow a psychoeducational format, meaning they are lecture-based with a focus on a person's emotions and motivation for change. While the initial intention of psychoeducation was to instruct individuals on the basics of their condition, including the diagnosis process, management, symptoms, prognosis, and treatment options, groups can cover a wide range of topics. Psychoeducational groups have been known to cover anything mental health-related from relapse prevention to anger management to medication adherence to nutrition for brain health and more. Four broad goals are at the core of all psychoeducational treatment:

- Transfer of therapeutic information
- Emotion processing
- Guidance in regards to self-help and self-care techniques
- Support for medication and other forms of treatment

Psychoeducation is evidence-based with a strong emphasis on the individual's participation, but psychoeducational principles can also be used to educate and/or support family members and friends of those living with mental illness. Psychoeducation traditionally uses pieces of cognitive-behavior therapy and the diathesis-stress model. Cognitive-behavior therapy focuses on modifying thoughts and, consequently, behaviors while the diathesis-stress model notes the source of mental conditions are both environmental and genetic in nature. This means that someone with a genetic predisposition for mental illness may or may not develop it depending on how supportive their environment is.

Psychoeducation is collaborative in nature, which encourages a discussion of concepts with the therapist to develop a deeper insight. This not only improves outcomes but assists in building rapport as part of the patient-provider relationship. Psychoeducation also enters other parts of treatment in mental health and it is not exclusive to occupational therapists. Psychoeducation can also be used individually to provide more concentrated and targeted intervention to patients on a one-on-one basis. This is usually indicated if a patient has physical limitations that prevent them from entering a group setting or they are demonstrating difficult behaviors that are not conducive to attending a group.

Group treatment is indicated for people who may benefit from:

- A sense of community and belonging
- Improved insight through social learning
- Assisting in the creation of a non-judgmental environment
- Enhanced social skills
- Role-playing to increase carryover of certain skills or concepts previously learned in group sessions
- Added support and varied perspectives from the presence of more than one mental health professional

Psychoeducational group treatment may not be appropriate for patients who have:

- Social phobias or severe anxiety that has not yet been stabilized
- Are sensitive to or clash with people who have strong personalities
- Specific triggers that are difficult to avoid during group discussion or education
- Active suicidal thoughts or are in crisis
- Outwardly aggressive or impulsive behaviors (however, patients who are impulsive may benefit from homogenous group settings where this type of behavior can be directly addressed)
- Openly and adamantly refused to attend group therapy or abide by group code of conduct set forth by the therapist or facility

Before any patient begins group therapy, it is important for the therapist to complete a

thorough assessment to determine whether or not they are able to engage in that form of treatment. Provider considerations for group therapy include resource availability (staffing, funding, materials, etc.); each client's needs, preferences, and phase in the recovery process; and group topics.

Patients may also receive individual therapy in mental health settings. This is what most people know as a traditional therapy session. One of the biggest and most obvious benefits of individual therapy is the ability to get concentrated attention from a mental health professional. This targeted intervention takes place in a completely private setting so patients can be assured of confidentiality. More security leads to improved patient disclosure and a better patient-provider relationship. This way, patients can then explore deeper issues that may not otherwise get resolved or even come up in discussion. Patients who participate in individual therapy have more flexibility to create schedules that work for their lives. Programming for group therapy sessions is often at a fixed time once per week, so it's more difficult to reschedule and someone can fall behind if they miss too much. Therapists who offer individual sessions are often easier to find since it only entails two people connecting rather than a large number of members with the same specific needs.

The downside to individual therapy is that sessions are more expensive and there is not as much of an opportunity for role-playing or perspectives from diverse people. People who get individual therapy are more likely to plateau, since there is less room for outside experiences and events to impact the plan of care. Some patients, especially those with anxiety disorders, also report that they are uncomfortable with the intense amount of intimacy between them and one other person during therapy sessions. Similarly, other patients with specific symptoms or personality traits may feel that therapists are being overly critical since all the feedback is directed at them.

Section 3 Personal Reflection

What strategies might an occupational therapist use to encourage someone to attend group therapy if they initially refuse?

Section 3 Key Words

- **Cognitive-behavioral therapy (CBT) -** A form of talk-based mental health therapy that firstly identifies a person's thought patterns and negative belief systems and

then focuses on modifying those ideals (called cognitive distortions) to form healthier behaviors, more effective coping strategies, and improved emotion regulation

- **Diathesis-stress model -** A theory that posits all conditions are dually genetic and environmental in nature, meaning that individuals who have a family history or genetic predisposition to certain conditions are far more likely to develop that condition if they have an unsupportive environment
- **Homogenous groups -** Groups that consist of the same type of patients who may have similar medical concerns/needs, goals, personal preferences, ages, socioeconomic status, and other identifying characteristics
- **Psychoeducation -** A systematic, didactic mental health treatment that involves the integration of emotional and motivational factors to increase self-help skills and allow people to better cope with and manage their condition
- **Role-playing -** A therapeutic technique that involves putting oneself in someone else's role; in a mental health setting, role-playing can help someone gain insight, enhance information retention, and improve the carry over of skills
- **Social learning theory -** A developmental theory that analyzes human behaviors and dissects it into three parts: cognition, behavior, and environmental factors (which impact the first two aspects); this was initially and specifically used to describe how children learn from others by observation, modelling, and imitation

Section 4: Mental Health Settings [7,8,9,10,11,12,13,14,15,16,17]

There are a range of mental health settings where occupational therapy professionals can treat patients of all ages with varying psychiatric needs. Some of the most common practice settings where mental health occupational therapists can work are:

Clubhouses

Clubhouses are a community-based mental health setting that got their name from the clubhouse model of mental health recovery. Clubhouses are open to community-dwelling individuals who are living with a chronic mental health concern. Participants are called (and viewed as) members rather than patients. This setting is very different

from other mental health practice areas in that members play an active, direct role in programming so they are receiving interventions that are helpful to their situation.

In alignment with this mantra, there is no plan of care, so there is no traditional evaluation or even discharge. The partnership between administration and members is intended to provide long-term support in the areas of employment, housing, and education. This not only empowers members to feel part of something greater but it also sets the tone for their role within a clubhouse. Clubhouses offer a greater sense of camaraderie so that members are surrounded with others who are in the same stage of recovery as they are.

Clubhouse programming follows work-ordered days that utilize each member's abilities and the facility operates on consensus decision-making through member participation. Members are able to obtain paid employment through local labor markets. They also get support in the process of seeking and sustaining affordable and secure housing as well as utilizing other community-based resources. Members have continual access to crisis services whenever they may need them, and they take part in evening and weekend recreational activities.

There is a high level of evidence surrounding the effectiveness of clubhouses in preventing and reducing the need for inpatient psychiatric hospitalizations. Additionally, research shows that members achieve 42% higher employment rates than individuals with mental health concerns who do not receive such intervention. This makes clubhouse settings a wonderful place for occupational therapists to make a difference.

Occupational therapists can assist with implementing and supervising any and all of the aforementioned services to clubhouse members. In particular, topics may cover interpersonal relationships, community mobility, social etiquette, money management, productive leisure, assertiveness, gainful employment, symptom management, and more. Occupational therapists will primarily provide group intervention in this setting because that is the true intent of the clubhouse model. Generally speaking, occupational therapists may have a hand in other job duties unique to the clubhouse setting, including:

- Assessing programming needs
- Identifying personal or group barriers to change and wellness
- Exploring strategies for behavior modification, improved symptom management, and increased treatment compliance

- Modifying existing resources
- If these changes are not possible, assisting in developing and obtaining new resources
- Adjusting interventions to the medical, psychiatric, social, physical, emotional, and intellectual needs and preferences of each person

Inpatient Psychiatric Setting

It's possible for OTs to work in a psychiatric unit (also called a ward) within a general inpatient hospital or for a therapist to be employed at an inpatient hospital that solely serves psychiatric patients. Some inpatient hospitals are short-term, so patients will stay there for 5-7 days before being discharged. After spending time in a short-term inpatient psychiatric ward, patients may return to their home or they may be transferred to a longer-term facility if they need further hospitalization. State psychiatric hospitals offer long-term stays (called involuntary commitments) for individuals who need a higher level of care. Patients can expect to stay in a state psychiatric hospital for 6-9 months, depending on the severity of their condition. Someone is admitted to a state psychiatric hospital only after being evaluated and given some form of treatment at another inpatient hospital. This is because state hospitals are not equipped to provide emergency or crisis services. People are sent to a state psychiatric hospital if they present with one of three grave concerns:

- They are a danger to others (e.g. they have or have acted on homicidal ideation)
- They are a danger to themselves (e.g. they have or have acted on suicidal ideation)
- Neglect of oneself (e.g. they are no longer able to care for themselves due to severely impaired cognitive functioning)

There are also separate centers within state psychiatric hospitals for individuals with mental illness who have committed a crime. These individuals are admitted to carry out their prison sentence in a therapeutic environment after a judge accepted their attorney's plea as "Not guilty by reason of insanity" also known as NGRI. These patients receive similar care as other patients in state psychiatric hospitals, but they have some group interventions that directly address their crime in an effort to prevent them from becoming repeat offenders. The state judicial system also requires patients in NGRI

programs to meet some additional requirements before being discharged to completely fulfill their mandates.

The overarching goal for patients in all of these settings is to achieve their baseline level of functioning through medication adjustments or additions. Group therapy is an adjunct to these treatments, which are all intended to stabilize patients so they can effectively return to their lives in the community. Some individual therapy sessions may be done in these settings, but the primary mode of service delivery is group therapy. Patients who are withdrawing from substances or are demonstrating aggressive behaviors are good candidates for individual therapy in inpatient settings. These individuals are likely the only ones who require this type of intervention, since this is usually the only way they can participate in therapy. Occupational therapists in inpatient psychiatric settings can address some of the following intervention areas:

- Productive leisure
- Stress management and relaxation
- Personal safety
- Values identification
- Role exploration and fulfillment
- Symptom management
- Medication adherence
- Relapse prevention
- Assertiveness training
- Anger management
- Emotion regulation
- Interpersonal conflict resolution

Most of these inpatient units are for patients 18 years and older. Some hospitals have specialized geropsychiatry units that cater to the psychiatric and aging-related needs of individuals over the age of 60. These geropsychiatry units serve many individuals who demonstrate aggressive or self-injurious behaviors that are usually secondary to dementia, stroke, or a traumatic brain injury (TBI). Some patients who engage in these

behaviors may not receive a mental health diagnosis for some time, if at all. Regardless of this occurrence, it's still crucial that these individuals receive stabilizing care on inpatient psychiatric units so they can reenter the community. Many older adults who have extended or repeated stays on geropsychiatry units may be discharged to certain skilled nursing facilities (SNFs) with specialized units that are equipped to deal with mental health concerns for long-term residents. Most SNFs must have a psychiatric certificate to show their competency and credibility in managing treatment (including administering medication) for diagnosed behavioral health concerns.

Another long-term residency option for older adults with mental health concerns is an assisted living facility (ALF). Many ALFs have memory care units that are equipped to deal with individuals who have severe cognitive impairments that make it impossible for them to safely live on their own. Most memory care units are able to handle difficult behaviors and co-occurring mental health concerns that often come along with neurocognitive disorders. Occupational therapists working on memory care units should be able to provide interventions such as:

- Life reminiscence
- Five-stage groups
- ADL/self-care retraining
- Role identification and fulfillment
- Relaxation and stress management
- Training staff on verbal de-escalation strategies
- Maintenance of social skills and relationships

These interventions all serve to improve the quality-of-life of an older adult with mental health concerns and maintain their skills in certain areas. These treatments are also sensitive to the complex and specific medical needs of older adults, which is an important consideration in all settings.

Another specialized population within the inpatient mental health practice arena is youth. There are not many short-term inpatient psychiatric wards that cater to children and adolescents, but there are inpatient psychiatric hospitals dedicated to the care of youth with mental health concerns. Similar to the elderly, youth have complex developmental concerns that interact with their psychiatric treatment. As a result, each

of these populations requires more specialized care to address the full spectrum of their needs. An occupational therapist working in an inpatient psychiatric hospital for children may perform interventions such as:

- Resiliency training
- ADL/self-care training
- Visual scheduling
- Behavior modification
- Emotion regulation
- Maintaining a healthy relationship with social media
- Stress management and relaxation techniques
- Sharing and socialization with peers
- Academic success, including accommodations
- Forming healthy attachments
- Transitioning to school
- Executive functioning training
- Exploration of hobbies
- Sensory integration therapy

Rehabilitation Facilities

Individuals with substance use disorders are able to undergo medically-supervised detoxification at residential rehabilitation facilities. Unlike other inpatient psychiatric facilities, where admission is typically involuntary because someone is placing themselves or others at risk, individuals can only get admitted to residential rehab for substance use if they voluntarily agree to do so. Another way that rehabilitation facilities such as these differ from traditional inpatient settings is that the length of treatment is predetermined. Some facilities offer 30-day programs while others offer 60- or 90-day rehabilitation programs. However, this does not mean that everyone's treatment will look the same. A plan of care at a rehabilitation facility is specific to the

type(s) of substances that an individual is withdrawing from. This is not only for their safety and the integrity of the detox process, but so that they get more out of the treatment in the long-term.

An occupational therapist's role in rehabilitation facilities that cater to individuals recovering from substance use disorders is often similar to their role in inpatient psychiatric settings. Group therapy is the typical mode of service delivery and topics may cover productive leisure, stress management and relaxation, personal safety, values identification, role exploration and fulfillment, symptom management, medication adherence, assertiveness training, anger management, emotion regulation, and interpersonal conflict resolution. The reason for this is because many patients in these facilities are dual diagnosis. This means they have active exacerbations of both a mental health condition and substance use disorder, which impacts the course of their substance use disorder recovery.

For this reason, it's important that occupational therapists address both conditions, since one plays a large part in the progression and recovery from another. For example, it's important to identify triggers that cause someone to experience cravings for substances. By delving into discussion that pinpoints triggers, a therapist can teach someone how to respond to them in a healthier way or avoid them altogether. This can also assist with managing other mental health concerns. Specific substance-related topics that therapists in rehabilitation facilities should be expected to address are:

- Relapse prevention
- Self-care and stress management
- HALT
- Support groups
- Mindfulness training
- Trigger identification
- "Play the tape" technique, which involves looking ahead to the consequences of your actions
- Seeking help the right way
- Building confidence

- Combating loneliness
- Grounding strategies
- WRAP
- Cognitive-behavior therapy
- Personal safety and emergency plans

Transitional Housing

This type of mental health setting is intended as a short-term, supportive housing option for homeless individuals, victims of domestic violence, or individuals who are moving from correctional facilities or inpatient psychiatric hospitals to the community. This setting is meant for people experiencing a crisis, but it can sometimes be an option for people who cannot return to an unsafe home after hospitalization or incarceration. Most individuals will be discharged to their home after these stays, but that isn't possible if they don't have a home or their previous home is too unsafe for them to return to. A requirement for someone to be released from an inpatient facility of any kind is having a safe discharge location. This housing option is short-term. Some supportive housing allows people to stay for two or three weeks, while others allow somewhat longer stays of up to two years.

Interventions in this setting are group sessions and occupational therapists can help instruct residents in some of the following areas:

- Community reintegration
- Money management and budgeting
- Self-care skills (hygiene, toileting, dressing, bathing, and eating)
- Personal safety
- Household maintenance
- Symptom management

Correctional Facilities

An OT's role in correctional facilities is very similar to their role in other mental health settings, since individuals who are incarcerated are in need of both transitional and rehabilitation services. Occupational therapists might work with adults in traditional prison settings, young adults and adults in short-term jail settings, or even in youth detention centers with children and adolescents who have committed crimes. Occupational therapists in any of these settings often run group therapy sessions that target specific inmate preference, but also ones that pertain to their needs. Group therapy often covers topics that are most relevant to inmates and will increase their chances of success in the community, including:

- Substance use and sobriety
- Continuing education
- Finding and sustaining employment
- Basic living skills, including money management
- Community resources
- Managing parole, probation, and legal concerns associated with their sentence

The last area is particularly important, since it will impact each functional and occupational aspect of the inmate's life. Additional subjects that should be covered include:

- Emotional adjustment to being out of prison
- Cognitive behavioral therapy
- Feelings of incompetence or inadequacy
- Family support structures
- Organizational skills
- Case management
- Social skills and productive socialization

It is not uncommon for occupational therapists to work alongside prison counselors, also known as correctional counselors, who meet with inmates individually to work

through more person-specific concerns. These sessions usually offer more targeted intervention for any existing mental health symptoms and their impact on a person's function and ability to reintegrate into society. But sessions do not need to focus only on inmates diagnosed with or exhibiting mental health concerns. Counseling can also address emotional beliefs or self-confidence issues that may prevent someone from developing new skills following their sentence. Since this is not a traditional healthcare setting or even a typical setting for OTs to work, professionals such as prison counselors and sometimes even recreation therapists will be a big source of collaboration and information exchange. Just as the ultimate goal of inpatient settings is to get patients back into the community and prevent rehospitalization -- while simultaneously preventing an exacerbation of mental health symptoms -- the goal of therapists in correctional facilities is to help inmates avoid reoffending. This is done by assisting them in building skills and dealing with issues that can develop into or contribute to illicit behaviors. Studies show that therapy programs, particularly those that are cognitive and behavioral in their focus, are able to reduce the rates of recidivism by up to 35%. This not only assists in improving the quality of life, occupational performance, and overall engagement of each inmate, but it serves the purpose of making the local and global communities safer.

Mental Health in the Schools

Addressing mental health in school-based settings has become increasingly important over the past 10 years. This can be seen in the expanse and addition of socioemotional learning departments within any therapeutic setting intended for children. Occupational therapists in school-based settings typically focus on helping children build fine and gross motor skills, motor planning, and coordination needed to achieve developmental milestones such as handwriting, scissor skills, and adaptive skills. However, these therapists and even other OTs working in more of a consultative role can help promote positive mental health and wellness for school-aged children. This is a setting where occupational therapists can contribute to the prevention of mental health concerns at the earliest stage. Not all children who will be diagnosed with a mental health condition exhibit symptoms this early in life, since some do not develop until young adulthood. But this is the best and most formative time for children to be taught the skills they need to manage their emotions and the behaviors that come along with them in order to avoid major crises that may occur in the future.

Additionally, if issues do arise at this point in a child's life, occupational therapists are

well-trained in mental health and can assist the child (and their family) in getting an early diagnosis, which helps lead to early treatment. Teachers do not have much (if any) training in mental health, so they may not know how to react to children who display concerns. Similarly, families may ignore their child's behavior either due to focus on younger children in the home or based on the belief that changes are just a "phase" that they will grow out of. For this reason, occupational therapists can provide education to families and teachers regarding prevention and who to get involved with, which aids in getting a child the early diagnosis they need. School-based workers who are better equipped to deal with these issues on the frontline are special education teachers, school psychologists, counselors, and social workers. So occupational therapists may work closely with these professionals to collaborate on behalf of a child.

One occupational therapist in particular has paved the way for mental health in school settings. Susan Bazyk has developed a curriculum called Every Moment Counts, which outlines three tiers of prevention for children with mental health concerns. She identifies the four qualities that are necessary for a child to have positive mental health: positive affect, positive social function, participation in daily and meaningful activities, and demonstrating resilience in the face of life stressors. She also emphasizes the importance of viewing mental health for children as a continuum so that mental health does not mean the absence of mental illness. As part of Tier 1, the following universal strategies should be a core part of education to benefit all children:

- Positive emotions
- Meaningful activities
- Supportive environments
- Knowledge of mental health
- Embedded strategies
- Capacity for learning

Tier 2 includes more targeted techniques that are intended to address at-risk youth. Interventions surrounding this level of the framework include:

- Bully prevention, including cyber bullying and physical violence
- Identifying and addressing children with strained family dynamics, such as poverty, divorce, or blended families

- Developing modifications or alternatives for certain school environments that are stressful (lunchroom, playground, gym, busy hallways in between classes)
- Social and emotional learning (also called socioemotional learning) curriculum focused on discussing emotions, behavior modification, and understanding the link between emotions and behaviors
- Participation in meaningful activities that enhance and utilize a child's strengths
- Building positive relationships with peers and staff
- Education and visual reminders regarding the zones of regulation to monitor and balance the child's own stress levels

Therapists in this setting can also assist with accommodations, small group interventions for multiple at-risk children with diverse needs, and co-treating (more appropriately referred to as co-teaching) with other providers such as social workers or psychologists. There are similar components of Tier 3 that focus on children who are currently exhibiting mental health concerns. Tier 3 has a large emphasis on mental health literacy for all to best assist these children. Interventions for Tier 3 include:

- Researching and discussing components of mental health concerns as well as plans of action
- Ensure that all children with mental health diagnoses or those demonstrating mental health symptoms are connected with the appropriate staff both at school and within the community
- Promote successful engagement and participation via paraprofessionals, accommodations, activity modifications, and specialized programming
- Encourage and instruct on help-seeking behaviors that promote personal safety
- Embedding mental health literacy activities into existing curriculum
- Develop materials that highlight the red flags and warning signs of mental health concerns
    - Emotions: Consistent irritability, depression, hopelessness, anxiety
    - Physical: Nausea, headaches, restlessness
    - Functional performance: Poor academic achievement, difficulty with

socialization, changes in sleep patterns, excessive or scanty appetite

- Cognition: Inability to be flexible or make decisions, difficulty with small daily transitions, trouble focusing, poor ability to meet deadlines and remain organized

These interventions can be modified for children from age 4 all the way up to age 18, so there is application across K-8 school settings as well as high schools.

Section 4 Personal Reflection

What are some ways that an occupational therapist can incorporate motor-based milestones into psychoeducational group treatment for children?

Section 4 Key Words

- **Assisted-living facility -** A long-term care facility where individuals benefit from in-home services such as recreation, rehabilitation, wellness checks, pastoral care, and more; services are available on a sliding scale, meaning residents can take advantage of amenities as they become medically necessary and their pricing will increase according to this model; also called an ALF
- **Clubhouse model -** A form of recovery-oriented mental health programming that uses a peer-focused environment to improve the independence and quality-of-life of community-dwelling individuals living with mental health concerns; these settings require a high level of participation from patients (called members) who must assist in forming and maintaining programs that meet their needs
- **Consensus decision-making -** A process where affected parties (individuals who will be impacted by the decisions) have in-depth discussions to find a mutually-beneficial solution to certain issues or topics
- **Deescalation strategies -** Techniques used to verbally deescalate someone who is demonstrating signs of physical or verbal aggression; this is used in many mental health settings to prevent difficult behaviors from evolving into violent incidents
- **Dual diagnosis -** A term used to refer to patients who are actively experiencing exacerbations of both substance use disorder and a mental health condition
- **Five-stage groups -** A model that proposes five part social groups for individuals

with cognitive and/or psychiatric impairments; groups begin with orientation, transition to movement-focused activities, then next to visual-perceptual activities, then target cognitive tasks, and end with a processing phase

- **Geropsychiatry unit -** Specialized, short-term inpatient care units for adults over the age of 60 who have mental health concerns
- **HALT -** An abbreviation used to educate patients about the most common triggers for substance use; this stands for hungry, angry, loneliness, and tired (fatigue)
- **Long-term care facility -** A residential facility where individuals with chronic illnesses can benefit from a range of medical and non-medical services, such as rehabilitation, recreation, pastoral care, wellness checks, and more; long-term care services provide the same amenities but are also available within the home, while long-term care facilities are places where individuals live and receive services in the same place, such as skilled nursing facilities or assisted living facilities; may be abbreviated LTC
- **Neurocognitive disorders -** A general term used to describe decreased mental/cognitive function; disorders include brain injuries, strokes and mini-strokes (CVAs and TIAs), all types of dementia, and late-stage medical conditions that cause brain changes such as hypoxia
- **Skilled nursing facility -** A facility where adults may go after the hospital if they need further nursing care and rehabilitation; skilled nursing facilities can sometimes have long-term care units that provide residential care for individuals with chronic conditions; also known as short-term rehab, STR, or SNF
- **Work-ordered days -** A schedule where recreational activities and rehabilitative programming is structured within the working hours of the clubhouse; since rehabilitation is provided during the day and recreational programming occurs in the evenings, clubhouses do not usually follow typical business hours
- **WRAP -** An intervention that assists patients in developing a plan for their recovery; this is an abbreviation that stands for Wellness Recovery Action Planning

Section 5: Mental Health Assessments

18,19,20,21,22,23,24,25,26,27,28,29

The evaluation process is a key part of any occupational therapy treatment. Mental health evaluations are particularly lengthy, as many can take between 30 and 90 minutes to administer. They usually come in the form of interviews, but some have self-report portions with questionnaires to gain subjective information from patients. Evaluations of this variety allow treatment to be client-centered in nature, which is particularly important to improve participation and motivation in mental health patients.

Allen Cognitive Level Assessment (ACL)

This assessment, in conjunction with the Allen Cognitive Level Screen (ACLS), is used to test someone's ability to make decisions, learn new skills, manage their own safety, and care for themselves. This is traditionally completed on adults with neurocognitive conditions such as dementia, but it can also be used to assess individuals with schizophrenia, depression, bipolar disorder, and more.

The ACL is a unique assessment in that it doesn't take the form of an interview or checklist like some evaluations do. This test involves someone completing four lacing tasks (a running stitch, whipstitch, error correcting, and a Cordovan stitch) on a piece of leather. Based on someone's performance on the screening form of the ACL, the rater assigns them a score between the lowest range (3.0) and the highest range (5.8). Someone who scores below 3.0 is not able to participate in the screen, so they receive a lower score. The ratings are broken down as follows:

- 0: Patient is in a coma and unable to respond
- 1: Patient needs 24/7 supervision due to significant impairments in cognition and awareness
- 2: Patient has some functional movement, but is largely unable to participate in self-care and needs 24/7 assistance to prevent wandering and injury.
- 3: Patient needs a moderate amount of supervision for self-care tasks.
- 4: Patient can live alone with some higher-level assistance for problem-solving and executive functioning. They are able to learn or stick to a fixed routine to

ensure their safety.

- 5: Patient can often learn new activities and skills, but they demonstrate a mild cognitive impairment. They can live alone with weekly check-ins or similar measures in place.
- 6: Patient has intact cognition and demonstrates no visible limitations.

There have been several modifications to this assessment since it was initially created in the 1980s, including the addition of the screen and the expansion to include the Allen Diagnostic Manual (ADM). The ADM details specific treatment activities and beneficial group interventions to remediate skills and assist in goal writing for patients based on their score, which makes it a highly useful tool for therapists who consistently administer this assessment. Despite the ACL having a somewhat unusual methodology, there is significant research surrounding the effectiveness and accuracy of the ACL levels.

Assessment of Communication and Interaction Skills (ACIS)

This assessment is based on the Model of Human Occupation and was developed by OTs. ACIS involves the use of observation to determine strengths and opportunities in the area of communication. Due to the structure of this assessment, therapists administering it should be able to complete the forms while watching a patient engage socially with others in a natural context.

The ACIS is appropriate for adults (anyone over the age of 18) who has psychosocial concerns, which includes people with Autism Spectrum Disorder or dementia. Areas that are scored include physicality (such as eye contact, gaze, gestures, orientation, and posture), exchange of information (including articulation, assertion, engagement, expression, sharing, and ability to sustain conversation), and relations (ability to collaborate, conform, and relate). Each item on the assessment is given a score between 1 and 4. Each number is represented as follows:

- 1: Deficit area
- 2: Ineffective area
- 3: Questionable area
- 4: Competent area

Bay Area Functional Performance Evaluation (BaFPE)

This function-based assessment contains two parts that determine how someone will perform in social situations as well as practical tasks. The first part involves completing five tasks and scoring patients on affect, performance, and cognition. The second portion specifically focuses on scoring someone's social abilities. Activities include sorting objects, making designs from blocks, writing a check, drawing certain shapes and items.

The BaFPE is intended for adolescents and adults with psychiatric diagnoses, traumatic brain injuries, dementia, or developmental disabilities. This assessment may be indicated in either inpatient or outpatient settings to determine a patient's ability to care for themselves. Additionally, the BaFPE is able to help adolescents in special education settings such as schools or traditional treatment settings.

Beck Depression Inventory (BDI)

This short questionnaire is intended to be self-report, but therapists can assist in administering it by asking the patient questions and recording their answers. As the name suggests, it is intended to identify feelings of hopelessness, helplessness, and despair and pinpoint behaviors that may indicate someone is depressed. The BDI is able to be used in individuals both with and without psychiatric concerns. Each person will respond on a 4-point Likert scale to 21 questions that ask someone how frequently they have feelings commonly associated with depression. Scores are classified as follows:

- 0-13: A score in this range indicates someone does not have many notable signs of depression
- 14-19: Mild concerns, indicating a person has some signs of depression
- 20-28: Moderate concerns, which suggest someone has several signs of depression
- 29-63: Severe concerns, which imply that someone has major symptoms pointing toward a marked case of depression

This assessment is not exclusive to OTs and it can be used by other clinicians such as social workers. It can even benefit lay individuals who want to assess their own depressive signs. The BDI can be administered in any setting where OTs want to engage in early identification of depression.

Canadian Occupational Performance Measure (COPM)

The COPM is a widely-used OT assessment that is intended to help patients recognize and prioritize obstacles, barriers, and even generalized issues that are impacting their performance. This assessment was designed by OTs and is intended for OTs to use, since it helps them develop their plans of care. The COPM is applicable for use with patients who have mental health concerns, but it can also be used for palliative care, musculoskeletal rehabilitation, neurocognitive conditions, and psychosocial concerns such as Autism Spectrum Disorder.

The COPM is considered a semi-structured interview that gives a patient scores (out of 10) in two different areas: performance and satisfaction. For this reason, the COPM is an ideal outcome measure to be administered at the start of treatment and outside of that, as needed, to reevaluate goals and needs. This assessment is ideal for adolescents or adults in any treatment setting. While the focus of the COPM is on performance and satisfaction within daily living skills, it can also help identify issues that prevent patients from engaging in other valued activities.

Executive Function Performance Test (EFPT)

This is another assessment designed to identify an individual's performance in higher-level executive functions, including:

- Initiation
- Execution
- Organization
- Completion
- Sequencing
- Judgment
- Safety

This can be used in inpatient and outpatient settings for adolescents and adults. The EFPT was designed for individuals with psychosocial concerns such as stroke, multiple sclerosis, mental health disorders, and brain injuries.

The aim of the EFPT is not for patients to make errors that are then recorded, rather instructions tell therapists to deliver whatever cues are needed to help the patient complete the task error-free. Cues are given progressively as follows: verbal guidance, then gestural guidance, then direct verbal assistance, then physical assistance. If a therapist provides a mix of cues to assist the patient, it is important that they indicate the highest level of cueing given to accurately reflect the patient's abilities and needs.

There are specific scripts that dictate what a therapist should say to guide patients through each task, but they are not to provide any positive or negative feedback throughout, as this can skew the results. Tasks include simple meal preparation, calling someone on a standard telephone, taking medication, paying bills, and balancing a checkbook. What makes this test unique is that it encompasses subjective and objective components by asking the patient to rank their abilities before completing the task. For example, before the checkbook task, the therapist will ask: "Will you be able to pay the bills?" to which the patient will reply with one of the following:

- 0: By yourself
- 1: With verbal guidance
- 2: With physical assistance
- 3: I won't be able to complete this task

Kohlman Evaluation of Living Skills (KELS)

The KELS is an ideal assessment for adolescents and adults, particularly those living with mental health concerns, traumatic brain injuries, or dementia. This may also be used to assess an older adult's ability to safely and independently live in the community. The KELS is a good way to test the living skills of individuals during a short-term hospitalization or even in an outpatient setting. The KELS is a bit limited in that a patient's scores may change over the course of their stay in an institutional setting if they are admitted for an extended period of time. The KELS tests living skills such as:

- Leisure
- Work
- Transportation
- Money management

- Household safety

The test is functional in nature so patients will need to complete tasks while a therapist observes them and scores their performance. The rating score is binary, so patients will be scored on the following rubric: independent (0 points), needing assistance (1 point), or not applicable (0 points). This does not allow for outside considerations or explanation, so some therapists may find it does not take all factors into account. All items cumulatively total 17. Patients who score between 6 and 17 are thought to need assistance while living in the community, while patients who score below a 5.5 are considered able to live independently. This assessment was designed by OTs and the contents of the tasks are very OT-based, but the test can be administered by any healthcare professional.

Milwaukee Evaluation of Daily Living Skills (MEDLS)

The MEDLS is a functional assessment that involves therapists observing patients as they perform a set of tasks. This is intended for adolescents and adults who are in institutional settings (such as hospitals or skilled nursing facilities) or attending day programs within the community. The MEDLS is to be used with individuals who have mental health conditions and are on the lower-functioning end of the spectrum.

As another test of daily living skills, MEDLS consists of 20 different self-care tasks and each of their subcomponents. This not only allows therapists to determine how someone performs in these tasks, but it lets them see what parts of each task need to be remediated. Similarly to the KELS, patients do not get any points for each task that they cannot perform, complete incorrectly, or need assistance with.

Mini Mental Status Exam (MMSE)

Originally used in emergency rooms to assess someone's immediate cognition and orientation, the MMSE is a short questionnaire-based evaluation. Unlike other questionnaires that ask patients about their feelings, behaviors, or abilities, the MMSE questions focus on getting a snapshot of someone's executive functioning by asking questions such as the date, serial counting abilities, expressive communication, and more.

Scoring is partially based on someone's education level, since that can impact their performance. Patients get one point per question component that they get correct.

Those points are totalled and then placed in one of the following categories:

- 25-30: Patient demonstrates clinically significant deficits, but they may not impact their functioning.
- 20-25: Patient demonstrates mild cognitive deficits that may necessitate supervision or assistance.
- 10-20: Patient has moderate cognitive deficits and requires 24-hour supervision for safety.
- 0-10: Patient exhibits severe/marked cognitive impairments and likely needs 24-hour supervision and extensive assistance with self-care tasks.

The MMSE is ideal for adults and is most often administered in inpatient settings such as psychiatric hospitals or intensive care units. The MMSE was developed specifically for individuals with dementia, traumatic brain injury, or mental health conditions.

Model of Human Occupation Screening Tool (MOHOST)

This is a screen based on the Model of Human Occupation that similarly assesses a patient's priorities and goals for therapy. The MOHOST requires the therapist to observe a patient engaging in typical daily activities. The therapist is then expected to rate the patient's performance as one of the following:

- F: facilitates participation
- A: allows participation
- I: inhibits participation
- R: restricts participation

This can be used to evaluate patients with chronic pain, cerebral palsy, mental health concerns, brain injuries, and other neurocognitive conditions, but it's also applicable for people with musculoskeletal deficits. The MOHOST is ideal for adults over the age of 18, but it simply serves as a precursor to identify whether or not someone is suited for the more extensive MOHO assessment.

Occupational Self Assessment (OSA)

As another assessment based on the Model of Human Occupation, the OSA aims to gauge a person's perception of their own competence across a range of activities. The OSA also inquires about the value that a person places on each activity in question. This assessment takes up to 15 minutes to administer and is a relatively short way for therapists to begin discussing goal setting and treatment planning.

Therapists go through an inventory of 21 activities and ask patients about how they feel about their performance of each task. They are to rate each activity on a scale of 1 to 4, with 1 meaning they have many problems with the activity and 4 representing that they are confident with it.

This is another assessment that can be used for any adult patient with physical and mental health concerns alike. There is a variety of evidence supporting its reliability for each of these populations.

Routine Task Inventory (RTI)

This assessment is intended to be an adjunctive evaluation to the Allen Cognitive Level test, since they both address neurocognitive disabilities such as dementia. The RTI is comprehensive in nature, as it consists of separate subtests that cover physical functioning (ADLs, medication management, and the use of adaptive equipment), community functioning (IADLs and child care), communication (comprehension and expression in the areas of writing and talking), and work readiness (scheduling, performing tasks, following instructions, and responding to emergencies).

Therapists must observe patients performing at least four separate tasks in order to have an ideal picture of the patients' abilities and needs. The RTI is intended for adult individuals with a range of mental health concerns, including dementia, stroke, brain injury, schizophrenia, and depression.

Test of Grocery Shopping Skills (TOGSS)

This cognitive-based assessment was designed to determine someone's cognitive status as it pertains to functional tasks. The test measures a patient's ability to accurately obtain 10 items from a group of products according to certain criteria. For example, they will be scored based on their ability to get an item they were cued to get, an item

of the appropriate size, and an item with the lowest cost possible. Patients are given a map of the store environment prior to the activity and are timed during the process.

The TOGSS is intended for adults with serious mental illness but it's also able to be administered on patients with cognitive issues including stroke, dementia, brain injury, and developmental disabilities.

Volitional Questionnaire

Similarly to many other mental health assessments, the Volitional Questionnaire uses a self-report rating scale to determine a patient's propensity and motivation for engaging in certain tasks. The level by which the patient engages in each task is rated on a scale of 1 to 4, meaning:

- 1: Passive engagement
- 2: Hesitant engagement
- 3: Involved engagement
- 4: Spontaneous engagement

This assessment is appropriate for children and teens ages 8-17 up through adults and the elderly. The Volitional Questionnaire is ideal for people with moderate to severe mental health concerns and developmental disabilities.

Section 5 Personal Reflection

What are some developmental considerations that might affect the way a therapist completes a mental health assessment on a child?

Section 5 Key Words

- **Client-centered -** A term used to describe something that takes a person's interests, needs, preferences, and goals into strong account; this also refers to a process that is highly collaborative between therapist and patient
- **Executive functions -** A set of higher-level cognitive management skills governed by the frontal lobe, including working memory, adaptive thinking, awareness,

self-monitoring, emotion regulation and coping, organization, impulse control, task initiation, planning, and prioritizing

- **Palliative care -** A form of medical care that is for individuals who are severely or terminally ill; this care includes a range of services that are solely intended on making the person as comfortable as possible; for this reason, it's also referred to as comfort care
- **Volition -** The act of doing something of your own will; this is not the same as someone expressing a preference to do a certain thing, rather this is someone acting on their desire to do that thing; this is similar to motivation, but volition focuses more on the action in combination with the feeling, as opposed to the mere thought of action

Section 6: Evidence-Based Strategies

30,31,32,33,34,35,36,37,38,39,40

There are a range of interventions that can assist people with mental health concerns. They can be broken down into some of the following categories:

Physiological Strategies

Physiological mental health techniques are those that address the body itself. There is a strong connection between the mind and the body, so these strategies aim to lessen the impact of mental health concerns (usually in the form of stress or anxiety) on a person's physical body. Some physiological strategies include:

- Acupuncture and acupressure: The stimulation of specific points on the body (called meridians) to relieve particular areas of discomfort and stress; acupuncture uses small, single-use needles inserted in the skin and acupressure involves stimulating those points with the thumb
- Aromatherapy: The use of specific smells (usually from natural sources such as essential oils) to relieve anxiety and stress
- Deep breathing: The act of purposeful and consistent breathing to calm the central nervous system and relieve anxiety; there are several types of deep breathing

    - Diaphragmatic breathing (also called belly breathing) - lay down and place your hands directly below the lungs so they rest on the diaphragm; when breathing in, pull the diaphragm inward toward the floor; when breathing out, let your hands feel it relax and expand to its normal state
    - Box breathing (also called square breathing) - breathe in for a count of four, hold the breath for a count of four, and breathe out for a count of four
    - 4-7-8 breathing - breathe in for a count of four, hold the breath for a count of 7, and breathe out for a count of eight
    - Alternate nostril breathing - use one finger to block one nostril as you slowly breathe in through the other; then block the other nostril as you slowly exhale from the other
    - Lion's breathing - open your mouth wide and stick your tongue all the way out as you sharply exhale then take a break to inhale normally
    - Pursed lip breathing - breathe in through the nose and out through the mouth with your lips gently touching
- Medication assisted treatment (MAT): A combination of prescriptions and counseling to assist patients with substance use disorder; prescriptions are intended to prevent the body from desiring certain substances, while therapy focuses on the emotions associated with cravings and substance use
- Meditation: The dedicated focus on a certain item or aspect to help clear the mind
    - Mantra meditation: An intense focus on a single positive saying or affirmation while the eyes are closed and you are blocking out distractions
    - Mindfulness meditation: A focus on the sensations associated with your surroundings (tastes, touches, sounds, sights, and smells)
    - Movement meditation: An intense focus on completing certain movements in a slow and rhythmic manner with attention given to how the body feels
- Progressive Muscle Relaxation (PMR): A practice that involves systematically tensing muscle groups one at a time, holding for 10-15 seconds, and then

relaxing; the sequence typically goes from the toes to the head and is intended to ease muscle tension that often accompanies stress

- Visualization: Also known as guided imagery, where someone pictures a desirable place (either real or imagined -- a favorite vacation spot, local place, or calming scenery) and focuses on it to relieve anxiety and depression
- Yoga: A form of exercise consisting of deep breathing, focus, and poses (called asanas) to strengthen the body and clear the mind

Cognitive Strategies

Cognitive mental health techniques are those that address the mind, including emotions, thought patterns, executive functions, and fixed beliefs. Some cognitive interventions include:

- Acceptance and Commitment Therapy (ACT): An interactive model of therapy that aims to promote psychological flexibility and adaptiveness; ACT operates on six principles: defusion, contact with the present (mindfulness), acceptance, values, observational skills, and committed action
- Cognitive Behavioral Therapy (CBT): A type of talk therapy that involves identifying and addressing cognitive distortions and forming emotion regulation strategies
- Dialectical Behavior Therapy (DBT): A type of interactive talk therapy that addresses four main areas, including distress tolerance, mindfulness, interpersonal effectiveness, and emotion regulation; this is particularly appropriate for individuals who have borderline personality disorder (BPD)
- Emotional Freedom Techniques (EFT): A strategy that involves using the hands to tap on specific points of the body (called meridians) while reciting a positive affirmation to relieve both emotional and physical discomfort
- Wellness Recovery Action Planning (WRAP): A planning-based strategy that therapists can use to increase patients' ability to prevent and respond to personal crises; it involves a combination of discussion and journaling

Skills Training

Another key aspect of mental health intervention for some patients is skills training. This involves giving patients the foundational knowledge they need to learn basic or specific skills. Not all patients need treatment to focus on each of these areas, but some lower-functioning individuals might need more targeted training to address a range of ADLs and IADLs, including:

- Grooming
- Bathing
- Dressing
- Eating
- Cooking
- Driving
- Money management
- Medication management
- Laundry
- Grocery shopping

Additional skills might include:

- Sleep hygiene
- Problem solving
- Organization
- Planning
- Productivity
- Time management
- Interpersonal communication
- Conflict resolution

- Emotion expression and regulation
- Sensory integration

As we mentioned earlier, skills training can be done in small groups of patients who have similar needs and are of an equivalent level of assistance. But patients who need more targeted intervention in these areas are usually better served by individual sessions.

Environmental Strategies

Patients with mental health concerns may need environmental intervention in the form of supportive housing or supportive employment. This may involve therapists addressing a patient's vocations, either paid employment, volunteer work, or other supportive arrangements. Some patients may need transitional housing where they can stay as therapists assist them in finding accommodations that meet their needs.

Additionally, accommodations can be helpful for people with mental health concerns. This may mean filling out and receiving a 504 accommodation for school-aged children or receiving special requests at a place of work. Some people may benefit from varied or fixed schedules, specific equipment, differing locations, particular projects, and more.

Section 6 Personal Reflection

What might a therapist need to consider when combining strategies from different categories to form a well-rounded intervention?

Section 6 Key Words

- **504 Accommodations** - A part of an individualized education program (IEP) that allows someone in a school-based setting to receive special requests to ensure for academic success
- **Cognitive strategies** - Techniques that address the mind along with its associated feelings, beliefs, and thoughts
- **Environmental strategies** - Accommodations that adjust the environment to ensure the success of someone with certain needs

- **Physiological strategies** - Techniques that address the body itself
- **Skills training** - The act of training someone in the completion of certain activities

Section 7: Case Study

A 30-year-old patient has been admitted to an acute inpatient hospital for an exacerbation of bipolar disorder. She presents with a euphoric affect during the first interaction, but has not yet been evaluated one-on-one. She has been struggling to keep up with demands at her job as a project manager and is in danger of losing her apartment due to being behind on rent. She has local family members who are supportive of her, but she has had irregular contact with them over the past 2 years. She has no children and a supportive ex-boyfriend. Her roommate (who provided supporting documentation upon her admission) reports that she stopped taking her medication one week before her admission.

1. What is the most appropriate occupational therapy evaluation for this patient?
2. Name two occupational therapy interventions that this patient may benefit the most from.

Section 8: Case Study Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the most appropriate occupational therapy evaluation for this patient?

   Since this patient is only expected to be on the unit for a short time, she may be a good candidate for the MMSE to determine her cognitive abilities at this time.

2. Name two occupational therapy interventions that this patient may benefit the most from.

   This patient would benefit most from education about work-related resources and accommodations, such as Employee Assistance Programs, part-time work, 1:1 guidance when completing particularly difficult projects, and organizational strategies to improve productivity and overall performance. She can also benefit

from education and planning surrounding medication management, since a lapse in regularly taking her medications is one of the factors that contributed to her hospital admission.

Section 9: Case Study

A 74-year-old patient with a new onset of violent behavior was sent to a state psychiatric hospital after striking a healthcare provider at an independent living facility. He has no prior history of mental health concerns and no other hospitalizations. The treatment team is discussing the possibility of a dementia diagnosis, but this is still unclear until all providers get a better picture of the patient's abilities. The occupational therapist met with the patient to determine his ability to safely live alone and reenter the community.

1. What is the best evaluation to give the occupational therapist this type of information?
2. How can the therapist best help this patient in the first several weeks at the facility?

Section 10: Case Study Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the best evaluation to give the occupational therapist this type of information?

   The occupational therapist can complete the KELS to determine how this individual can function in a living environment. This will not only give the therapist information on how their cognitive functioning is but it will allow them to see if they are able to appropriately assess safety risks that may arise in their environment.

2. How can the therapist best help this patient in the first several weeks at the facility?

If the patient may potentially have dementia, one of the best things the OT can do first off is create a structure and routine for them. This will not only minimize behavioral issues, but it will make the patient more comfortable. The OT should also train staff on how to approach patients with dementia and cognitive deficits so that they avoid confrontation or escalation.

References

1. American Occupational Therapy Association. (2018). Occupational Therapy's Role in Mental Health Recovery. Retrievedf rom https://www.aota.org/About-Occupational-Therapy/Professionals/MH/mental-health-recovery.aspx
2. OT Centennial. (2019). Decades: OT's Important Events. Retrieved from http://www.otcentennial.org/events/events-by-decades
3. Mental Health Foundation. (2021). Prevention and Mental Health. Retrieved from https://www.mentalhealth.org.uk/a-to-z/p/prevention-and-mental-health
4. Youth.gov. (2020). Mental Health Promotion and Prevention. Retrieved from https://youth.gov/youth-topics/youth-mental-health/mental-health-promotion-prevention
5. Mental Health America. (2019). Prevention and Early Intervention in Mental Health. Retrieved from https://mhanational.org/issues/prevention-and-early-intervention-mental-health
6. Sarkhel, S., Singh, O. P., & Arora, M. (2020). Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation. Indian Journal of Psychiatry, 62(Suppl 2), S319–S323. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_780_19
7. Clubhouse International. (2019). What Clubhouses Do. Retrieved from https://clubhouse-intl.org/what-we-do/what-clubhouses-do/
8. Medline Plus. (2021). Neurocognitive Disorder. Retrieved from https://medlineplus.gov/ency/article/001401.htm
9. American Occupational Therapy Association. (2019). Occupational Therapy's Distinct Value in Mental Health Promotion, Prevention, & Intervention. Retrieved from https://www.aota.org/-/media/Corporate/Files/Practice/MentalHealth/

Distinct-Value-Mental-Health.pdf

10. Substance Abuse and Mental Health Services Administration. (2021). Homelessness Resources: Housing and Shelter. Retrieved from https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-shelter

11. Herlache-Pretzer, E. & Jacob, J. (2018). From Prison to the Community. The American Occupational Therapy Association, 23(7). Retrieved from https://www.aota.org/-/media/corporate/files/secure/publications/otp/2018/otp-volume-23-issue-7-prison.pdf

12. Han, W. & Redlich, A.D. (2017). The Impact of Community Treatment on Recidivism Among Mental Health Court Participants. Psychiatric Services, 67(4). https://doi.org/10.1176/appi.ps.201500006

13. National Alliance on Mental Illness. (2019). Mental Health in Schools. Retrieved from https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools

14. National Association of School Psychologists. (2021). Comprehensive School-Based Mental and Behavioral Health Services and School Psychologists [handout].

15. Association for Children's Mental Health. (2020). Problems at School. Retrieved from http://www.acmh-mi.org/get-help/navigating/problems-at-school/

16. Danielson, M. L., Bitsko, R. H., Holbrook, J. R., Charania, S. N., Claussen, A. H., McKeown, R. E., Cuffe, S. P., Owens, J. S., Evans, S. W., Kubicek, L., & Flory, K. (2020). Community-based prevalence of externalizing and internalizing disorders among school-aged children and adolescents in four geographically dispersed school districts in the United States. Child Psychiatry & Human Development, 52, 500-514. https://doi.org/10.1007/s10578-020-01027-z

17. Every Moment Counts. (2020). Foundations of Every Moment Counts. Retrieved from https://everymomentcounts.org/foundations/

18. Allen Cognitive Group. (2018). Assessments. Retrieved from https://allencognitive.com/acls-5-lacls-5/assessments-1-acls_lacls/

19. Model of Human Occupation Theory and Application. (2019). Assessment of

Communication and Interaction Skills. Retrieved from https://www.moho.uic.edu/productDetails.aspx?aid=1

20. Maddak. (2020). Bay Area Functional Performance Evaluation. Retrieved from https://www.maddak.com/pdf/Content/Assessments_2020_BaFPE.pdf
21. American Psychological Association. (2020). Beck Depression Inventory. Retrieved from https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression
22. The Canadian Occupational Performance Measure. (2019). The COPM in Use. Retrieved from https://www.thecopm.ca/use/
23. Shirley Ryan Ability Lab. (2018). Executive Function Performance Test. Retrieved from https://www.sralab.org/rehabilitation-measures/executive-function-performance-test
24. Shirley Ryan Ability Lab. (2020). Kohlman Evaluation of Living Skills. Retrieved from https://www.sralab.org/rehabilitation-measures/kohlman-evaluation-living-skills
25. Dementia Care Central. (2020). Mini-Mental State Exam (MMSE) Alzheimer's/Dementia Test: Administration, Accuracy, and Scoring. Retrieved from https://www.dementiacarecentral.com/mini-mental-state-exam/
26. Shirley Ryan Ability Lab. (2019). Model of Human Occupation Screening Tool. Retrieved from https://www.sralab.org/rehabilitation-measures/model-human-occupation-screening-tool
27. Allen Cognitive Network. (2017). Routine Task Inventory-Expanded. Retrieved from http://www.allen-cognitive-network.org/index.php/allen-cognitive-model/routine-task-inventory-expanded-rti-e
28. Shirley Ryan Ability Lab. (2018). Test of Grocery Shopping Skills. Retrieved from https://www.sralab.org/rehabilitation-measures/test-grocery-shopping-skills
29. Shirley Ryan Ability Lab. (2019). Volitional Questionnaire. Retrieved from https://www.sralab.org/rehabilitation-measures/volitional-questionnaire
30. Fowler, P. (2020). Breathing Techniques for Stress Relief. Retrieved from https://www.webmd.com/balance/stress-management/stress-relief-breathing-techniques

31. Anthony, K. (2018). EFT Tapping. Retrieved from https://www.healthline.com/health/eft-tapping

32. Brennan, D. (2021). What to Know About Acupuncture for Depression. Retrieved from https://www.webmd.com/depression/what-to-know-about-acupuncture-for-depression

33. Krans, B. (2017). Aromatherapy for Depression. Retrieved from https://www.healthline.com/health/depression/aromatherapy

34. American Psychological Association. (2017). What is Cognitive Behavioral Therapy? Retrieved from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

35. Psychology Today. (2019). Dialectical Behavior Therapy. Retrieved from https://www.psychologytoday.com/us/therapy-types/dialectical-behavior-therapy

36. Substance Abuse and Mental Health Services Administration. (2021). Medication-Assisted Treatment. Retrieved from https://www.samhsa.gov/medication-assisted-treatment

37. Mayo Clinic. (2020). Meditation: A Simple, Fast Way to Reduce Stress. Retrieved from https://www.mayoclinic.org/tests-procedures/meditation/in-depth/meditation/art-20045858

38. University of Michigan Health. (2020). Stress Management: Doing Progressive Muscle Relaxation. Retrieved from https://www.uofmhealth.org/health-library/uz2225

39. Johns Hopkins Medicine. (2019). What is Imagery? Retrieved from https://www.hopkinsmedicine.org/health/wellness-and-prevention/imagery

40. Hutchinson, T.S. (2019). 5 Ways Yoga Can Benefit Your Mental Health. Retrieved https://www.psychologytoday.com/us/blog/silencing-your-inner-bully/201901/5-ways-yoga-can-benefit-your-mental-health