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Occupational Therapy's Role in Serious Mental Illness

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“I never dismissed a mental illness before because of my mom. But I never understood it until I had it. And it's a wild, wild, wild ride. It really is.”

-Justice (An individual living with schizoaffective disorder and PTSD)

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Objectives:

1. Provide an electronic resource that outlines the occupational therapy process when working with individuals with serious mental illness and supports inclusion and reimbursement for occupational therapy practitioners in this setting.
2. Define the multiple roles occupational therapy practitioners can fulfill in this setting and the varied diagnoses/populations involved.
3. Present appropriate screening, assessment, outcome measure and intervention tools that are relevant when working with individuals with serious mental illness.
4. Offer information and resources on critical elements of care related to mental health care including but not limited to intersectionality, language, reimbursement, suicide prevention, social determinants of health and provider burnout.
5. Provide valuable information and materials regarding the "lived experience" of adults living with a mental illness in order to inform and understand the needs of those who experience a SMI.

Table of Contents:

A: Purpose

The intent of this electronic manual is to provide a client-centered and evidence-based resource to inform students, clinicians, and educators of occupational therapy's unique role in working with adults with serious mental illness (SMI) and those experiencing psychosis. This manual, while not exhaustive, is designed to serve as a user-friendly resource for providing valid, equitable care to those with serious mental illness. In the most recent version of the Accreditation Council for Occupational Therapy Education (ACOTE ®) 2018 standards, occupational therapy and occupational therapy assistant students are required to demonstrate competency in the ability to "design and implement intervention strategies to **remediate and or/compensate for functional cognitive deficits**, visual deficits and **psychosocial and behavioral health** deficits that affect occupational performance" (ACOTE ®, 2018, p. 29). In addition, occupational therapy and occupational therapy assistant students are expected to **be prepared to work with populations across the lifespan in relation to mental health** (ACOTE ®, 2018, p. 19).

To support the need for this manual, a study surveying occupational therapy practitioners who worked in a physical rehabilitation setting, expressed that they received minimal education related to evaluating and treating the mental health needs of their clients and felt dissatisfied with the care they provided related to those needs (Simpson et al., 2018). Another qualitative research study found that new occupational therapy graduates working in a mental health setting expressed difficulty with administering appropriate assessments, remembering medication and diagnosis information, managing work-place stress, and finding accessible resources (Lloyd et al., 2007). Manualization of occupational therapy practice and interventions have been found to help practitioners identify their role and focus, specify appropriate intervention procedures and reason through clinical problems (Blanche et al., 2011). This manual is intended serve as a bridge between OT/OTA curriculum and clinical practice, ensuring that occupational therapy practitioners have resources to provide evidence-based quality care to individuals, caregivers and/or groups with serious mental illness. In addition, these resources will allow clinicians and students to provide more thoughtful and inclusive care to patients.

This manual can be also used to advocate for the inclusion of occupational therapy services on the interprofessional and certified behavioral health team. The content and resources provided can also serve to provide a rationale for hiring occupational therapy practitioners in a mental/behavioral health setting. The origins of the occupational therapy profession have its roots in mental health, encouraging clients who lived in asylums to participate in meaningful roles, tasks, and routines to manage symptoms. However, the impact of World War I required the profession to shift its focus in order to work with returning soldiers experiencing shell shock and trauma from combat (Christiansen & Haertl, 2018). The impact of World War I and World War II created an opportunity for occupational therapy professionals to align and create employment under the medical model and subsequently, occupational therapy practitioners shifted out of mental health settings and into rehabilitation settings (Castaneda, 2013). In 2019, AOTA reported that less than 2.5% of occupational therapy practitioners work in a mental health setting (American Occupational Therapy Association [AOTA], 2019).

One mechanism to increase occupational therapy positions in the community may be through obtaining reimbursement of services provided through Medicare. When the Protecting Access to Medicaid Act of 2014 was passed, it aimed at improving community behavioral health services and required Certified Community Behavioral Health Clinics (CCBHCs) to provide "coordinated, integrated, quality care that is person-centered and recover-oriented and integrates physical and behavioral health care (Substance Abuse Mental Health Services Administration [SAMHSA], 2015)" (Lannigan, 2016). SAMHSA included occupational therapists as potential practitioners to meet the goals in the CCBHCs. Although occupational therapy practitioners are skilled in assessing and treating functional cognitive impairments, identifying barriers to recovery, and empowering individuals to engage in daily activities that enhance well-being and community participation, there is a low prevalence of occupational therapy practitioners at these CCBHCs (Lannigan, 2016). A 2020 report published by the Office of Behavioral Health, Disability and Aging Policy and the Office of the Assistant Secretary for Planning and Evaluation reported that only 16% of CCBHCs across the country have occupational therapy practitioners on staff (Siegwarth et al., 2020). In addition, a majority of US states do not currently recognize occupational practitioners as qualified mental and behavioral health providers (Wilburn et al., 2020). Not only does inclusion of occupational therapy practitioners as qualified behavioral health providers increase recognition of the profession as a whole, but this inclusion also allows practitioners to receive reimbursement for provided services when working with individuals who receive Medicaid (Wilburn et al., 2020).

Lastly, interprofessional health care providers in the field of mental and behavioral health, such as psychiatrists, psychologists, case managers, social workers, nurse practitioners, physician assistants, speech therapists, peer support staff and more, can utilize this manual to better understand the distinct value of occupational therapy as a support to individuals and/or groups who experience a SMI. Interprofessional collaboration is defined by four core competencies focused on enhancing team-based patient care and improving health outcomes including values and ethics, roles and responsibilities, interprofessional communication and teams and teamwork (Interprofessional Education Collaborative, 2016). For interprofessional collaboration to be successful, it is crucial that each member of the interdisciplinary team understand the roles and responsibilities of all practitioners involved to enhance communication, teamwork and care provided (Interprofessional Education Collaborative, 2016).

Occupational Therapy Practice Framework: Domain and Process, 4th ed

The Occupational Therapy Practice Framework (OTPF-4), figure below, is an official document of the American Occupational Therapy Association (AOTA). "Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, policymakers, and consumers, the OTPF-4 presents a summary of interrelated constructs that describe occupational therapy practice" (2020, p. 1). As such, the OTPF-4 will be utilized throughout the manual to highlight the occupational therapy process in regard to specific content areas related to assessment, intervention, client care and outcomes. "Occupational therapy is defined as the therapeutic use of everyday life occupations with persons, groups, or populations (i.e., the client) for the purpose of enhancing participation" (AOTA 2020, p. 1).

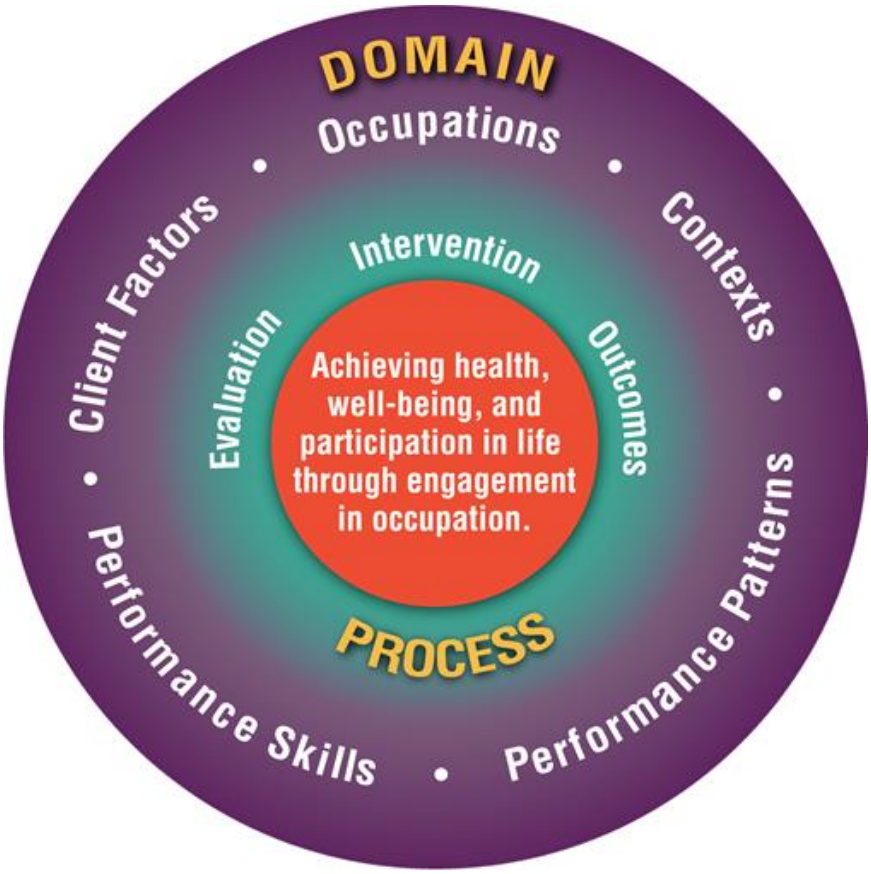

Figure Legend:
Occupational Therapy Domain and Process

From: **Occupational Therapy Practice Framework: Domain and Process—Fourth Edition** Am J Occup Ther. 2020;74(Supplement_2):7412410010p1-7412410010p87. doi:10.5014/ajot.2020.74S2001

***Please note: Throughout the manual the term "occupational therapy practitioner" is utilized to describe occupational therapists and occupational therapy assistants (AOTA, 2015b).**

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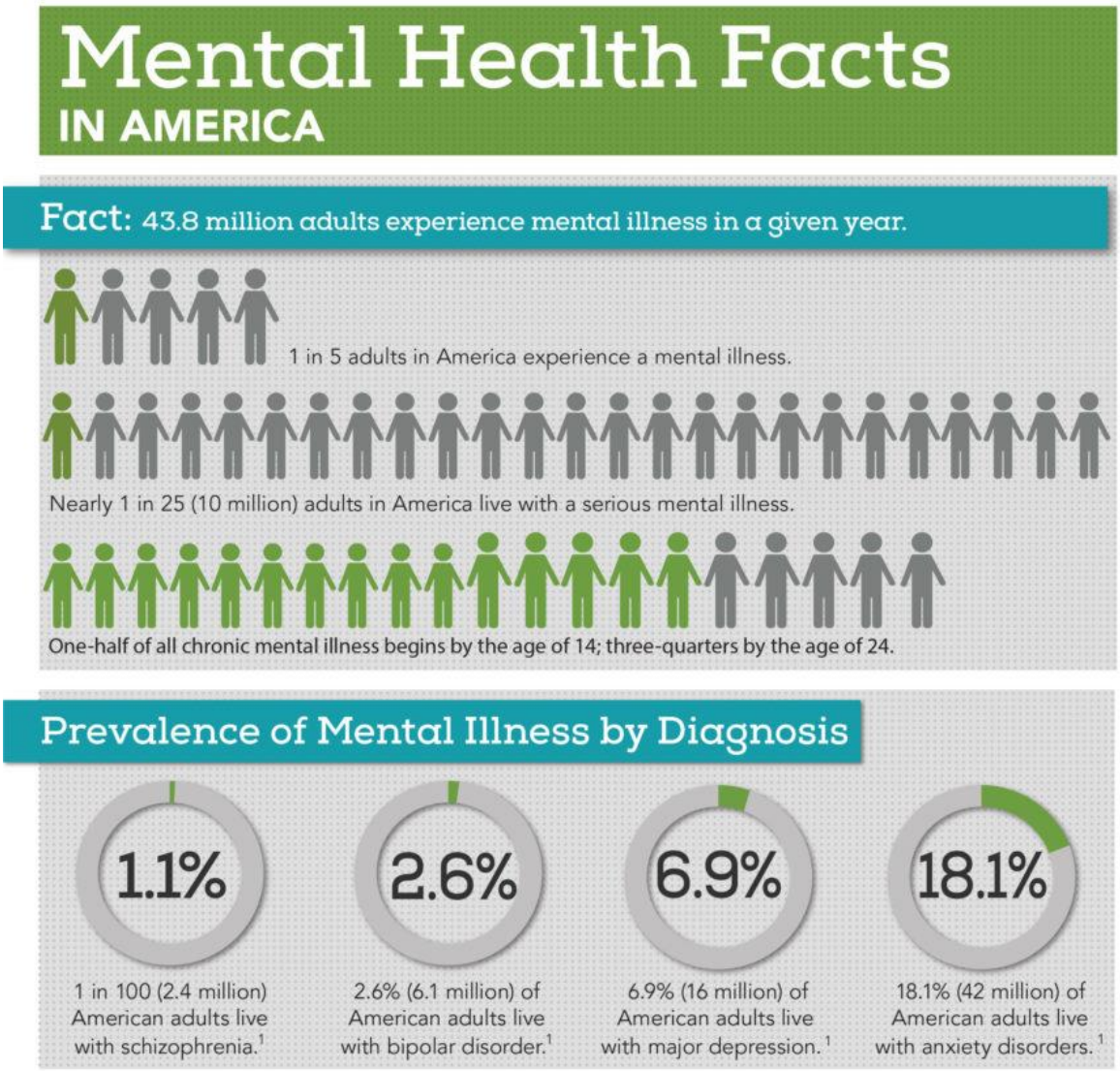
B: Definitions and Disorders of Serious Mental Illness (SMI)

This section defines "serious mental illness" and includes information about the diagnoses and symptoms involved. Serious mental illness is a "mental, behavioral or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (National Institute of Mental Health, 2020; Parekh, 2018). In 2020, 5.6% of individuals residing in the United States were found living with serious mental illness and the prevalence was higher among adults who reported two or more racial identities (National Institute of Mental Health, 2022). Although serious mental illness can include any disorder that results in significant functional impairment, the main disorders included under this subset of mental illness include **schizophrenia spectrum disorders, bipolar and related disorders and depressive disorders** (Substance Abuse and Mental Health Services Administration, 2022; Parekh, 2018).



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Occupational therapy practitioners are not qualified to diagnosis a psychiatric disorder, but can provide consultative, individual and group interventions related to symptom and condition management. **According to the OTPF-4**, occupational therapy practitioners are skilled to provide services related to "managing physical and mental health needs, using coping strategies for illness, trauma history or societal stigma; managing pain; managing chronic disease; recognizing symptom changes and fluctuations; developing and using strategies for managing and regulating emotions; planning time and establishing behavioral patterns for restorative activities; using community and social supports and navigating the health care system" (American Occupational Therapy Association, 2020, p. 32).

Schizophrenia Spectrum and Other Psychotic Disorders:

Schizophrenia disorders interfere with a person's ability to think clearly, manage emotions and make decisions (*Schizophrenia*, n.d.) These disorders are defined by experiences in one or more of the following domains: ((American Psychiatric Association, 2022; NHS, 2019; *Schizophrenia*, n.d.).

***Delusions*:** A strong belief that are not shared by others and may be based on an unrealistic view. Beliefs are typically still held, even when contradictory evidence is presented.

***Hallucinations**:* Experience of seeing, hearing, smelling or feeling things that others cannot perceive. Even though others around cannot experience the sensations, hallucinations are very real to the person experiencing them and are not under voluntary control.

***Disordered Thinking*:** Experience of confusion, inattention, memory challenges and disorganized speech. Individual may engage in tangential speech, digressing to multiple random topics.

***Negative Symptoms**:* Experience of losing interest and motivation in daily activities, social withdrawal and diminished emotional expression.

Abnormal Motor Behavior: Decreased or excessive motor behavior in reactivity to the environment.

The disorders included on the spectrum are schizophrenia, delusional disorder, schizotypal disorder, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, catatonia and other specified schizophrenia spectrum and other psychotic disorder (American Psychiatric Association, 2022).

Resources for more information:

- https://www.psychiatry.org/psychiatrists/practice/dsm
- https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizophrenia
- https://sczaction.org/about-schizophrenia/
- https://www.nimh.nih.gov/health/topics/schizophrenia

Bipolar and Related Disorders:

Bipolar disorders result in changes in an individual's mood, energy levels and daily functioning, creating intense emotional states and fluctuation (American Psychiatric Association, 2022). Key features of the disorders include manic episodes, hypomanic episodes and/or major depressive episodes. (American Psychiatric Association, 2022; Howland & Sehamy, 2021)

Manic Episode: The experience of consistent elevated, irritable and high-spirited mood, lasting at least one week, that may result in decreased need or sleep, faster speech, increased activity, potential involvement in risky behavior, distractibility and experience of racing thoughts.

Hypomanic Episode: The experience of elevated, irritable and high-spirited mood that presents less severe than a manic episode, lasts for a shorter period of time (4-5 days) and does not lead to major problems in daily functioning.

Major Depressive Episode: The experience of persistent depressive symptoms, over at least a 2-week period, that may involve decreased interest and pleasure in everyday activities, appetite changes, sleep disturbances, extreme fatigue, diminished ability to concentrate, feelings of excessive guilt and/or suicidal ideation.

The disorders included in this category are bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder and unspecified bipolar and related disorder (American Psychiatric Association, 2022).

Resources for more information:

- https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders
- https://www.nimh.nih.gov/health/topics/bipolar-disorder

Depressive Disorders:

Depressive disorders all have the presence of sad, empty, or irritable mood, accompanied by cognitive and physical changes that greatly impact functioning and cause significant distress in areas of functioning. Key features of depressive disorder include: (American Psychiatric Association, 2022; *Depression*, n.d.).

- Depressed or “empty” feeling mood
- Diminished interest and/or pleasure in almost all daily activities
- Feelings of hopelessness
- Significant changes in appetite and diet that may cause weight loss or weight gain
- Sleep disturbances include insomnia or excessive sleep
- Decreased energy and extreme fatigue
- Experience of restlessness
- Difficulty concentrating and making decisions
- Suicidal thoughts, ideations and/or attempts

Disorders included in this category include disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder and unspecified depressive disorder (American Psychiatric Association, 2022).

Resources for more information:

- https://www.nimh.nih.gov/health/topics/depression
- https://www.psychiatry.org/patients-families/depression/what-is-depression

Psychosis:

Psychosis symptoms are characterized by a disruption in a person’s thoughts, perceptions and understanding that make it difficult to differentiate what is real and what is not (NAMI, n.d.; NHS, 2022). The two main symptoms of psychosis include hallucinations and delusions, and both may cause severe distress or behavior change (NHS, 2022). Psychotic episodes can be triggered for multiple reasons including, but not limited to, genetics, trauma, substance use, mental illness and/or physical illness. An important to distinction to note is that psychosis is a symptom, not an illness or disease (NAMI, n.d.; NHS, 2022).

Resources for more information:

- https://sczaction.org/about-psychosis/
- https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis
- https://dictionary.apa.org/psychosis
- https://dictionary.apa.org/reality-testing

Resource related to DSM-5 Disorders and Coding:

- https://www.psychiatry.org/psychiatrists/practice/dsm/updates-to-dsm-5/coding-updates/2020-coding-updates

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C: Occupational Therapy Practitioner Roles

Occupational therapy practitioners play a vital role in evaluation, treatment and recovery of individuals with serious mental illness. They provide evidence-based, client-centered care focused on daily occupation to ensure individuals develop and maintain positive mental health, engage meaningfully in everyday activities and promote wellness and quality of life (American Occupational Therapy Association, 2016). OT intervention can be provided across the lifespan, during different stages of mental health need and in various settings (American Occupational Therapy Association, 2016; Champagne & Gray, 2016). Occupational therapy practitioners can provide mental health services in hospitals, acute and long-term-care facilities, forensic justice centers, residential and day programs, skilled nursing facilities, community-based centers, schools, employment programs, outpatient clinics and private practices (Champagne & Gray, 2016). Occupational therapy practitioners can also provide programming and interventions for mental health prevention, promoting the development of positive mental health and well-being for all individuals (American Occupational Therapy Association, 2016). In addition to working directly with individuals with serious mental illness, occupational therapy practitioners also contribute to program development and advocacy efforts (Wens et al., n.d.)

An occupational therapy practitioner's role can vary based on local and state legislation. In some states, occupational therapy practitioners are considered qualified mental health professionals or certified behavioral health specialists, while in many states they are not. In recent years, occupational therapy practitioners have become part of coordinated specialty care (CSC) teams particularly in the treatment of first episode psychosis (FEP) (U.S. Department of Health and Human Services, n.d.). Occupational therapy practitioners may also assume other roles to support an individual or group's independence and promote recovery including that of consultant, case manager, community health advocate, entrepreneur, program manager and supervisor (Scaffa & Reitz, 2020).

- **Occupational therapy practitioner:** Approach mental well-being through a holistic approach to improve an individual's participation and engagement in daily life (Wens et al., n.d.) Occupational therapists are skilled to provide individual and group programming to increase functioning in areas including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, leisure and social participation (American Occupational Therapy, 2020).
- **Consultant:** Provide expert advice and resources related to program development, supervisory models or organizational issues to help solve problems or provide sustainability during significant change (Scaffa & Reitz, 2020)
- **Case manager:** Ensure access to resources and services in the community and promote living in the community through the development of independent life skills such as money management, problem solving and social interaction (Scaffa & Reitz, 2020).

- **Community health advocate:** Identify and advocate for the physical, emotional, social, educational and occupational needs of individuals in the community to ensure equitable access to services. Occupational therapists can lobby for change in local and national legislature to benefit individuals with serious mental illness (Scaffa & Reitz, 2020).
- **Entrepreneur:** Organizes and manages a business related to providing services to specific individuals or populations. As an entrepreneur, occupational therapists are responsible for financial management, marketing, providing leadership, team building and create an organized work environment (Scaffa & Reitz, 2020).
- **Program manager:** Develop and execute programming by conducting a needs assessment, evaluating the strengths and weaknesses of an organization, collaborating with other staff involved, planning budgeting and supervision and providing programming. (Scaffa & Reitz, 2020).
- **Supervisor**: Ensure that quality, safe occupational therapy services are being provided. Occupational therapists are typically responsible for delegating tasks, conducting performance reviews, training staff and fieldwork students and solving administrative problems that arise (Scaffa & Reitz, 2020).

Resources for more information:

OT Distinct Value: https://www.aota.org/-/media/corporate/files/practice/mentalhealth/distinct-value-mental-health.pdf

AOTA Advocacy Issues: https://www.aota.org/advocacy/issues/increasing-access-to-behavioral-health

EASA Model: https://easacommunity.org/PDF/OT-Manual.pdf

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D: Interprofessional Collaboration

Interprofessional collaboration is defined as "multiple health workers from different professional backgrounds work[ing] together with patients, families and communities to deliver the highest quality of care" (World Health Organization (WHO, 2010, p.7). Interprofessional collaboration has been shown to reduce healthcare costs while improving client centered care and the overall client experience (Johnson, 2017; Ndibu Muntu Keba Kebe et al., 2019). In addition, health care practitioners engaged in interprofessional collaboration have been found to develop a common understanding of the role of each team member, increased communication skills and flexibility in the shared decision-making process (Andvig et al., 2014; De Sutter et al., 2019). Interprofessional collaboration may also benefit practitioner job satisfaction, as it contributes to a positive work environment (Ndibu Muntu Keba Kebe et al., 2019). In mental health care specifically, collaboration between mental health professionals has been shown to reduce error, improve client's overall health status and strengthen the quality of care received (Ndibu Muntu Keba Kebe et al., 2019).

Interprofessional collaboration thrives on teamwork and research has found that the "prerequisites for...teams are trust, safety and minimizing and managing conflicts between team members. A well-functioning team uses information sharing, good communication, participative decision-making and address new ideas, practices or ways of organizing treatment delivery" (Andvig et al., 2014, p. 2). Interprofessional collaboration key components of shared decision making, mutual trust in team members, a genuine belief in the power of the interdisciplinary team and conflict management aligns with the characteristics of a well-functioning team to provide the best care to each individual (Ndibu Muntu Keba Kebe et al., 2019; Johnson, 2017). The mental health interdisciplinary team includes practitioners from various disciplines, each with a unique skillset and approach to mental health assessment, treatment and recovery. The interdisciplinary team can include, but is not limited to, occupational therapists, clinical psychologists, counselors, psychiatrists, psychiatric nurse practitioners, case managers, clinical social workers, primary care physicians, certified peer specialists and recovery support staff (National Alliance on Mental Health (NAMI), 2020; Pitts & Braveman, 2019). Members of the interdisciplinary team collaborate throughout the continuum of care and create a smooth transition from intake to discharge to community integration for each client (Andvig et al., 2014). This support throughout the care process has been shown to improve quality of life and reduce the rate of readmission (Andvig et al., 2014).

Occupational therapy practitioners play a unique and necessary role on the interprofessional team. Practitioners are skilled in assessing individuals from a holistic view, understanding the personal factors, environmental contexts and components of a task that may interfere with participation in daily occupation (American Occupational Therapy, 2020). When working with other disciplines, occupational therapy practitioners can provide support by "helping to construct interventions and communication styles to meet the needs of an individual, promote an understanding of the symptoms or diagnosis within a broader context and educating team members of sensory considerations for individuals (Wen et al., n.d.). During the goal writing process, occupational therapy practitioners work with case managers, psychology practitioners

and recovery support staff to ensure all personal factors are being considered (Wen et al., n.d.). Occupational therapy practitioners can also provide guidance on environmental accommodations to ensure the context in which the individual is receiving services best supports the client's needs and promotes optimal performance (Wen et al., n.d.; American Occupational Therapy Association, 2020).

Resources for more information:

- NAMI: https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals
- Psych Treatment Team: https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=90&contentid=P02585
- National Council For Behavioral Health: https://www.thenationalcouncil.org/wp-content/uploads/2020/10/102920_MDI-High-Functioning-Team-Based-Care-Toolkit_V2.pdf?daf=375ateTbd56
- AOTA: Continuing Ed: https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CE-Article-June-2017.pdf
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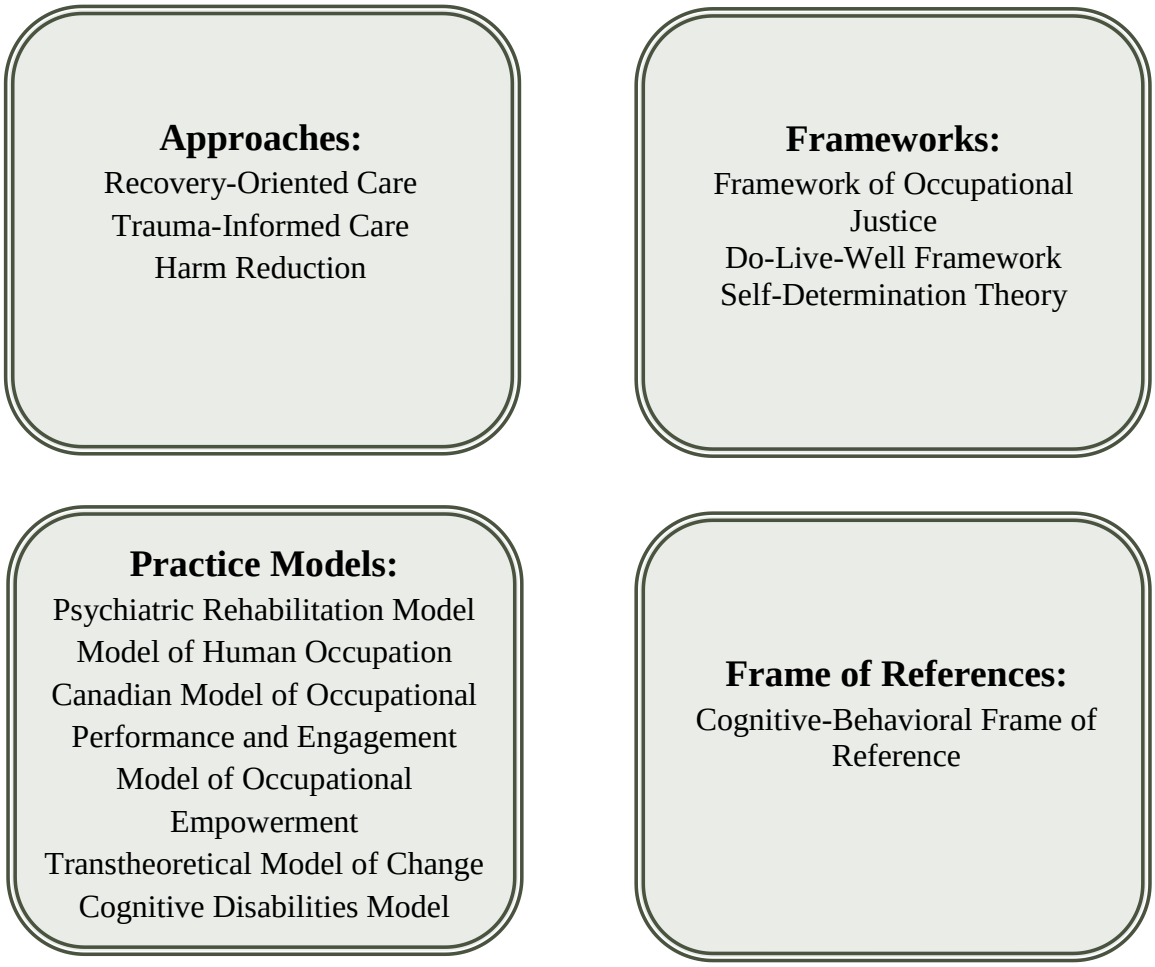
E: Practice Models and Frameworks

This section, while not exhaustive, includes approaches, practice models and frameworks that provide theoretical perspectives to support the occupational therapy process for individuals with serious mental illness. Occupational therapy practitioners use theoretical principles and models to interpret performance, guide clinical reasoning and select appropriate interventions (American Occupational Therapy Association [AOTA], 2020). As the profession shifts back toward its original roots in mental health, grounding assessment and intervention in evidence-based, theoretical perspectives is necessary to advocate for the specialized skills occupational therapy practitioners provide (Ikiugu et al., 2017). **The OTPF-4 (2020)** also provides a framework to ground occupational therapy practice and outline the occupational therapy process (AOTA, 2020). It is important to note that the OTPF-4 "does not serve as a taxonomy, theory or model of occupational therapy. By design, it is used to guide occupational therapy practice in conjunction with other knowledge and evidence" (AOTA, 2020, p. 4).



Approaches:

Recovery-Oriented Care:

Since the 1990s, there has been a shift in mental health care from symptom management and hospitalization to a recovery-oriented care approach that highlights the aspirations and ambitions of individuals with serious mental illness (Flemming-Castaldy, 2020). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential in the dimensions of health, home, purpose and community (SAMHSA, 2020). A recovery-oriented approach focuses on building resilience in individuals with serious mental illness, promoting hope for each individual's future and advocating for the belief that these individuals can regain a meaningful life (Jacob, 2015; Nugent et al., 2017). Recovery-oriented care acknowledges the need for optimism and a shared belief of a meaningful life for individuals with serious mental illness from each team member, including the individual, their support system, the mental health professionals involved in care and members of the community (Jacob, 2015).

The principles of recovery closely align with American Occupational Therapy Association's Vision 2025: "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (American Journal of Occupational Therapy, 2017). In addition, occupational therapy practitioners use recovery model principles including, but not limited to, using a holistic, dynamic approach to functioning, promoting shared-decision making, demonstrating respect towards the individual and their choices, and empowering individuals to live the life they desire (Champagne & Gray, 2016; Flemming-Castaldy, 2020).

Trauma-Informed Care:

SAMHSA (2014) defines trauma as a "singular or cumulative experiences that result in adverse effects on functioning and mental, physical, emotional or spiritual well-being." (p. 7). Individuals with serious mental illness have a higher risk of experiencing trauma and it must be acknowledged and addressed during care. SAMHSA (2014) asserts that trauma must be viewed through a socio-ecological context. One's personal characteristics, environmental context and sociocultural and political factors has a direct impact on the experience of and ability to cope with trauma (Milhelicova et al., 2018). Not only does a serious mental illness diagnosis increase the risk of trauma, but research found that those who face additional discrimination based on race, sexual orientation and gender are at an even high risk (Milhelicova et al., 2018).

A trauma-informed care approach asserts that in order to provide effective health care services, practitioners must recognize an individual's entire life situation, including past and present experiences (Trauma-Informed Care Implementation Resource Center, 2020). Trauma-informed practitioners need to acknowledge the effect of trauma on recovery, identify and understand the signs and symptoms of trauma in individuals and their support system, integrate trauma-informed practice principles into everyday care and actively resist re-traumatization (SAMHSA, 2014; Trauma-Informed Care Implementation Resource Center, 2020) If implemented

successfully, “delivering services in settings that are experienced as safe by trauma survivors will buffer stress and enhance coping resources, and therefore, reduce barriers to ameliorative care and promote wellness” (Milhelicova et al., 2018 p. 144). The core principles of implementing this holistic approach include: (Trauma-Informed Care Implementation Resource Center, 2020)

- **Safety:** Create a physically and psychologically safe environment for care.
- **Trustworthiness and transparency:** Commit to building and maintaining trust by remaining transparent along the treatment process.
- **Peer support:** Include individuals with shared experiences into service delivery.
- **Collaboration:** Shared decision making between clients and staff to limit power differences.
- **Empowerment:** Approach care with a strengths-based lens, believing in resilience and ability to heal from trauma.
- **Humility and responsiveness**: Constant recognition, reflection and actions based on biases and stereotypes.

A trauma-informed care approach is crucial at each stage of the occupational therapy process. During intake and evaluation, occupational therapy practitioners should explore both past and present effects of trauma and the impact it has on everyday performance. During interventions, trauma principles should be implemented into each treatment session, providing trauma-related coping strategies and avoiding re-traumatization (Lynch & Mahler, 2021) Exposure to trauma impacts brain functioning and everyday performance. When trauma occurs, the brain goes on high alert, triggering increased heartrate, increased breathing rate and increased attention to sensory stimuli in the everyday environment (Ashcraft & Lynch, 2021) In addition, trauma has lasting impacts on parts of the brain that control emotion regulation, executive functioning, reasoning skills and attention (Ashcraft & Lynch, 2021) Individuals who are exposed to trauma also may develop a negative belief system about oneself and the health care system, causing individuals to feel unsafe in treatment centers and programs (Milhelicova et al., 2018). According to the OTPF-4, occupational therapists can provide interventions that increase occupational engagement and participation in daily life including coping strategies for trauma history, developing a self-identity, identifying personal strengths, managing and regulating emotions, navigating intimate partner relationships and managing the healthcare experience (AOTA, 2020).

Harm Reduction:

Harm reduction advocacy and programming began in the 1980’s during the height of both the AIDs/HIV and crack cocaine epidemic (Des Jarlais, 2017). Activists across the country began initiating syringe exchange programs to decrease the spread of the HIV virus among people who inject drugs (Des Jarlais, 2017). Although the syringe exchange programs were first proposed to decrease the transmission of blood-borne infection, they quickly expanded to providing health and social services to individuals who use drugs and community members who do not use drugs (Des Jarlais, 2017). Harm Reduction International (2020) asserts that “harm reduction,” grounded in justice and human rights, “refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug polices and

drug laws without judgement, coercion and discrimination". However, it is important to note that Harm Reduction International and The National Harm Reduction Coalition highlight there is no universal definition of harm reduction, as harm reduction approaches are intended to be specific to each individual and community, (Harm Reduction International, 2020; National Harm Reduction Coalition, n.d). Instead, the National Harm Reduction Coalition (n.d) outlines eight principles of care to correctly implement harm reduction practice. The eight principles can be found here: *https://harmreduction.org/about-us/principles-of-harm-reduction/*

Using a harm-reduction approach involves meeting people where they are at, disentangling "the notion that drug use equals harm," and respecting the rights of individuals who use drugs (Hawk et al., 2017 p. 2; Harm Reduction International, 2022). Although harm reduction typically is used when working with individual who use drugs, current research shows that a harm reduction approach can be extended to other health risk behaviors and be implemented in a majority of healthcare settings (Hawk et al., 2017). In alignment with the principles defined by the National Harm Reduction Coalition, Hawk and colleagues (2017) set out to define general harm reduction principles in healthcare settings. Through interviews with patients and staff members, six principles were identified including humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination (Hawk et al., 2017). Applying these principles to individuals with chronic conditions or health-risk behaviors increases patient engagement and has been found to provide long-term improvement in individual goals and outcomes (Hawk et al., 2017). Below are the definitions and strategies to implement such principles in healthcare.

From "Harm reduction principles for healthcare settings" by M. Hawk et. al., 2007, *Harm Reduction Journal 14*, 1-7. http://dx.doi.org/10.1186/s12954-017-0178-6

Principle	Definition	Approaches
1. Humanism	• Providers value, care for, respect, and dignify patients as individuals. • It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits. • Understanding why patients make decisions is empowering for providers.	• Moral judgments made against patients do not produce positive health outcomes. • Grudges are not held against patients. • Services are user-friendly and responsive to patients' needs. • Providers accept patients' choices.
2. Pragmatism	• None of us will ever achieve perfect health behaviors. • Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.	• Abstinence is neither prioritized nor assumed to be the goal of the patient. • A range of supportive approaches is provided. • Care messages should be about actual harms to patients as opposed to moral or societal standards. • It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes.
3. Individualism	• Every person presents with his/her own needs and strengths. • People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.	• Strengths and needs are assessed for each patient, and no assumptions are made based on harmful health behaviors. • There is not a universal application of protocol or messaging for patients. Instead, providers tailor messages and interventions for each patient and maximize treatment options for each patient served.
4. Autonomy	• Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities.	• Provider-patient partnerships are important, and these are exemplified by patient-driven care, shared decision-making, and reciprocal learning. • Care negotiations are based on the current state of the patient.
5. Incrementalism	• Any positive change is a step toward improved health, and positive change can take years. • It is important to understand and plan for backward movements.	• Providers can help patients celebrate any positive movement. • It is important to recognize that at times, all people experience plateaus or negative trajectories. • Providing positive reinforcement is valuable.
6. Accountability without termination	• Patients are responsible for their choices and health behaviors. • Patients are not "fired" for not achieving goals. • Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.	• While helping patients to understand the impact of their choices and behaviors is valuable, backwards movement is not penalized.

Practice Models:

Psychiatric Rehabilitation Model:

The psychiatric rehabilitation model takes principles from physical rehabilitation and community integration to help individuals with serious mental illness build skills and access resources needed to live a meaningful life in their environment of choice (Castaldy, 2020). This model asserts that health is attained when individuals engage in meaningful occupation, change is achieved through personal empowerment and choice and interventions should enable doing in an individual's chosen environment (Castaldy, 2020). Although not specifically an occupation-based model, occupational therapy practitioners can use this model to guide goal setting, building capacities and empowering engagement in roles (Castaldy, 2020).

Canadian Model of Occupational Performance and Engagement (CMOP-E):

The CMOP-E model asserts that the interaction between the person, environment and occupation results in one's ability to perform and engage in daily, meaningful occupations (Townsend & Polatajko, 2007). Within this model, the person involves the spirituality of the individual and the affective, cognitive and physical abilities one has. The environment involves anything from the physical, cultural, social or institutional environment where an individual exists and performs. Occupation involves the performance of self-care, productivity and leisure activities (Townsend and Polatajko, 2007). Assessments and interventions grounded in this model enable clients to be involved in the treatment planning by encouraging clients to choose the occupations that are most meaningful to them to focus on (Townsend and Polatajko, 2007; Ikiugu et al., 2017).

https://ottheory.com/therapy-model/canadian-model-occupational-performance-and-engagement-cmop-e

Model of Human Occupation (MOHO):

The Model of Human Occupation asserts that individuals are constantly interacting with the environment and behavior is a result of both inherent human traits and environmental influences (Albarado & Stromsdorfer, 2022). This model defines three inherent human traits including volition, habituation and performance (Kielhofner & Burke, 1980, Cole & Tufano, 2019). Volition involves an individual's values and interests and may motivate occupational engagement. Habituation involves maintaining daily routines and patterns and performance refers to skills and actions (Kielhofner & Burke, 1980). Strengths and barriers to daily occupation stem from an imbalance in the dynamic system of volition, habituation, performance capacity and environmental capacity (*Introduction to MOHO*, 2022). When care is grounded in the model of human occupation, occupational therapy practitioners focus on what motivates individuals, how individuals build routines and habits and understand how activities are performed (Albarado & Stromsdorfer, 2022; Cole & Tufano, 2019)

https://ottheory.com/therapy-model/model-human-occupations-moho

Model of Occupational Empowerment:

The model of occupational empowerment asserts that living in a disempowering environment, which can include barriers such as poverty, substance use, violence or limited social support, leads to occupational deprivation and an unhealthy occupational identity (Fisher & Hotchkiss, 2008). Occupational therapy grounded in this model aims to empower individuals to develop a positive occupational identity to further enhance self-efficacy and promote engagement in meaningful activity (Fisher & Hotchkiss, 2008).

https://ottheory.com/therapy-model/model-occupational-empowerment

Transtheoretical Model (Stages of Change):

The transtheoretical model of change focuses on the process of intentional behavioral change and asserts that individuals move through six stages of change and treatment should be catered to each stage (Prochaska & Velicer, 1997; HABITS Lab, 2012). The stages include precontemplation, contemplation, preparation, action and maintenance (Prochaska & Velicer, 1997; LaMorte, 2019; HABITS Lab, 2012). Individuals in the precontemplation phase are not planning on changing their behavior and may be unaware that change needs to occur (HABITS Lab, 2012). Those in the contemplation stage are aware that change is needed, but still weighing the pros and cons of making such change and those in preparation create a plan of action for change (HABITS Lab, 2012). During the action stage, individuals begin to change their behavior and are more committed to their plan of action (HABITS Lab, 2012). Finally, the maintenance stage is marked by a 6-month commitment to change but acknowledges that relapse is still possible and okay (HABITS Lab, 2012). Although individuals can move forward and backward through the stages of change, the model asserts that behavior change is not quick and rather occurs through a continuous cycle (HABITS Lab, 2012). Intervention can be provided at each level of change to motivate individuals and help move closer to change.

https://habitslab.umbc.edu/recommended-articles/

Cognitive Disabilities Model:

The Cognitive Disabilities model provides a foundation for working with individuals who have functional performance deficits related to cognition and information processing capacity during an activity (Allen Cognitive Group, n.d.). The model asserts that there are six cognitive levels related to performance including automatic actions, postural actions, manual actions, goal-directed actions, exploratory actions and planned activities. These cognitive levels include performance skills and can be assessed to determine level of cognitive functioning. (Cole & Tufano, 2019). Once an individual's cognitive level is identified, further assessment and intervention can be designed to adapt tasks and environments to optimize performance and safety at one's given functional level (Cole and Tufano, 2019).

https://ottheory.com/therapy-model/allens-cognitive-disabilities-model-cdm

Frameworks:

Framework of Occupational Justice (FOJ):

The framework of occupational justice states that "the inter-relationships of structural factors and contextual factors supports or restricts occupational outcomes, occupational rights and injustices" (Townsend, 2012, p.13). The framework highlights that all individuals should be able to decide what is most meaningful and engage in those activities in all environments and communities (Townsend, 2012). Individuals with mental illness may be excluded from everyday activities and experience occupational deprivation, occupational alienation, occupational imbalance and occupational marginalization (Townsend, 2012). Occupational therapy practitioners using this framework are responsible for advocating for the justice of their clients and contributing to a more inclusive society. (Townsend, 2012).

https://ottheory.com/therapy-model/framework-occupational-justice-foj

Do-Live-Well framework:

The Do-Live-Well framework asserts that everyday activity matters and is essential to an individual's health and wellbeing (Moll et al., 2015). This framework includes four building blocks including dimension of experience (dimensions that occur during occupation), activity patterns (engagement, meaning, balance, choice and routine that shapes health and well-being), health and wellbeing outcomes (range of physical, mental, social, emotional and spiritual well-being) and forces influencing activity engagement (contextual factors that affect daily participation) (Moll et al., 2015). Using this framework to guide practice requires that occupational therapy practitioners empower individuals to reflect on their patterns of engagement and engage in opportunities that promote health and well-being (Moll et al., 2015).

https://ottheory.com/therapy-model/do-live-well-framework

Self-Determination Theory:

The Self-Determination theory (SDT) provides a framework for human motivation and asserts that individuals have three psychological needs that influence motivation and behavior including: competence, autonomy and relatedness (University of Rochester Medical Center, 2022). Competence refers to the experience of mastery and being successful in activity, autonomy refers to feeling in control of one's behaviors and having a choice and relatedness refers to the need to develop a sense of belonging and connection with others (University of Rochester Medical Center, 2022). In addition, SDT highlights the influence of social and cultural factors on both intrinsic and extrinsic motivation (Center for Self Determination Theory, 2022). When the environment supports autonomy, competence and relatedness, an individual has enhanced motivation and improved satisfaction in participation in daily life (Center for Self Determination Theory, 2022). When using this theory to guide practice, practitioners provide interventions that create an environment and daily routine to support these three psychological needs and maintain motivation (Center for Self-Determination Theory, 2022; University of Rochester Medical Center, 2022).

https://selfdeterminationtheory.org/theory/

Frames of Reference:

Cognitive-Behavioral Frame of Reference:

The cognitive-behavioral frame of reference focuses on five aspects of life experience that are interrelated and influenced by the physical and social environment. These aspects include thoughts, behaviors, emotion/mood, physiological responses, and the environment (Duncan, 2011). The frame of reference asserts that when one is functioning efficiently, they have the ability to process, respond and react appropriately in everyday situations (Duncan, 2011). This frame of reference can be used to understand a client's occupational identity and needs, while providing cognitive behavioral techniques to shift thoughts, emotions and behaviors (Duncan, 2011).

https://ottheory.com/therapy-model/cognitive-behavioral-frame-reference

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F: Screening Tools, Assessments & Outcome Measures

This section, while not exhaustive, includes screening tools, assessments and outcome measures that are reliable and valid for use with individuals with a serious mental illness. **The OTPF-4 states** that the evaluation process involves "finding out what the client wants and needs to do; determining what the client can do and has done; and identifying supports and barriers to health, well-being and participation (American Occupational Therapy Association, 2020, p. 21). Information gathered during the evaluation process is then used to determine client's values, create goals in collaboration with the client and guide intervention planning (American Occupational Therapy Association, 2020).

A screening tool is used to determine an individual's need for occupational therapy evaluation and services or referral to another service if not appropriate. Screening tools typically involve client information, referral information, a brief occupational profile and recommendations for future (Gatley & Borcherding, 2016).

An assessment is utilized to gather more information about the client and understand aspects of the person that are needs, strengths or challenge areas. Standardized tests or survey instruments are used to determine factors that may support or hinder everyday participation (Gatley & Borcherding, 2016).

An outcome measure is used to plan future interactions, capture change over time and evaluate the programming provided (Gatley & Borcherding, 2016). Assessments that can also be used as outcome measures are denoted with a *.

Considerations for Administering Assessments with Individuals with Serious Mental Illness:

- Individuals with serious mental illness can have difficulty sharing personal information and communicating their needs. During the occupational profile, therapists should develop rapport, demonstrate respect and appreciation for the individual and ensure the individual feels like the expert of their own situation (Brown, 2012).
- Be mindful when selecting self-report assessments when caregivers or a mental health professional is the one reporting the information, as they may not provide the most accurate representation of the client's daily life. Combining a self-report assessment with a performance-based one may provide a clearer picture (Brown, 2012).
- Sensory process is a major concern among individuals with serious mental illness. These difficulties may greatly affect performance in everyday activities and need to be explored (Brown, 2012).
- Cognitive impairments and difficulty in cognitive processing should not be assumed. Specific assessments should be used to determine areas of cognitive functioning that may be impacting performance and daily life (Brown, 2012).
- Individuals with serious mental illness may need modifications or adaptive equipment to engage in activities selected for evaluation. Adjustments should be made and noted to reflect the client's cognitive ability (Brown, 2012).

Allen Cognitive Level Screen:

Standardized screening that assesses functional cognition and provides an understanding of individuals learning and problem-solving skills during participation in three basic tasks.

https://www.sralab.org/rehabilitation-measures/allen-cognitive-level-screen, https://allencognitive.com/acls-5-lacls-5/assessments-1-acls_lacls/

Occupational Profile:

https://www.aota.org/~/media/Corporate/Files/Practice/Manage/Documentation/AOTA-Occupational-Profile-Template.pdf

****Canadian Occupational Performance Measure (COPM):***

A semi-structured interview that evaluates an individual's perceived performance and satisfaction in areas of self-care, productivity and leisure. Information from the interview can be used to create goals for therapeutic interventions and detect change subjective change over time (Lanigan, 2016; Brown, 2012)

*If using as an outcome measure, a change of 2 points or more has been identified as a clinically significant difference.

https://www.sralab.org/rehabilitation-measures/canadian-occupational-performance-measure

https://www.thecopm.ca/casestudy/responsiveness-of-the-copm/

***Occupational Performance History Interview II (OPHI-II)*:**

A semi-structured interview and life history narrative that addresses roles, daily routines, occupational behavioral settings, occupational choice and life events. A 4-point rating scale is included to evaluate occupational identity, occupational competence and the impact of a client's behavioral on their environment. Results can be used to identify strengths and weaknesses to guide intervention (Lannigan, 2016; Brown, 2012).

https://www.moho.uic.edu/productDetails.aspx?aid=31

****Occupational Self-Assessment:***

Initial assessment tool aimed at measuring self-perceptions of occupational competence and values of each occupation. Responses can be used to guide collaborative goal-writing and identify how one's illness impacts occupational competence.

*Can be used as an outcome measure.

https://www.sralab.org/rehabilitation-measures/occupational-self-assessment

Role Checklist:

Self-report questionnaire and rating form that gathers information on perceptions of a client's roles in the past, present and future. Responses can be used to identify significant roles and any

changes in perception related to roles (Lannigan, 2016). This assessment is found to have adequate test-retest reliability in the serious mental health population.

https://www.sralab.org/rehabilitation-measures/role-checklist-version-3#:~:text=The%20RC%20presents%20and%20defines,10%20roles%20(role%20incumbency

ADL/IADLs:

Performance Assessment of Self-Care Skills (PASS):

Performance-based observational assessment that evaluates performance in 26 tasks related to functional mobility, personal self-care, ADL and IADL activity. Tasks are scored based on level of assistance needed, adequacy of performance and safety while completing the activity. Responses can be used to establish functional status prior to treatment (Lannigan, 2016; Brown, 2012).

*Can be used as an outcome measure to assess change in functional status. Tasks and assessment must be administered in a standardized manner to ensure test-retest reliability and accuracy of outcomes.

https://www.shrs.pitt.edu/ot/resources/performance-assessment-self-care-skills-pass

https://www.sralab.org/rehabilitation-measures/performance-assessment-self-care-skills

Assessment of Motor and Process Skills:

Performance-based, observational assessment that measures performance of tasks related to ADLs in one's natural environment. Performance is looked at through motor and process skills and is rated on a four-point Likert scale ranging from "Competent" to "Marked deficient performance." This assessment is shown to have acceptable-excellent psychometrics when used with individuals with schizophrenia or psychiatric disorders. It is important to note that this assessment requires training and a certificate.

*Can be used as an outcome measure and has been shown detect change in functional activity.

https://strokengine.ca/en/assessments/assessment-of-motor-and-process-skills-amps/

https://www.sralab.org/rehabilitation-measures/assessment-motor-and-process-skills

***Kohlman Evaluation of Living Skills (KELS)**:*

Assessment that uses observation, interview and performance-based activities to evaluate performance in essential living skills related to self-care, safety and health, transportation and telephone, money management and work and leisure. Activities are rated as "independent" or "needs assistance" and scores can be used to determine ability to live independently in the community (Lannigan, 2016; Brown, 2012)

*If using as an outcome measure, minimal detectable change in the mental health population has been reported as 1.416 for inpatient and 1.185 for outpatient.

https://strokengine.ca/en/assessments/assessment-of-motor-and-process-skills-amps/_

https://www.sralab.org/rehabilitation-measures/kohlman-evaluation-living-skills

***Test of Grocery Shopping Skills (TOGSS)*:**

Performance-based measure that assesses executive functioning during a live grocery shopping task in a client's natural context. Individuals are rated on accuracy on locating and selecting items at the lowest cost and aisle redundancy is considered. The TOGSS has been shown to work best in assessing individuals with serious mental illness and has strong psychometric properties. (Lannigan, 2016; Brown, 2012).

*Can be used as an outcome measure to assess the effectiveness of interventions (Lannigan, 2016)

https://www.sralab.org/rehabilitation-measures/test-grocery-shopping-skills

Adolescent/Adult Sensory Profile:

Self-report assessment measuring sensory performance patterns and the impact on functional performance. Questions include sensory processing in areas of Taste/Smell, Movement, Visual, Touch, Activity Level and Auditory and preferences are categorized as low registration, sensation seeking, sensory sensitivity and sensation avoiding (Brown & Dunn, 2002; Brown 2012).

https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Motor-Sensory/Adolescent-Adult-Sensory-Profile/p/100000434.html

Leisure:

Modified Interest Checklist:

Self-report assessment to rate level of interest in 68 leisure activities in the past, present and future (Lannigan, 2016; Brown, 2012).

https://www.moho.uic.edu/productDetails.aspx?aid=38

Engagement in Meaningful Activity Survey (EMAS):

Self-report assessment that uses a Likert-scale rating to measure engagement in meaningful activity. Has strong psychometric testing for the mental health population (Goldberg et al., 2002).

http://dolivewell.ca/wp-content/uploads/2015/05/Engagement-in-Meaningful-Activities-Survey_May-2015.pdf

Work:

Work Environment Impact Scale:

Semi-structured interview to examine and rate 17 factors of the work environment that impact work performance, satisfaction and well-being. Ratings and results can be used to make recommendations for workplace accommodations (Lannigan, 2016). Items include have high internal consistency and face validity in psychiatric populations.

https://www.sralab.org/rehabilitation-measures/work-environment-impact-scale

Social Participation:

Assessment of Communication and Interaction Skills:

Observational assessment that uses a rating scale to evaluate an individual's communication and interaction skills in tasks and activities. Responses identify strength and problem areas and can be used to create goals and guide interventions (Lannigan, 2016; Brown, 2012).

https://www.moho.uic.edu/productDetails.aspx?aid=1,

****Evaluation of Social Interaction (ESI):***

Observation-based evaluation that assess 27 social interaction occupational performance skills. Individuals are observed during at least two natural social exchanges with a person they need or want to interact with. ESI scores can be compared to normative means of an age-matched, healthy individual.

https://www.innovativeotsolutions.com/wp-content/uploads/2018/06/esiReportSupplement.pdf

*If using as an outcome measure, can measure positive or negative change in social interaction skills observationally and/or statistically. A change in scores of at .3 indicates an observational change in social interaction. If the change in ESI measure is at least as large as the sum of the Standard Error of Measurements for each measure, there has been a statistically meaningful change in social interaction.

Cognition:

Behavior Rating Inventory of Executive Function-Adult Version (BRIEF-A):

Self-report assessment that evaluates an adult's executive functions and self-regulation in their everyday environment. Results can assess a main domain of global executive functioning or two domains of behavioral regulation and metacognition.

https://scienceofbehaviorchange.org/measures/behavior-rating-inventory-of-executive-function-adults/; https://www.parinc.com/Products/Pkey/25

Dynamic Lowenstein Occupational Therapy Cognitive Assessment (DLOTCA)*:*

Performance-based battery consisting of tasks related to seven cognitive areas with 28 subsets to evaluate cognitive functioning. (Lannigan, 2016; Brown, 2012). Results from assessment can be used to determine ability to learn, follow cues and awareness of limited functioning.

https://www.sralab.org/rehabilitation-measures/dynamic-lowenstein-occupational-therapy-cognitive-assessment

Executive Function Performance Test:

Performance-based measure designed to assess executive functioning skills to determine which executive functions are impacting performance, an individual's capacity for independence and the amount of assistance needed to complete a task (Brown, 2012) Four-five tasks are used for assessment depending on severity of impairment including hand washing, oatmeal preparation, telephone use, taking medications and paying bills.

*If using as an outcome measure, minimal detectable change for individuals with schizophrenia is reported as 3.74 and normative data exists for both chronic and acute schizophrenia.

https://www.sralab.org/rehabilitation-measures/executive-function-performance-test#mental-health

Test of Everyday Attention:

Battery of eight everyday activities used to evaluate selective attention, sustained attention and attentional switching. Uses everyday materials in real-life scenarios and identifies different patterns of attention breakdown (Brown, 2012; Ward, Ridgeway & Nimmo-Smith, 1994).

https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/The-Test-of-Everyday-Attention/p/100000182.html

Montreal Cognitive Assessment (MoCA):

Rapid, performance-based cognition screen that assesses multiple cognitive domains including visual spatial and executive functions, naming, memory, attention, language, abstraction and orientation. Scoring cut offs differentiate mild, moderate and severe cognitive impairment. Research has demonstrated that the MoCA is appropriate to use with individuals with schizophrenia and other mental health disorders. Cut off scores are provided specifically for individuals with schizophrenia.

https://www.sralab.org/rehabilitation-measures/montreal-cognitive-assessment

Quality of Life:

***Beck Anxiety Inventory*:**

Self-report assessment used to identify anxiety severity. The assessment uses a 4-point Likert scale from "Not at all" to "Severely" to rate symptoms of anxiety during the present week. Score ranges are provided to indicate different levels of anxiety.

https://www.sralab.org/rehabilitation-measures/beck-anxiety-inventory

General Self-Efficacy Scale:

Self-report assessment that measures perception of self-efficacy. Ratings can be used to predict an individual's coping abilities. Normative data is provided for individuals with schizophrenia.

https://www.sralab.org/rehabilitation-measures/general-self-efficacy-scale

WHO Quality of Life-BREF (WHOQOL-BREF):

Self-report assessment that assesses quality of life in four domains including physical health, psychological health, social relationships and environment. Items are rated on a 5-point Likert scale and a domain, and overall score is calculated.

*If using as an outcome measure, minimal detectable change is 8.12 and standard error for measurement is 2.93.

https://www.sralab.org/rehabilitation-measures/who-quality-life-bref-whoqol-bref#mental-health

***University of Rhode Island Change Assessment Scale (URICA)**:*

Self-report assessment used to measure an individual's stage of change. A 5-point Likert Scale is used to rate agreement with statements related to stage of change and readiness to change. Versions of the URICA exist for different circumstances including an alcohol version, substance use version, psychotherapy version and domestic violence version.

*If using as an outcome measure, the URICA can be used to track shifts in behaviors and attitudes related to change.

https://habitslab.umbc.edu/urica/

Overall Functioning:

Global Assessment of Functioning Scale:

Observation-based scale that assesses the impact of mental health symptoms on psychological, social and occupational functioning. Scores range from 0-100 and a higher score represents higher everyday functioning. Questions are related to both the level of functioning in daily life and the severity of mental illness symptoms.

https://www.sralab.org/rehabilitation-measures/global-assessment-functioning

Goal Setting:

Goal Attainment Scale (GAS):

A measure used to create individualized goals and scale them in a standardized way that indicates the extent to which a patient's goals are met. Goal attainment scaling highlights shared decision making and allows an individual to participate in the therapeutic process (McCue et al., 2019). An interview is used to identify a SMART goal, weigh the goal and determine an expected outcome.

https://www.sralab.org/rehabilitation-measures/goal-attainment-scale

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G: Interventions

This section, while not exhaustive, includes interventions within the scope of practice for occupational therapy that are valid for use with individuals with serious mental illness. These interventions are designed to establish, modify, and/or maintain performance, prevent disability, and promote health and wellness in occupations such as, but not limited to, activities of daily living (ADLs), instrumental activities of daily living (IADLs), social participation, work, education, and health management (Brown et al., 2019; American Occupational Therapy Association, 2020). Occupational therapy practitioners contribute significantly to recovery of individuals with serious mental illness by collaborating with the interdisciplinary care team to provide, holistic, person-directed, and recovery-oriented services across the continuum of care (Brown et al., 2019; Flemming-Castaldy, 2020). DeAngelis et al., (2019) found that a community based occupational therapy program with interventions focused on stress/anger management, sleep hygiene, money management, healthy eating, and leisure and skill development resulted in significant improvements in individual performance and satisfaction with engagement in daily activities. These findings were supported by post discharge narratives and outcomes of the retrospectively analyzed pre/post scores obtained through the Canadian Occupational Performance Measure (COPM) (DeAngelis et al., 2019). Additionally, Beker & DeAngelis (2021) demonstrate the efficacy of OT services with young adults in their article discussing the outcomes of an educational training group implemented in permanent supportive housing.

When working with individuals with serious mental illness, the symptomology and experience of their diagnosis can impact ability to perform meaningful occupations. Specific examples include:

- Changes in motivation and volition impacting one's ability to complete daily tasks needed to maintain the upkeep of the home, grocery shop or participate in meal preparation/cleanup, and participation in personal hygiene/grooming and bathing routines.
- Side effects of prescribed medications impacting the ability to operate a vehicle, sleep, socialize with others, or complete ADLs/IADLs.
- Limited access and understanding of the public transportation system impacting the ability to leave the home for both necessary and voluntary tasks. The result may lead to decreased community mobility causing social isolation, the inability to travel to medical appointments, or the inability to pick up groceries and medications necessary to manage symptoms (Selhub, 2020).
- Emotional regulation and fluctuations in mood impacting communication management and the ability to maintain contact with one's care team and support system (family, friends, community members, etc.)

The challenges listed, while not representative of every individual's experience with mental illness, represent some common challenges that may occur on a daily basis. Changes in ADL/IADL performance may be short term or long term. Depending on the needs of each unique individual, practitioners can use activity analysis, activity adaptations, compensatory strategies, environmental modifications, and explicit skill training to foster occupational performance and

education to promote personal empowerment and autonomy (Swarbrick and Noyes, 2018; Gray et al., 2018). Activity analysis can be performed to observe an individual's ability to perform a task in their natural environment and assess the quality of the performance skills during actual performance of the task (American Occupational Therapy Association, 2020). In response to the individual's performance, occupational therapy practitioners are then able to make adaptations to activities, introduce strategies such as energy conservation techniques, visual cues for memory/attention, and make changes to the environment such as rearranging furniture or adding furniture if needed for resting (American Occupational Therapy Association, 2020). Promotion of improved social skills, emotional regulation, and confidence advocating for oneself can be achieved through use of exercises in assertive communication and self-confidence building (American Occupational Therapy Association, 2020). These interventions can facilitate effective and safe completion of tasks. Occupational therapy practitioners are also able to provide interventions that address physical wellbeing and functioning of an individual. Similar to rehabilitation and outpatient settings, occupational therapists in mental health settings can recommend adaptive equipment, work on general strengthening, balance, positioning, help devise a non-pharmaceutical pain management plan, make environmental and lifestyle adaptations for low vision and more (Flemming-Castaldy, 2020; Brown et al., 2019; American Occupational Therapy Association, 2020; Boyt Schell, B.A. & Gillen, 2019).

Services should be administered in the natural environment when possible and education and training should be provided to multidisciplinary staff, community workers, and people who interact daily with the individual on methods to support their autonomy and recovery (Flemming-Castaldy, 2020). Individuals and their families (if indicated) should be involved in goal planning for their treatment whenever possible. Goals for an individual working with occupational therapy may look like engaging or re-engaging in personally meaningful occupations, partaking in occupations that need to be completed (such as housework or financial management), facilitating smooth transition between services or different milestones in life (work, school, geographical moves), and community integration (American Occupational Therapy Association, 2020; Pahwa et al., 2014). Community integration has been deemed an essential component of recovery and a challenge for individuals with serious mental health diagnoses (Pahwa et al., 2014). What integration looks like, and the specifics of the goals vary from person to person, however, research has shown that integration of individuals with serious mental illness into spaces with individuals who do not experience serious mental illness is important in creating a blend of supports and experiences that contribute to feelings of belonging, acceptance, and social integration (Pahwa et al, 2014).

Below please find additional intervention tools for use with individuals with serious mental illness. In addition to information in this section, please refer to the "Critical Elements of Care" section of this manual for considerations to keep in mind when working with individuals with serious mental illness. "Critical Elements of Care" includes information on common medications, adverse childhood experiences/trauma, suicide prevention, compassion fatigue and burnout, de-escalation, social determinants of health, and language which can guide approach to treatment planning.

Cognitive Behavioral Interventions:

Cognitive behavioral interventions are evidence-based strategies that have been validated for use in many populations, including individuals with serious mental illness. Under this approach, clients are directed to problem-solve current needs and modify dysfunctional behaviors and/or distorted thinking (Rathod et al., 2015; Brown et al., 2019). The cognitive model is a client-centered approach that hypothesizes that people's emotions and behaviors are influenced by their perception of events (Rathod et al., 2015). There is strong evidence for use of cognitive behavioral therapy (CBT) and its effectiveness for mental health outcomes in individuals who have had adverse childhood experiences, particularly those who have experienced sexual abuse (Lorec et al., 2020).

When an individual has a negative perception of an event and continues to focus on this thought pattern, cognitive behavioral interventions can be used to challenge these thoughts, commonly referred to as cognitive distortions. There are many different types of cognitive distortions, some common ones may be (Hagen et al., 2011):

- All or nothing thinking – situations are always seen as success or failure, everything or nothing, good or bad with no acknowledgement of any results between the two extremes
- Discounting the positive – ignoring or invalidating good things that have happened to the individual, positives are seen as coincidence
- Personalization and Blame - entirely blaming oneself or someone else for a situation that realistically had many factors out of control of the individual, can often lead to individuals feeling inadequate or experiencing feelings of shame and/or guilt

OT's role in intervention and treatment involves challenging the individual through the learning of new thoughts and thought processes. This can be done through education and working with individuals to acknowledge irrational ideas and negative thoughts, assertiveness training, role-playing, and combined interventions such as cognitive behavioral in conjunction with medication management, stress management/coping skills trainings, mindfulness, etc. (Rathod et al., 2015; American Occupational Therapy Association, 2020).

Dialectical Behavior Interventions:

Dialectical Behavior Therapy (DBT) is a modified type of cognitive-behavioral therapy. Some of the concepts and interventions of DBT align and further complement the intervention approaches beyond the CBT approach (Dimeff, L., & Linehan, M.M, 2001). DBT is focused on teaching individuals' skills and strategies to facilitate their ability to develop healthy ways of coping with stress, regulating their emotions, and forming/improving their relationships with others (Dimeff, L. & Linehan, M.M., 2001). DBT teaches four core skills (Dialectical Behavior Therapy, n.d., Simon-Fleischer, n.d.):

- *Mindfulness* – ability to non-judgmentally observe oneself and one's surroundings in order to become more mentally aware of physical and mental triggers

- *Distress Tolerance* – ability to deal with stressful and/or painful situations when unable to change the outcome; learning to tolerate it, accept the outcome, and continue to move forward
- *Emotional Regulation* – assists individuals in understanding their emotions and making them work for them; working on recognizing intense emotions and responding to them in a productive manner; education about the function of emotions
- Interpersonal Skills - learning to communicate what an individual wants or needs, boundary setting, teaching self-respect and respect for others,

Compassion Focused Interventions:

Compassion focused interventions aim to promote mental and emotional wellbeing through encouraging those receiving treatment to be compassionate towards themselves and other people (Gilbert, 2014). Compassion focused interventions are similar to cognitive behavioral therapy (CBT) in that both examine the role behavior, cognition, and emotion play in the body and how individuals respond to challenges (Beaumont, 2012). However, the two still remain different and implement separate interventions. Compassion focused interventions act as an effective supplement to CBT since they offer ways to target the specific emotions of shame, guilt, and self-blame (Gilbert, 2014; Beaumont, 2012). Braehler et al. (2013) found that an increase in compassion was associated with a reduction in depression and in perceived social marginalization. Compassion focused interventions call upon the occupational therapy practitioner to incorporate mindfulness, stress management/coping skills and other interventions that encourage self-reflection and facilitate development of insight (American Occupational Therapy Association, 2020). Intervention types guided by the OTPF-4 (American Occupational Therapy Association, 2020) that align with the tenets of compassion focused interventions are self-regulation and self-advocacy.

Peer Support Group Interventions:

Peer support interventions are designed, developed, and implemented by individuals who share the lived experience of mental illness, or other experiences similar to other members of the group (Flemming-Castaldy, 2020; Brown et al., 2019). These services can enhance or complement professional services. Peer support services have been designated by the Centers for Medicare and Medicaid services (CMS) as an evidence-based practice in community mental health (Flemming-Castaldy, 2020). Benefits of receiving peer-support services include development of coping/stress management strategies, promoting community participation, increased engagement in health management and accessing community services, and reduction in hospital admissions and emergency room visits (Bellamy et al., 2017; Brown et al., 2019). Additionally, peer support services foster hope and optimism because individuals tend to connect more easily with others who have shared experiences and are now modeling and sharing their success in recovery (Swarbick, 2017). In order to become a certified peer support specialist an individual must receive training in peer support competencies and pass an exam (SAMHSA, 2020; Flemming-

Castaldy, 2020). The core competencies as defined by SAMHSA (2020) are recovery-oriented care, person-centered care, voluntary, relationship-focused, and trauma-informed.

The occupational therapy practitioner's role in peer support interventions is their collaborative relationship with consumers and peer service providers to develop, implement, promote, and evaluate peer-directed programs (Flemming-Castaldy, 2020). OTs are able to provide consultative and administrative services drawing upon their expertise to address participation complexities and challenges to recovery or programming that are beyond the expertise or knowledge of the peer service providers (Brown et al., 2019; Flemming-Castaldy, 2020).

Recovery-Oriented Cognitive Therapy (CT-R):

The cognitive model guides this intervention by helping practitioners to understand what makes an individual flourish and what barriers produce stagnation in life, in terms of personal beliefs they hold about themselves, others, and what is to come of the future (Beck et al., 2021). Individuals with mental health diagnosis who feel disconnected from others and purpose in life may view themselves as fundamentally different or incapable and feel disinterested or unable to engage in valued occupations (Brown et al., 2019). Practitioners using the recovery oriented cognitive therapy approach (CT-R) must attempt to locate the adaptive mode (person's best self) in the individual, energize it and then help the individual actualize and strengthen it (Beck et al., 2021) Using CT-R a practitioner can help an induvial identify this self and strengthen any underlying positive beliefs in order to pursue a meaningful life and develop resiliency (Beck et al., 2021). The four core features of CT-R are listed below (Beck et al., 2021):

- *Access and energize* – this core feature of CT-R embodies human connection. Practitioners must meet an individual where they are at and determine interests and activities that will engage them, once a response is received energizing requires repeating the activity over time to build a relationship – lots of questions during this phase, asking for advice on things they are passionate about or enjoy
- *Develop* – once trust is gained, and the individual has developed more energy it is the appropriate time to focus on the life the person wants to have – identifying aspirations during this phase and finding the meaning and motivation behind them
- *Actualize* – this phase involves collaboratively breaking down aspirations into small achievable steps, addressing challenges in the context of the individual's aspirations, and finding meaningful roles to connect to the aspirations
- *Strengthen* – during this phase attention is drawn to positive experiences or accomplishments and these accomplishments and newly developed skills/experiences are used to develop future resiliency

Motivational Interviewing

Motivational Interviewing (MI) is a client-centered intervention that is useful when working with individuals who may be contemplating making behavioral changes (Miller & Rollnick, 2012; OT-Innovations, n.d.). Motivational Interviewing helps a client explore and resolve ambivalence by first determining what stage of change in the Transtheoretical Model they are in and using specific strategies given the stage of change to foster motivation within the individual to

facilitate behavioral changes (Miller & Rollnick, 2012; OT-Innovations, n.d.). The five general principles of MI are: empathetic communication, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy (OT-Innovations, n.d.). Some of the communication strategies needed to communicate effectively during MI are:

- Reflective listening
- Asking open-ended questions
- Use of affirmations
- Summarization

Symptom Management – Psychological and Physical:

Symptom and condition management falls under health management in the OTPF-4 (American Occupational Therapy Association, 2020). Occupational therapy practitioners can assist individuals with symptom management by teaching coping strategies/stress management skills, relaxation techniques, techniques to manage medication side effects, memory strategies, anger management, utilizing community and social supports, and navigating and communicating with the healthcare system (American Occupational Therapy Association, 2020; Cara, 2019). One specific intervention that has produced positive outcomes in individuals with serious mental illness is the creation of a Wellness Recovery Action Plan (WRAP). WRAP is an effective self-management tool with an emphasis on patient-led creation of the resource (Pratt et al., 2013). To create a WRAP an individual must develop a "wellness toolbox" comprised of strategies and skills for maintaining daily wellness, dealing with symptom triggers, managing early warning signs, and addressing worsening symptoms (Flemming-Castaldy, 2020). Once this wellness toolbox is created, the information contained within is used to create an action plan. The action plan can then be utilized if a crisis arises and impedes the individual's ability to self-manage, make decisions, or be physically safe (Flemming-Castaldy, 2020).

Intervention Approaches in Mental Health, Guided by the Occupational Therapy Practice Framework: Domain and Process (4th ed.):

- Health Promotion – this approach does not assume a disability is present and interventions are designed to enhance activity performance in a natural context (American Occupational Therapy Association, 2020).
- Maintain – this approach recognizes that capabilities and health can be lost or diminished without intervention and provides supports that allow individual to preserve capabilities they have regained (American Occupational Therapy Association, 2020).
- Remediation/Restoration - this approach is designed to establish a performance skill or ability that has not already been present or to restore a performance skill or ability that has been impaired (American Occupational Therapy Association, 2020).
- Compensation/Adaptation - this approach is implemented when an individual cannot complete desired occupations in a "typical" way. Performance of an activity analysis is helpful and can be used to determine any activity adaptations, compensatory techniques,

and environmental modifications that could enable occupational engagement (American Occupational Therapy Association, 2020).

- Disability Prevention – this approach accepts and addresses the reality that all individuals can be at risk for developing problems with their occupational performance. Interventions that prevent the occurrence or evolution of barriers to performance are provided. The interventions can target the client, context, or activity variables (American Occupational Therapy Association, 2020).

Please find additional resources, in the form of links and text recommendations, for skill development and intervention/treatment guidance in the "Additional Resources for Skill Development, Enhancement and Information" section of this manual.

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H: First Episode Psychosis

First episode psychosis (FEP) is generally characterized as a disruption of a person's perception of reality that may make it difficult for them to realize what is real and what is not. The National Institute of Mental Health (n.d.) estimates that approximately 100,000 adolescents and young adults in the US experience FEP each year and three out of 100 people will experience psychosis at some time in their lives. Common signs and symptoms of first episode psychosis are withdrawing from family and friends, sudden decline in self-care, mood swings, forgetfulness, trouble concentrating, delusions, hallucinations, and impulsivity (Brown et al., 2019; NAMI, n.d.). Research has shown that a majority of functional decline occurs during a "critical period" (comprised of a prodromal period and first episode psychosis) and functional status achieved during the first 2-5 years may predict lifelong functioning (Brown et al., 2019; Fusar-Poli et al., 2013; National Institute of Mental Health, n.d.). During the prodromal period early signs of dysfunction appear and the client is considered high risk (HR) but does not yet meet diagnostic criteria for a psychotic disorder (please refer to definitions and disorders section of manual for all diagnostic criteria) (Brown et al., 2019). FEP refers to the period of time in which the client has met diagnostic criteria for a psychotic disorder and includes the first 2-5 years after diagnosis (Brown et al., 2019; National Institute for Mental Health, n.d.). It is critical to be aware that "people experiencing a first episode of psychosis frequently have co-occurring substance use disorders, usually involving alcohol and cannabis, which put them at risk for prolonged psychosis, psychotic relapse, and other adverse outcomes" (Wisdom, Manuel & Drake, 2011, p.1007).

Literature indicates that clients have the best treatment outcomes when they receive appropriate treatment for psychosis as early as possible following the onset of symptoms (Brown et al., 2019; Department of Human Services, n.d.). The World Health Organization (WHO) recommends treatment occur within the first 12 weeks following the onset of symptoms (Department of Human Services, n.d.). However, improvements in functional outcomes and recovery from symptoms were seen in clients who received treatment within the first 74 weeks of illness onset in a study that investigated a comprehensive, multi-disciplinary, team-based approach to treatment for young patients experiencing FEP (Kane et al., 2016; American Psychiatric Association, 2015). The experimental treatment program, called NAVIGATE, included four core interventions: medication management, family psychoeducation, resilience-focused individual therapy, and supported employment and education (Kane et al., 2016). The functional outcomes of clients participating in NAVIGATE were compared to those receiving the control "community care" determined by clinician choice and service availability with no additional training, supervision, or guidance on treating FEP provided to the community care providers (Kane et al., 2016). While the results of the study showed greater improvement in outcomes in the clients who participated in the NAVIGATE intervention versus the community care within 74 weeks of symptom onset, the effects were even more profound for those in the NAVIGATE group with shorter duration of untreated psychosis (Kane et al., 2016). The NAVIGATE program was developed as part of the Early Treatment Program (ETP) study which is part of the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) initiative. RAISE supports a variety of treatments for FEP, especially Coordinated Specialty Care

(CSC) which involves interventions like those seen in the NAVIGATE program in Kane et al.'s (2016) study (National Institute of Mental Health, n.d.). Coordinated specialty Care is a recovery-oriented treatment program that involves shared decision making between the client and a team of specialists in order to create a personalized treatment plan (National Institute of Mental Health, n.d.). The five components of CSC are (Brown et al., 2019; National Institute of Mental Health, n.d.; National Council for Mental Wellbeing, n.d.):

- ***Psychotherapy*** – this therapy can be done in individual or group format, cognitive behavioral therapy (CBT) is an evidence-based intervention that has been proven effective in consumers experiencing psychosis
- ***Medication Management*** – Knowing type and purpose of medications, taking medications as scheduled, and communicating the importance of taking medication even after symptom improvement
- ***Family Education and Support*** – Psychoeducation is crucial so that consumers can choose the support people they want involved in their care/recovery and family supports will get information that enables them to play an active role in the recovery process
- ***Case Management*** – Part of person-centered care, the case manager can help the consumer and family navigate treatment and provide them with additional resources
- ***Work, Education and Support*** – This is designed to foster autonomy and provide support with goal setting - this can include returning to work or school after an absence, developing new personal and/or professional interests, and making new social connections

The role of occupational therapy (OT) when working with clients experiencing FEP is to help the individual maintain a sense of self through engagement in meaningful activities designed for success (Brown et al., 2019). The OTPF-4 (American Occupational Therapy Association, 2020) suggests that OT practitioners can assist clients experiencing FEP with occupations such as symptom and condition management, medication management, education, work, social participation, and activities of daily living. The initial assessment with a client aims to determine baseline functioning, what they would like to be able to do, any strengths and abilities they possess, and their future goals (Brown et al., 2019). This is done by interviewing the client and any family supports participating in their care and administering standardized or non-standardized assessments (Brown et al., 2019). Assessment of cognitive performance falls under the scope of practice for OT and is typically a major focus in their initial assessment and subsequent intervention and treatment planning when working with clients experiencing FEP (Brown et al., 2019). Psychosis may impact executive functioning and see a change in processing skills and social interaction skills as well as attention, memory, perception, and thought (Brown et al., 2019; American Occupational Therapy Association, 2020). OT practitioners can provide opportunities for clients to utilize feedback from physical, social, and cultural environments around them to improve functioning in performance skill domains impacted by their psychotic symptoms (Brown et al., 2019; American Occupational Therapy Association, 2020).

If a client reports persistent adverse side effects to medication the occupational therapy practitioner should encourage the client to consult their physician as soon as possible to address these concerns. Please find links to additional resources on FEP below.

Resources for more information*:*

FEP Treatment: https://www.psychiatry.org/newsroom/news-releases/real-world-multifaceted-treatment-for-first-episode-psychosis-improves-multiple-patient-outcomes

Penn Psych Psychosis Eval & recovery Center: https://www.med.upenn.edu/bbl/penn-perc.html

Horizon House Outpatient Services: https://www.hhinc.org/behavioral-health-services/outpatient-services/

Understanding FEP: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-5006.pdf

FEP FAQ: https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/First-Episode-Psychosis.aspx

Recovery After Initial Schizophrenia Episode: https://www.nimh.nih.gov/health/topics/schizophrenia/raise

Coordinated Specialty Care for First Episode Psychosis: https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-manual-i-outreach-and-recruitment

Early Intervention Treatments for Psychosis: https://www.thenationalcouncil.org/topics/first-episode-psychosis/

Early Serious Mental Illness Treatment Locator: https://www.samhsa.gov/esmi-treatment-locator

Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov/

Early Onset Schizophrenia Community of Practice: https://www.thenationalcouncil.org/practice-improvement/early-onset-schizophrenia-community-practice/

Coordinated Specialty Care – FEP Programs: https://www.nasmhpd.org/sites/default/files/Policy_Brief-Coordinated_Specialty_Care_First_Episode_Psychosis_Programs.pdf

Early Intervention in Mental Health: https://iepa.org.au/

Early Assessment and Support Alliance: https://easacommunity.org/

Adolescent Development and Preventative Treatment Program: http://www.adaptprogram.com/

BeST Center Resources: https://www.neomed.edu/wp-content/uploads/Best-Practices-in-Schizophrenia-Treatment-BeST-Center-Practices.pdf

Best Practices in Schizophrenia Treatment: https://www.neomed.edu/bestcenter/

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I: Lived Experience

This section includes transcribed and recorded content collected from 3 interviews conducted with individuals living with a serious mental illness. Each individual completed a formal university sponsored signed consent form prior to participating in the recorded interview. All three individuals who were interviewed are currently living in permanent supportive housing. The National Alliance to End Homelessness (2021) defines permanent supportive housing as "an intervention that combines affordable housing assistance with voluntary support services [that] build independent living and tenancy skills and connect people with community-based health care, treatment and employment services, to address the needs of chronically homeless people" (p. 1). Previous literature highlights that learning from mental health lived experience positively impacted students' understanding of serious mental illness diagnosis, symptoms and recovery (Ridley et al., 2016). In addition, people living with serious mental illness help address the impact of social determinants of health, gaps in treatment delivery, and health inequities (Vojtila et al., 2021). As mental health care shifts to a recovery-based model, individuals living with serious mental illness are experts of their own lives and provide valuable information about the mental health experience, misconceptions and stigma and best practice (Ridley et al., 2016; Vojtila et al., 2021).

The questions included in the interview were based on initial themes found while developing a Lived Experience-Based Digital Resource (Peck et al., 2020). Individuals who experienced psychosis were interviewed to create video-recorded interviews used for peer support and interview responses were separated into six themes including "My Journey," "My Identity," "Connections," "Daily Life," and "Mental Health Experience" (Peck et al., 2020). The interview questions for the lived experience section of this manual were crafted based on the six themes found. Questions were reviewed and feedback was provided by practitioners who work in the mental health setting including an occupational therapist, a clinical social worker who works in a community-based mental health setting and licensed professional counselor who is the director of a university's student counseling center. The feedback was integrated, and questions were approved before initiating the interviews.

For this section, we define lived experience as "personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people" (Chandler & Munday, 2016). Please note that our lived experience was collected in order to gain perspective from individuals, not for data analysis related to trends, themes or conclusions. This section of the manual was approved by the universities Institutional Review Board (IRB) for interview. All names provided are pseudonyms to maintain confidentiality.

Questions:

- Can you please share your mental health diagnosis and what it means to you?
- What strengths, skills or supports do you feel help you navigate life with your mental health diagnosis?
- What things have you found difficult to do because of your mental health?
- Have you ever experienced issues related to stigma and discrimination because of your mental health diagnosis?
- Can you describe your experiences with the mental health professionals that have been involved in your treatment?
- Can you describe your experiences with the mental health services you have received (i.e., making appointments, locating the office etc.)?
- Is there anything that has made it difficult for you to seek help for your mental health challenges? Has anything helped you seek assistance?
- What is something you want health care professionals to know about living with mental illness?
- Is there anything else you want to add that hasn't been asked?

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Lived Experience Transcriptions: Interview 1

Evert is a 73-year-old male living with schizophrenia and symptoms of paranoia and has a history of substance use and being unhoused. He has been residing at a permanent supportive housing residence for the past four years and reports that he is currently sober.

OTS: Hello, we are putting together materials to help occupational therapists and potentially other health care providers better understand and address the needs of people living with a serious mental illness. As part of our doctoral project, we want to include the lived experiences of people who have mental illness because it's important for health care providers to hear firsthand experience. We compiled nine questions related to your journey and experience with mental illness. We know your answers and stories will inform future practitioners and hopefully improve the quality of care provided. All the information provided will be kept confidential. Your name and address will not be shared. So please feel free to share as much or as little as you wish. You are not required to answer anything you do not feel comfortable sharing. And please know that participating in this interview is not mandatory and you can stop at any time. We appreciate your time today. And we'll confirm everything we collect from you for accuracy prior to completing and sharing our project with others.

Do we have your verbal permission to record today?

E: Yeah, alrighty.

OTS: All right, so we'll start off with our first question which is **could you please share your diagnosis and what that means to you?**

E: Um, I'm schizophrenia paranoid. Uh it means that I'm sick and I seek help. Um, it's very complicated at times and within me depression frustration, anxiety, panic attacks happen. And um by seeking help I can deal with this, constant therapists, and the groups I go to give me enough tools to deal with, to recognize when when when when the attacks happen.

OTS: So, like you said, you talked about your psychiatrist and the groups a**re there any like strengths or skills that you have that you feel help you sort of navigate life with your diagnosis?**

E: Well right now, um well I go to art classes that's very relaxing and is a challenge to keep me busy to get me outside myself. It helped me create my moods or a what I want to do and what I wanna create. And then I go to self-help groups like AA, NA, DTR. I see my psychiatrist; I've talked to people around here they got the same symptoms that we can identify with each other with.

OTS: Awesome. **Are there any things that you find difficult to do because of your diagnosis?**

E: Yes. To clean your house. It's very hard because sometimes I could be feeling good and the depression is set in and it may last maybe an hour some days, someday 24 hour or even longer. Medicine help, but I know talking and keeping busy gets me outside of myself. I don't isolate like I used to.

OTS: Okay that's good. I know you said your art classes. So, when you're in your depression phase then it becomes hard to do things like cleaning.

E: It's very hard to concentrate. I sit on the bed maybe for hours just staring at that the wall.

OTS: Alright, thanks for sharing that. **Have you ever had to navigate any issues related to like stigma or discrimination based on your mental illness or times that you've gone through different symptoms?**

E: People, well, in the beginning people used to call me all kinds of names and wouldn't have bothered with me. I felt alone and like I said when I start seeking health and coming around, people start gravitating towards me more.

OTS: That's good. **And what about from like any doctors or anything like that? Have you had any issues with stigma for mental illness or they've all been pretty supportive?**

E: Well, I have fired some doctors and therapists because I thought they weren't giving me what I wanted and needed. That was the way to do it loudly. But basically, I get support if I get the right therapist or doctor.

OTS: How would you describe your relationship with the health professionals and services that were involved in your mental health journey?

E: Well, I'm serious about recovery. And I take them serious too. We have fun and everything, but I take it personally, we get personal. I ask some personal questions that you know not too personal, but like I identify with something they may have done, what I had done, maybe she had better, or she had had the experience, or the learned from the books, or both. I guess I am very fortunate with my therapist and Doctor.

OTS: That's good. It's good to have like a common experience. About how long have you been seeing some of these therapists?

E: Since 1971.

OTS: Okay. Is that when you were first diagnosed?

E: Yes.

OTS: Okay. And do you think that your care has like changed since 1971? Or your mindset has changed?

E: Oh, it's changed, uh, to the point where I'm almost ready to say I'm not sick anymore. What I'm saying is progress and all the trauma I went through, um, as a child because I was sick at the age of six years old, and a whole lot of things happened to me. I stuffed a whole last stuff down with and certain things cause I'm not fighting. Well, as the mind got better, I'd be calm, and they go away. And you're frustrated, but like the point is, back in my childhood, I remember it. Yeah.

OTS: Okay, so it seems that you've come a long way.

E: Yeah.

OTS: Is there anything that has made it hard for you to seek help, like when you said you had to get rid of some doctors or therapists. Was there anything that made it hard to find new mental health professionals?

E: Um, no. The program that I was in at the time was a good program, they had therapists and doctors. I just told them I didn't want to see that doctor or that therapist at that time and they appoint me a new, new therapist or a doctor.

OTS: It seems like having supports and having those programs that kind of helped you find other.

E: Kind of? It does help. I had I had a mental block. A very tough mental block it seemed like my my whole life was just a mental block that it's been tore down or I feel pressured but not as much pressure as before. I feel basically good all the days. Pressure is something that I'm learning to really deal with without copping out before I go get a drink to deal with it or go get a drug or just walk away from it and don't think about it. Or just be angry. All that negativity is going away, it's going away, right? I'm not sure, I'll get angry, and pressure will hit- but I can deal with it now better.

OTS: That's awesome. Yeah, how would you I guess when you were first like in the 1970s How would you see yourself dealing with it and how is it different?

E: In the 70s, I was completely, totally sick. Hallucination, seeing things, my personalities, different personalities came out. At that time, I was on drugs and drinking and I was in the hospital 32 times, that's how sick I was over a period of time.

OTS: Thanks for sharing that. **And what is something you want healthcare professionals to know about living with mental illness?**

E: Um, they need structure because living here is okay, the workers, they have their problems, they do clash, sometimes we do clash but we get that ironed out. But here seems like some people won't do their part, don't want to take the medicine. Some are doing drugs. Some of them won't wash, some of them won't clean up like the cluster or the bathroom or the chores. They borrow money and beg all the time and those things are rules. They got rules for that but like the rules are not being enforced. I feel that if they enforce the rules, see I was here before, and it was better. They enforced the rules. I don't know if it is because of new workers or what it is. But they need to enforce the rules and have more rules to go by. Structure.

OTS: Yeah, that's good to know. **If you were to be meeting like a new doctor or a new healthcare professional, or therapist, what would you want them to know about schizophrenia or things like that?**

E: I think I want them to know that when a person walks into their office, in the beginning, they don't really want to be there. They don't really want to take their medicine. They really don't know nothing about it. Um, they're going to cop out. Like, I think we need to have like classes to teach on in the beginning that when a new person come in, a class to tell what it is about, about the medicine, about your rights because at one time I didn't know I had rights to fire doctor or

nurse. Yeah, I think they should have some kind of class, some kind of class for new people to meet with somebody for 15 to 20 minutes to talk about it.

OTS: Yeah, that's awesome. Yeah, I can imagine that it is a big shock when you're first going right? Yeah. All these things are happening that you don't necessarily know and all these medications that you don't know anything about.

E: Right. Because I know, when I first came, when I first started, I didn't know about medicine, how it makes you sleepy, side effects, so I rebelled. I wouldn't take it. I wouldn't talk to the doctor. I remember one doctor I had, he kept on medicating me, medicating me, over medicating me. I didn't I didn't know that was what was going on. So, I stopped taking medicine and so that's how I ended up in the hospital. When I learned by talking to people that had the same problem that I had or the mental illness we talk, and I start catching on right. So, I've done that ever since, you know I'm doing pretty good.

OTS: Is there anything else that you'd like to add? **Maybe any other part of your experience that we didn't specifically ask about?**

E: I think a place like this, it would be nice to hire a therapist or y'all OT, right?

OTS: Yeah.

E: Because we're constantly running to the case manager with situations or problems, they said we can do it. But then sometimes they don't have the time, or you know, or there's too many people waiting maybe, have to wait two or three days. After two or three days maybe, I'll forget about it. I'll say yeah. Maybe if they had some kind of like like, you know, therapist or therapists or to my work in places like this you know? They will keep busy. Because we, maybe maybe me maybe the other people, we get together we talk about problems. Sometimes we get stuck on E, you know, I mean. Well, like about back in the day, you couldn't talk really talk about the Bible or worshipping but today therapists you can do do that and that's a good stuff.

OTS: Is that something that has like helped you in your journey?

E: Yeah. Viewing power bigger than oneself, to get outside of myself because I thought I was an all-powerful individual. You know, the toughest, Big Dog Eat Dog. That's the kind of world I was in, right? When I came to therapy even though I was married, I was staying with my mother, I love them but there was still like resentment, anger, frustration, copping out because I'm trying to understand them. Why did with it do another without any rewards? And when I came to therapy, I felt that and I rebel against the people, you know in groups and stuff like that. Right? And the point is a power bigger than myself. They help me get outside myself. Mine is the Creator. Yeah, yeah.

OTS: Yeah, you are a creator, and it seems like art is a good way to get out of your head.

E: Right.

OTS: Alright, so yeah, as … said anything else that we didn't touch or that you want others to know?

E: Yeah. Also, maybe, even though, a therapist or Ot or OT students may not be able to work here. I was wondering maybe like, through y'all curriculum or your class, you know your classes. Maybe ya'll can come out to these places and do that, you know discuss it you know like maybe an hour of y'all just talking about it, like a meeting.

OTS: That sounds like a really good idea, like having students come and talk about maybe like, what schizophrenia is? Right. About medication because like you said, it's good to be educated on that before you're just given all those medications.

E: Like I didn't even know what schizophrenia was. I thought I was a mind reader. (laughs)

OTS: Well, thank you so much for your time. I think we've covered everything.

E: Okay. All right. That's it!

Transcribed by https://otter.ai

Lived Experience Transcriptions: Interview 2

Justice is a 51-year-old woman living with schizoaffective disorder and PTSD. She also has a history of substance use and being unhoused. She was diagnosed with schizoaffective in 2018 and has been living at a permanent supportive housing residence for 9 months. Justice is currently in the process of applying for one-bedroom apartments for more independent living.

OTS: Hello, we are putting together materials to help occupational therapists and potentially other health care providers better understand and address the needs of people living with a serious mental illness. As part of our doctoral project, we want to include the lived experiences of people who have mental illness because it's important for health care providers to hear firsthand experience. We compiled nine questions related to your journey and experience with mental illness. We know your answers and stories will inform future practitioners and hopefully improve the quality of care provided. All the information provided will be kept confidential. Your name and address will not be shared. So please feel free to share as much or as little as you wish. You are not required to answer anything you do not feel comfortable sharing. And please know that participating in this interview is not mandatory and you can stop at any time. We appreciate your time today. And we'll confirm everything we collect from you for accuracy prior to completing and sharing our project with others.

Do we have your verbal permission to record today?

J: Yes.

OTS: All right. **Can you please share your mental health diagnosis and what it means to you?**

J: I have schizophrenia PTSD, there's one that starts with a C, maybe. I don't remember them all, there's four of them I'm schizoaffective, I don't know there's a couple other things in there. And what do they mean to me? When before I got on the proper medication, it meant pure chaos. But now that I'm on the right regimen of medicine, it's, I'm back to being normal.

OTS: Thank you for sharing. **What strengths, skills, or supports do you feel you have to help navigate life with your mental health diagnosis?**

J: Drugs, keep me sane. And I never thought I'd say that. Um, what was the rest of the question?

OTS: Just any skills or supports you feel like you've gained and that you have that help you navigate life with a mental health diagnosis?

J: Going, being around people and doing things and not necessarily being in one-on-one groups, just going to groups. But being a part of life like the group that I'm associated with, which is... they don't just do the formal sit down we're going to read out of this book because it's that day. They take us out into the community and do things with us so that we're re acclimated.

OTS: You were talking about that they bring you out in the community?

J: They bring us into the community, we do things. We go to the movies, we go bowling, we go to art shows. They don't just think of us as blahs, like they don't think of this as our diagnosis. They think of as people so it's a wonderful, wonderful way of looking at the world and helping

us remember that we are not just numbers in a book, you know? That we are okay to survive in the world. So, I mean.... wohoo!

OTS: Yeah, that sounds really helpful. Like you said they remind you that you're also just the people in this world who need to interact and not just like a number or statistic in a textbook.

J: Exactly. It's an awesome program.

OTS: I'm glad. Okay, so **what things have you found difficult to do because of your mental health diagnosis or any symptoms?**

J: Um, sometimes I get in my head, and that's real hard to get out of. And with the holidays, I use the grandkids as an excuse not to go to group. Um, so I haven't been to group in a long time. It's been a couple months. They call me every day. Somebody touches base with me. I I touch base with you guys. I try and relate with.... I try and get her to do stuff from, but she has a lot of body ailments. And so, I am trying to find a buddy, you know, and ... not it. I got to find another buddy to do things with outside of you know, being here or you know. And maybe when I start going back to groups, I'll find a buddy at group who, you know, wants to do things outside of group. So that's, I gotta get back to group.

OTS: Yeah. **Have you ever experienced issues related to stigma or discrimination of your mental health diagnosis?**

J: All the time, even my family is the worst culprit. My son just tells me I'm crazy straight up. I mean, he, He's the worst. My dad, he doesn't believe in mental health problems. He thinks God can cure everything. My grandmother is very supportive. She's gone through this with one of her daughters. One of her sisters. She says it runs very deep in the .... side of our lives. So, it's, it's, you know, I try not to tell anybody anymore in the beginning, I was like, I'm schizophrenic. Go ahead, say something mean, you know, but now I just, I'm more laid back about it.

OTS: Yeah, thanks for sharing that sounds hard. Just your people around you, it's a hard thing to understand. **What about any experiences you've had with mental health professionals that have been involved in your treatment?**

J: Um, they're different. They try, some try. Okay, so some try to be understanding, some are undermining and others, they just do as I say. So, you have a wide variety there.

OTS: Okay. Thank you for sharing. **Can you describe your experiences with the mental health services you've received? So, like making an appointment getting to the office, sort of like how they work with you?**

J: As long as you get there? They're fine. You just got to get there.

OTS: Is there anything that has made it hard for you to seek help for your mental health problems?

J: Myself. I make it difficult on myself. I, I wake up, I get dressed, then I catch a mood and I'm like, I'm not walking out the door and that's difficult.

OTS: Yeah, that seems like that could interfere with just even going somewhere.

J: Yes. I've gone to the grocery store, grocery shopped, got all my groceries filled and turned around walked out. Weird you know? I, just, something will stress me out and I just can't finish.

OTS: Okay. And then **what about anything that has helped you seek assistance for mental health problems?**

J: People you know, my son can be understanding of my group. Like he wants me to go to group you know? When I say his house, he's like, "Are you sure you're not missing groups?" because he hears them call me you know, and I'm like, No, I'm okay. We're doing it over the phone. So far so good. You know when we can't do it over the phone any more than I got to go home.

OTS: Okay, you were saying that people usually are what help you seek assistance and just follow up?

J: Yeah, my son does, people here do like ... does. He's like you're going to group, you know, just in a nonchalant way. So, it's helpful.

OTS: Okay. And then what is something you would want healthcare professionals, so this doesn't necessarily have to be a mental health care professional it could be like doctors you see at an ER or any health care professional, you come in contact with. So, **what would you want them to know about living with mental illness?**

J: I want them to know it all? I want them to know all of me because I might go in with a fractured ass but what did, what happened to get that? Did I, was it, am I manic, am I depressed? There's a whole, you know, a whole world of things could have happened for me to fall and break my ass.

OTS: Yeah, that's a really good point. For health care providers to be educated on what schizophrenia is, what things are difficult. So, they know what you are going in with.

J: Exactly, exactly.

OTS: Thank you for sharing that? Anything else that you want to share?

J: Be open, don't shut people out just because they have something wrong with their head. You know, give them a bath, shave them, cut their hair, there is a human being under all of that, you know? With the ladies, brush her hair, you know, give them a bath. So, what they're screaming and yelling at you, they have something to say under that. you know? I know.

OTS: Yeah, that's great advice. I think just remembering that people are human. And there's always a human being under whatever is happening.

J: Yeah, it's just and it's so important. Like, she's trying to, he/she, yelling and screaming or not talking at all, like, something's going on, figure it the fuck out. Don't just say, oh, well, I can't deal with this. And here's the script for five zanies and send them out the door, you know? Because that's not the answer. And somebody is going to bring them right back tomorrow when

you're gonna say, she was here yesterday, and you know, she's just looking for drugs. No, you just gave her drugs. You know?

OTS: Yeah, that's really important. I think that will help a lot of people.

J: I hope so. Because being, having mental illness. I never. I never dismissed a mental illness before because of my mom. But I never understood it until I had it. And it's a wild, wild wild ride. It really is.

OTS: Yeah. Thank you so much for sharing all of your answers today and everything. I really think it will be really helpful for everyone to hear. So, if you don't have anything else, just thank you again for participating.

J: You're welcome.

Transcribed by https://otter.ai

Lived Experience Transcriptions: Interview 3

Lucy is a 58-year-old woman living with bipolar disorder with a history of being unhoused. Lucy has been living at a permanent supportive housing facility for the past 13 years and receives case management services onsite.

OTS: Hello, we are putting together materials to help occupational therapists and potentially other health care providers better understand and address the needs of people living with a serious mental illness. As part of our doctoral project, we want to include the lived experiences of people who have mental illness because it's important for health care providers to hear firsthand experience. We compiled nine questions related to your journey and experience with mental illness. We know your answers and stories will inform future practitioners and hopefully improve the quality of care provided. All the information provided will be kept confidential. Your name and address will not be shared. So please feel free to share as much or as little as you wish. You are not required to answer anything you do not feel comfortable sharing. And please know that participating in this interview is not mandatory and you can stop at any time. We appreciate your time today. And we'll confirm everything we collect from you for accuracy prior to completing and sharing our project with others. Do we have your verbal permission to record you today?

L: Yes.

OTS: All right. So, our first question, **can you please share a little about your mental health diagnosis and what it means to you?**

L: Oh, my mental health diagnosis is basically depression and basically, I have, suffer from major depression. And a little bit bipolar. I've been suffering through the years, even though I didn't, I didn't actually go to a doctor. But I had to go back on my own to find out, I knew something wasn't right. So, I've been going since 1980. And I knew something wasn't right. So, I was suffering from depression really major depression. It kind of means that I couldn't do certain things. I lost interest in certain stuff. It started for really, when I was in school, then I knew something wasn't right, because I wasn't interested in school. And I ended up, my grades ended up getting lower than average. I was I was having average grades. I was just, I just wasn't interested in school. And that's when I think my depression started. So, I knew I had to do something about it. So, I start going to therapy and stuff like that through the years.

OTS: All right, thank you for sharing. **What strength skills or supports do you feel helped you navigate life with your mental health diagnosis?**

L: Basically, start going to therapy. Um, I used to be really shy and quiet in school and everything. But I kind of like I was probably like my mom. She was like, quite shy, and she didn't talk about things. So I knew I didn't want to be like that. So that's why I kind of like open up more now than I used to so. I opened more I talk about it I talked about if I need to talk to my family member or friends. I just talk about what's wrong. I don't just keep it bottled up inside like I used to.

OTS: So, you feel like family members and friends help support you and you feel open talking to them.

L: I feel open talking to them. Basically, therapy going to therapists. Therapy, going to a lot of therapy.

OTS: How long have you been going to therapy?

L: I've been going to therapy really since the 1980s Yeah, since the 1980s I went to ....., that was my first therapy. I just went on my own.

OTS: Thank you for sharing. What things have you found difficult to do because of your mental health?

L: Um, as far as like I used to love to do laundry. I used to always love to go to the laundromat and do laundry but it's like now I'm not interested. And I'm not able to like, I'm able to do my clothes but I just get tired, like tired. And I'm just not interested in certain things like I used to be or interested in certain activity like I used to be you know, it's just aint the same like it used to be.

OTS: So, you feel like you've lost some interests and passions and hobbies you used to enjoy before?

L: Yeah, I lost passion. Especially when I do activity. I don't make it through. I don't like finish it. Like I should.

OTS: So you get started, but you've found that you have trouble finishing?

L: Yeah.

OTS: Have you ever experienced issues related to stigma and discrimination because of your mental health diagnosis?

L: That's um?

OTS: Like from peers or health professionals? Do you feel like you've ever been treated differently because of your diagnoses?

L: Yeah. I feel like people look at me differently. You know. I guess they could look at me and see somethings not right. You know? So, they kind of treat me, like an outsider or something.

OTS: You feel like you are kind of made to be an outsider sometimes because of your diagnosis?

L: Not really, I feel like an outsider, but I feel as though I really wasn't made to be outsider. You know, So, I want to be insider I don't want to be left out.

OTS: Do you feel like people leave you out when they find out some of your mental health diagnosis sometimes, is that what you're meaning?

L: Yeah. Sometimes when I have a conversation, I can tell that they don't just come out and say, but they just through the conversation, they talk to me different.

OTS: Yeah, the way they're acting?

L: Yeah, the way they acting.

OTS: Thanks for sharing that. And sometimes those can be tough, tough conversations to have and think about. **Can you describe your experiences with the mental health professionals that have been involved in your treatment? Like any of your therapist or psychiatrist?**

L: I had some through the years that I get to talk out what's bothering me anything and it helps to talk about what's wrong and what's bothering me. You know, some of them are shorter than other. Some of them will listen for a long time. Some of them for short term.

OTS: Do you feel like you've seen a bunch of different health professionals? Or have you been sticking kind of with the same ones consistently?

L: Um, I've been seeing a bunch. I was trying to stick with the same one, but I've been going to different one through the years.

OTS: Okay.

L: I was going to stick with.... It's a place called.... it's for people with mental issues, housing issues, I was gonna stick with them. But everything, that didn't work out.

OTS: So, you try and kind of stick with one organization and try and help get you to that.

L: Mhmm.

OTS: That kind of leads into this next question. I'm going to **ask you to describe your experiences with mental health services you have received, so that's like, how's it been for you to make appointments? And are the offices located far away**? Just tell us a little bit about that.

L: Oh, um, it's been easy. I had no problem make appointments. They'll, they'll see me right away and I try not to go too far out. I try to go nearby and so that's been kind of easy.

OTS: Okay.

L: There's been no problem. I haven't been going far out. It's been trying to get closer to where I live at.

OTS: That's good to hear. So, you found that there are office locations close to you?

L: Mhmm, close to me.

OTS: Has it been easy for you to get there? Are you walking or taking public transit?

L: I basically catch the bus? But I always take my friend.

OTS: All right. Take a friend?

L: Always take him with me. Because I tried to get the van service even though he, my therapist, wanted me to take the van service sometimes, but sometimes they don't be on time like they're supposed to. Yeah, so I'm kind of paranoia going on by myself, so I always taken him with me

OTS: A buddy? Okay. That's good. And when you make your appointments, are you normally making them yourself or do other people help you set them up?

L: Basically, making myself.

OTS: Okay. Awesome. **Is there anything that has made it hard for you to seek help for your mental health problems?**

L: Not really. Sometimes, I don't feel like going but I go anyway. You know because I know I need it. It's been kind of, a little easy to make appointment.

OTS: On those days where you said, it feels kind of hard because you don't feel like going, what helps you get up and kind of go because you know, you need to go what things help you seek assistance?

L: Oh, um basically as long as I take my medicine, that makes me get the urge to go. But medicine, my meditation. I always tell everybody I need to take my meds.

OTS: Okay, so you're on it with the meds?

L: Yeah, as long as I get on my meds, I'm in the mood to do certain things.

OTS: Do you feel like they help you get the urge to have that motivation to do stuff again?

L: Yeah, yeah, yeah. Yeah, without the meds. All right.

OTS: What is something you want healthcare professionals to know about living with a mental illness?

L: About living with a person with mental illness?

OTS: Yeah, like if you if we put a health care doctor in front of you and said you could tell them anything you want about what it's like to live with a mental illness? What would you say to them?

L: Oh, I'd basically say that it's not easy. You know. And I will say that you have to get some kind of supports, you know, you have to talk it out. You can't keep it inside. You got to seek if you feel comfortable with it, talking to. It can be a friend, family member, a therapist, a caseworker. But it's not good to keep it inside, you got to really talk about whatever was bothering you. And it really helped. It does.

OTS: Thank you for sharing. And the last question is, **is there anything else that you would like to add to this interview that hasn't been asked yet?** So, anything that I haven't asked you about that you'd like to share with us?

L: Oh, it is good to know your diagnosis. If you don't know your diagnosis, it's good to find out, like through a professional or through a therapist. They the ones who will know. Yes. So, it's good to kind of know your diagnosis so you can know what's happening to you, why you're going through what you're going through. So, it was good to get a professional to know your diagnosis, that's important.

OTS: So, you feel it's help you a lot, once you understand your diagnosis, you feel like you're better able to understand your care and what works for you?

L: Yeah, once you know your diagnosis then you understand what you're going through? And then you can see why is this, you know, I'm going through this, why is this happening.

OTS: Alright, well thank you for your time and for your participation today. And if you have nothing else that concludes our interview.

L: That's it!

OTS: Yes.

L: Okay

OTS: Thank you very much!

L: You welcome!

Transcribed by https://otter.ai

J: Reimbursement

Funding for mental health services typically includes private insurance, Medicare and Medicaid; city and local government-budgeted allocations; and private federal grants (Flemming-Castaldy, 2020). Within these possible funding sources, there are often requirements that determine whether or not occupational therapy services can receive reimbursement for their treatment. Coverage from private insurances varies greatly, with 28 states not requiring any coverage for mental health services and only five states mandating comprehensive coverage (Gray et al., 2018). The specifics of reimbursement vary by state. In Pennsylvania, the VA reimburses occupational therapy for mental health services, block funding allowing institutions to determine how to spend funds results in some reimbursement in inpatient settings, and legislation detailing OT's role in providing care for substance use exists. In Pennsylvania, Medicare Part A pays for inpatient psychiatric, and substance use services and Medicare Part B covers outpatient mental health and substance use services (Pennsylvania Health Law Project, 2020). Medicaid covers more than Medicare with Pennsylvania's Medicaid Behavioral Health Managed Care plans authorizing possible coverage of mental health inpatient hospitalization, partial hospital programs, crisis intervention services, peer support services, outpatient therapy, and targeted case management (Pennsylvania Health Law Project, 2020). Requirements for coverage vary by state and by plan so individuals must work closely with their care team to determine if the OT services they are seeking can be reimbursed by any form of insurance or payment method they have access to and choose to use.

Reimbursement of occupational therapy services in community mental health and outpatient settings are not always outlined as clearly as reimbursement in other practice settings. Part of the reason that occupational therapy services in community mental health settings are seldom reimbursed by private insurances or Medicaid and Medicare is because few states recognize occupational therapy practitioners as qualified mental health professionals (Gray et al., 2018). Pennsylvania is included in the states that do not recognize occupational therapy practitioners as Qualified Mental Health Professionals (QMHP) or Qualified Mental Health Providers (QBHP). The Medicaid program is the largest payer of mental health services in the U.S., but it has an extremely low number of providers (Wilburn et al., 2021). Recognizing occupational therapy practitioners as QMHP's or QBHP's has the potential to decrease care shortage in behavioral and mental services for beneficiaries (Wilburn et al., 2021; Gray et al., 2018). In order to advocate for successful inclusion of occupational therapy practitioners more efficiently as QMHP and/or QBHPs states need to make a coordinated effort to identify barriers/opportunities and look to the limited states who do provide comprehensive coverage for mental health services for example (Wilburn et al., 2021). Another way to advocate for occupational therapy practitioner's incorporation into mental health care is to produce further research highlighting the effectiveness of services with this population. A recent article by DeAngelis et al. (2019) found community-based occupational therapy has the potential to enhance engagement and increase satisfaction in the performance of daily tasks and activities that are healthy and significant to the individual. The conclusion of this article calls for further research and consideration of expanding OT's role to include titles such as consultant or program director and recognition as a qualified mental service provider (DeAngelis et al., 2019).

Including OTs as part of the interdisciplinary health care team can potentially improve outcomes in these areas of occupation (and more) as seen in the OTPF-4: community participation, relationship building, peer group participation, job performance/maintenance, employment seeking, and education participation (Wilburn et al., 2021, American Occupational Therapy Association, 2020). The Pennsylvania Occupational Therapy Association (POTA) mental health task force created a committee of OT/OTA mental health experts in part to advocate for reimbursement of occupational therapy behavioral/mental health services in all practice settings and to attain Qualified Mental Health Professional (QMHP) status for occupational therapy practitioners in the state of Pennsylvania. While QMHP status has not been achieved as of 2022 the committee continues to advocate, collaborate and reach out to state and local representatives to share occupational therapy outcomes in attempts to reach this goal.

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K: Critical Elements of Care

This section, while not exhaustive, includes content related critical factors that impact care and services individuals with serious mental illness receive.

a: Social Determinants of Health, Diversity Equity, and Inclusion and Intersectionality

This section provides information and resources on how social determinants of health, diversity, equity, and inclusion, and intersectionality play a role in individuals with serious mental illness seeking, accessing, and receiving care. According to the World Health Organization, social determinants of health are defined as the conditions in which people are born, grow, live, work, and age (Compton & Shim, 2015). Money, power, and resources influence these conditions (Compton & Shim, 2015). **The role of DEI in working with individuals with serious mental illness is to facilitate the creation of policies and programs that represent and promote participation of different groups of people (Moreno & Chhatwal, 2020).** However, this is sometimes complicated by the inequities in which the profession of occupational therapy is deeply rooted (Whalley Hammell, 2021). Occupational therapy as a profession is saturated with Western, urban, middle-class norms and values that are exemplified in the major theories and models often used to inform practice (Whalley Hammell, 2021). Critics from other geographic regions of the world have previously commented on the dominance of models and frameworks derived from very specific Eurocentric and Western cultures which result in limited relevance, and potential oppression, when used to guide intervention in diverse socioeconomic, political, and cultural contexts (Moreno & Chhatwal, 2020; Whalley Hammell, 2021). The dominance of these white-washed, Western centered theories has likely resulted from the profession's failure to prioritize education, research, and action on widespread systemic injustices as well as other social determinants of health. In order to effectively advance knowledge and practice to address inequities in SDOH and how those impact program and policy creation, the profession must work towards achieving structural competency (Whalley Hammell, 2021).

Disparities exist on basis of race, ethnicity, gender, culture, and sexual orientation to name a few (Moreno & Chhatwal, 2020). Quality care is often determined by access to consistent sources of primary care and often times low-income individuals, racial/ethnic minorities, and those who are uninsured tend to lack primary care physicians and rely on "safety nets" such as community health centers or hospital systems (Hussein et al., 2016). Additional lack of cultural understanding by healthcare providers who do see diverse patient populations regularly contributes to the underdiagnosis or misdiagnosis of mental illness (American Psychiatric Association, 2017). Racial and ethnic minority youth with behavioral health issues who do seek help are often referred to juvenile justice systems as opposed to specialty primary care unlike their white counterparts (American Psychiatric Association, 2017). Other common barriers to care in diverse patient populations are language barriers, general mistrust in the healthcare system, mental illness stigma, and lack of diversity in mental healthcare providers themselves (American Psychiatric Association, 2017).

In response to these barriers to care in underserved and underrepresented populations, understanding the impact of one's SDOH data can be used to take the initial steps towards developing inclusive and consistent programming.

Resources for more information on how SDOH, DEI, and Intersectionality impact the mental health experience for various populations:

Structural Racism and Racial Inequalities: https://www.psychiatry.org/newsroom/news-releases/structural-racism-contributes-to-the-racial-inequities-in-social-determinants-of-psychosis-per-review-in-the-american-journal-of-psychiatry

Mental Health Facts for African American/Black Population: https://www.psychiatry.org/psychiatrists/cultural-competency/education/african-american-patients

Mental Health Facts for Indigenous Population: https://www.psychiatry.org/psychiatrists/cultural-competency/education/indigenous-patients

Mental Health Facts for Asian Americans: https://www.psychiatry.org/psychiatrists/cultural-competency/education/asian-american-patients

Mental Health Facts for Hispanics and Latinos/as: https://www.psychiatry.org/psychiatrists/cultural-competency/education/hispanic-patients

Mental Health Facts for LGBTQ population: https://www.psychiatry.org/psychiatrists/cultural-competency/education/lgbtq-patients

Mental Health Facts for Women: https://www.psychiatry.org/psychiatrists/cultural-competency/education/women-patients

Infographic Mental Health Men: https://www.mhanational.org/infographic-mental-health-men

Men and Mental Health: https://www.nimh.nih.gov/health/topics/men-and-mental-health

NAMI Mental Health by the Numbers Infographics: https://www.nami.org/mhstats

Fostering Inclusion in American Neighborhoods: https://www.jchs.harvard.edu/sites/default/files/a_shared_future_fostering_inclusion.pdf

Census Income Data Tables: https://www.census.gov/topics/income-poverty/income/data/tables.html

Census Health Stats: https://www.census.gov/topics/health.html

Education and Socioeconomic Status: https://www.apa.org/pi/ses/resources/publications/education

Intersectionality Toolkit: https://www.luthercollege.edu/public/images/Intersectionality_Tookit_and_other_resources.pdf

Mental Health Facts Diverse Populations: https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

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b: Inclusive Language

This section provides information and resources on the power of language when working with individuals with serious mental illness. The language and words used to describe the mental health experience contribute to an individual's thoughts and beliefs about themselves and can cause one to feel stigmatized, unsafe or disrespected (Volkow et al., 2021; Education Development Center, 2019; Resources for Integrated Care, 2020). Stigma and negative feelings about oneself and one's experience can impact an individual's desire to seek help (Volkow et al., 2021; Education Development Center, 2019; Resources for Integrated Care, 2020). Because stigma is an ongoing concern for individuals living with serious mental illness, practitioners need to start receiving education on working with different client populations as students to best prepare for clinical practice (Mollo et al., 2021). A retrospective study, spanning almost ten years, that examined occupational therapy student's perspective on a simulated patient encounter with an individual with an SMI showed that exposing students to the complexities of working with this population in supportive, structured environment can have a positive impact on student's perceptions of serious mental illness, the application of knowledge while providing client centered care and the ability to build strong, trusting relationships with clients (Mollo et al., 2021). Another way to combat stigma is to focus on using inclusive, person-centered language.

Currently, person-centered language is recommended when working with individuals with mental illness (Volkow et al., 2021, Resources for Integrated Care, 2020; Hyams et al., 2018). Person-centered language acknowledges each individual as a whole person, respects the dignity and identity of every individual and emphasizes that the individual is an expert in their own lives and needs (Resources for Integrated Care, 2020; Hyams et al., 2018). However, it is still important to ask individuals what type of language they prefer, as each person is unique, and some prefer identity-first language (Resources for Integrated Care, 2020). In addition, language that is strengths-based versus deficit-based supports recovery-oriented care and decreases stigma (Hyams et al., 2018, Resources for Integrated Care, 2020).

Another necessary component of inclusive language is respecting and using affirming, gender neutral language for individuals with non-binary gender identities. This type of language includes asking for an individual's name, preferred pronouns and respecting/using this information throughout all points of care, even when the individual is not present. Transgender and gender non-binary individuals face significantly higher rates of mental health challenges, substance use, self-harm and suicidal ideation (Baldwin et al., 2018). In health care settings, these individuals often face discrimination and stigma from health care providers that stem from lack of knowledge and experience, non-inclusive patient forms, incorrect pronoun usage, pathologizing gender differences and denial of transition-related care (Baldwin et al., 2018; Seelman et al., 2017). The anticipation of stigma and discrimination contributes to delaying or avoiding medical care which may increase both physical and mental health challenges (Seelman et al., 2017). In 2020, a national survey on LGBTQ youth mental health found that "transgender and nonbinary youth who reported having pronouns respected by all or most people in their lives attempted suicide at half the rate of those who did not have their pronouns respected" (Trevor

Project, 2021). This data highlights the importance of using proper pronouns and names, as it greatly impacts an individual's mental health. The National LGBT Health Education Center (2017) identifies that best practice for creating an affirming environment for non-binary people involves "training staff to avoid gender-specific language," "asking patients for their names and pronouns routinely," "sharing pronoun and name information with other staff members so that everyone refers to the patient respectfully," and "demonstrating a wiliness to learn from patients" (p. 12).

Resources for more information on using person-centered and strengths-based language to support recovery in individuals with serious mental ill ness:

Person-Centered Language: https://practicetransformation.umn.edu/clinical-tools/person-centered-language/

NIH: Words Matter: https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Strengths Based Language: https://www.spokanecounty.org/DocumentCenter/View/3053/Strengths-Based-Language---Reference-Sheet-PDF

Person-Centered Language at a Glance: https://www.resourcesforintegratedcare.com/sites/default/files/Using_Person_Centered_Language_Graphic.pdf

Using Person Centered Language: https://www.resourcesforintegratedcare.com/sites/default/files/Using_Person_Centered_Language_Tip_Sheet.pdf

Gender Affirming Care: https://kognito.com/blog/gender-affirming-care-effective-communication-for-better-patient-outcomes

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Baldwin, A., Dodge, B., Schick, V.R., Light, B., Schnarrs, P.W., Herbenick, D.K., & Fortenberry, D. (2018). Transgender and genderqueer individual's experiences with health care providers. What's working, what's not and where do we go from here. *Journal of health care for the poor and underserved. 29*(4), p. 1300-1318. https://doi.org/10.1353/hpu.2018.0097

Education Development Center. (2019, March). *Words matter: How language choice can reduce stigma.* Preventionsolutions. https://preventionsolutions.edc.org/services/resources/words-matter-how-language-choice-can-reduce-stigma

Hyams, K, Prater, N., Rohovit, J., Meyer-Kalos, P.S. (2018). *Person-centered language*. Clinical Tip No. 8 (April, 2018): Center for Practice Transformation, University of Minnesota.

The Trevor Project. (2021). *2021 National Survey on LGBTQ Youth Mental Health.* The Trevor Project. https://www.thetrevorproject.org/survey-2021/?section=ResearchMethodology

Mollo, K., DeAngelis, T., Capron, M. & Wells, S. (2021). Student perspectives and standardized patient feedback on an innovative simulated patient encounter. *Journal of Occupational Therapy Education 5*(2), doi: https://encompass.eku.edu/jote/vol5/iss2/13

National LGBT Health Education Center (2017). *Providing affirmation care for patients with non-binary gender identities.* Health Resources and Services Administration. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2017/02/Providing-Affirmative-Care-for-People-with-Non-Binary-Gender-Identities.pdf

Seelman, K.L., Colon-Diaz, M., LeCroix, R.H., Xavier-Brief, M., & Kattari, L. (2017). Transgender non-inclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health. 2*(1). http://online.liebertpub.com/doi/10.1089/trgh.2016.0024

Resources for Integrated Care. (2020). *Using person-centered language.* Retrieved from: https://www.resourcesforintegratedcare.com/sites/default/files/Using_Person_Centered_Language_Tip_Sheet.pdf

Volkow, N. D., Gordon, J. A., & Koob, G. F. (2021). Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology*, *46*(13), 2230–2232. https://doi.org/10.1038/s41386-021-01069-4

c: Common Medications and Occupational Therapy's Roles and Responsibilities

This section provides an overview of the common medications prescribed for individuals with serious mental illness. Serious mental illness treatment often involves both medication and nonpharmaceutical strategies to address functional impairments and barriers to daily living (Substance Abuse Mental Health Services Administration [SAMHSA], 2022). Often times, the medications used to treat serious mental illnesses come with a host of side effects, precautions and contraindications that may impact performance and everyday functioning. It is important to remember that medications work differently for every individual and what works for one person, may not work for another (National Institute of Mental Health, 2016). Occupational therapy practitioners are not permitted to prescribe pharmacological agents but must be prepared to refer to and collaborate with psychiatrists, nurse practitioners and physician assistants to support client needs.

According to the Occupational Therapy Practice Framework Fourth Edition (OTPF-4), occupational therapy practitioners are equipped to build skills around "communicating with physicians about prescriptions, filling prescriptions at the pharmacy, interpreting medication instructions, taking medications on a routine basis, refilling prescriptions in a timely manner," "recognizing symptom changes and fluctuations and establishing behavioral patterns for restorative activities to manage condition" (American Occupational Therapy Association, 2020, p. 7412410010p32).

Categories of medications prescribed for individuals with serious mental illness include:

Antidepressants:

Antidepressants are most commonly used to treat depression, but can also be prescribed for anxiety, chronic pain, sleep disorders and bipolar disorders and work by acting on neurotransmitters to balance an individual's mood and emotional responses (National Institute of Mental Health, 2016; BC Schizophrenia Society, 2018). Three different types of antidepressants are commonly prescribed including selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), and bupropion (National Institute of Mental Health, 2016; BC Schizophrenia Society, 2018) Some common side effects of antidepressants include nausea and vomiting, weight gain, drowsiness, agitation and sexual dysfunction (National Institute of Mental Health, 2016). Severe symptoms may include suicidal ideation, panic attacks, unusual behavior change, extreme interest in activity and insomnia (National Institute of Mental Health, 2016).

Resources for more information on antidepressant medication:

- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/antidepressant-medications
- https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/antidepressants/overview/

Anti-Anxiety Medications:

Anti-anxiety medications are prescribed to reduce the symptoms of anxiety included extreme fear, worry and panic. The most common group of medications given are benzodiazepines but buspirone can also be used for chronic anxiety (National Institute of Mental Health, 2016; BC Schizophrenia Society, 2018). Anti-anxiety medication may have side effects including, but not limited to, nausea, headache, tiredness and confusion. Severe symptoms may include dizziness, difficulty thinking or remembering, muscle or joint pain, blurred vision and change in sex drive (National Institute of Mental Health, 2016).

Resources for more information on anti-anxiety medication:

- https://www.helpguide.org/articles/anxiety/anxiety-medication.htm
- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/anti-anxiety-medications-benzodiazepines

Antipsychotics:

Antipsychotic medications are prescribed to manage symptoms of psychosis and relieve symptoms (National Institute of Mental Health, 2016; BC Schizophrenia Society, 2018). Antipsychotics are mainly used to treat schizophrenia but can also be used in other mental disorders that involve psychosis (Centre for Addiction and Mental Health [CAMH], n.d.). Both first-generation and second-generation antipsychotics are used to treat symptoms of serious mental illness and every individual responds differently (National Institute of Mental Health, 2016). Antipsychotics may have multiple side effects, including but not limited to, tiredness, dry mouth, constipation, weight gain, vomiting, low blood pressure, uncontrollable muscle movements, tremors, and muscle spasms (National Institute of Mental Health, 2016; CAMH, n.d.). Those who use antipsychotic medications long-term are more suspectable to develop tardive dyskinesia (National Institute of Mental Health, 2016; National Alliance on Mental Illness, n.d.). Tardive dyskinesia is a movement disorder characterized by repetitive movements in the face, neck, legs and arms that are outside of the individual's control (National Alliance on Mental Illness [NAMI], n.d.). Some symptoms include neck twisting, difficulty swallowing, eye blinking, involuntary tongue movements and head jerking (NAMI, n.d.). These symptoms may impact one's ability to participate in their life and engage in daily activities.

Resources for more information on antipsychotic medication:

- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/antipsychotic-medication
- https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/antipsychotic-medications
- https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Tardive-Dyskinesia
- https://www.talkabouttd.com/what-is-tardive-dyskinesia-td?gclid=Cj0KCQiAnuGNBhCPARIsACbnLzp4WMKJ-

ip0CMSxp0H2wCOse1QO91TB9bsGb6I9vaBgqaQ-U81RS68aAhcfEALw_wcB&gclsrc=aw.ds

Mood Stabilizers:

Mood stabilizers are primarily used to treat bipolar and related disorders, but can also be used to treat depression, schizoaffective disorder and impulse control disorders (National Institute of Mental Health, 2016). Some common side effects of mood stabilizers include, but are not limited to, excessive thirst, tremors, irregular heartbeat, seizures, hallucinations and swelling in extremities (National Institute of Mental Health, 2016). Anticonvulsants have also been found to help control unstable moods and are sometimes prescribed as a mood stabilizer (National Institute of Mental Health, 2016; BC Schizophrenia Society, 2018). Some common side effects of anticonvulsant medication include, but are not limited to, drowsiness, headache, irregular bowel movements, changes in appetite, abnormal thinking, tremors, hair loss and vision issues (National Institute of Mental Health, 2016).

Resources for more information on mood stabilizer medication:

- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/mood-stabilizing-medication
- https://www.uofmhealth.org/health-library/pl1025

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American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). American Journal of Occupational Therapy, 74(Suppl. 2), 7412410010. https://doi. Org/10.5014/ajot.2020.74S2001

BC Schizophrenia Society (2018). *Medications and more*. Heretohelp. https://www.heretohelp.bc.ca/factsheet/treating-mental-illness-medications-and-more#medications

Centre for Addiction and Mental Health [CAMH]. (n.d.) *Antipsychotic medications.* CAMH. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/antipsychotic-medication

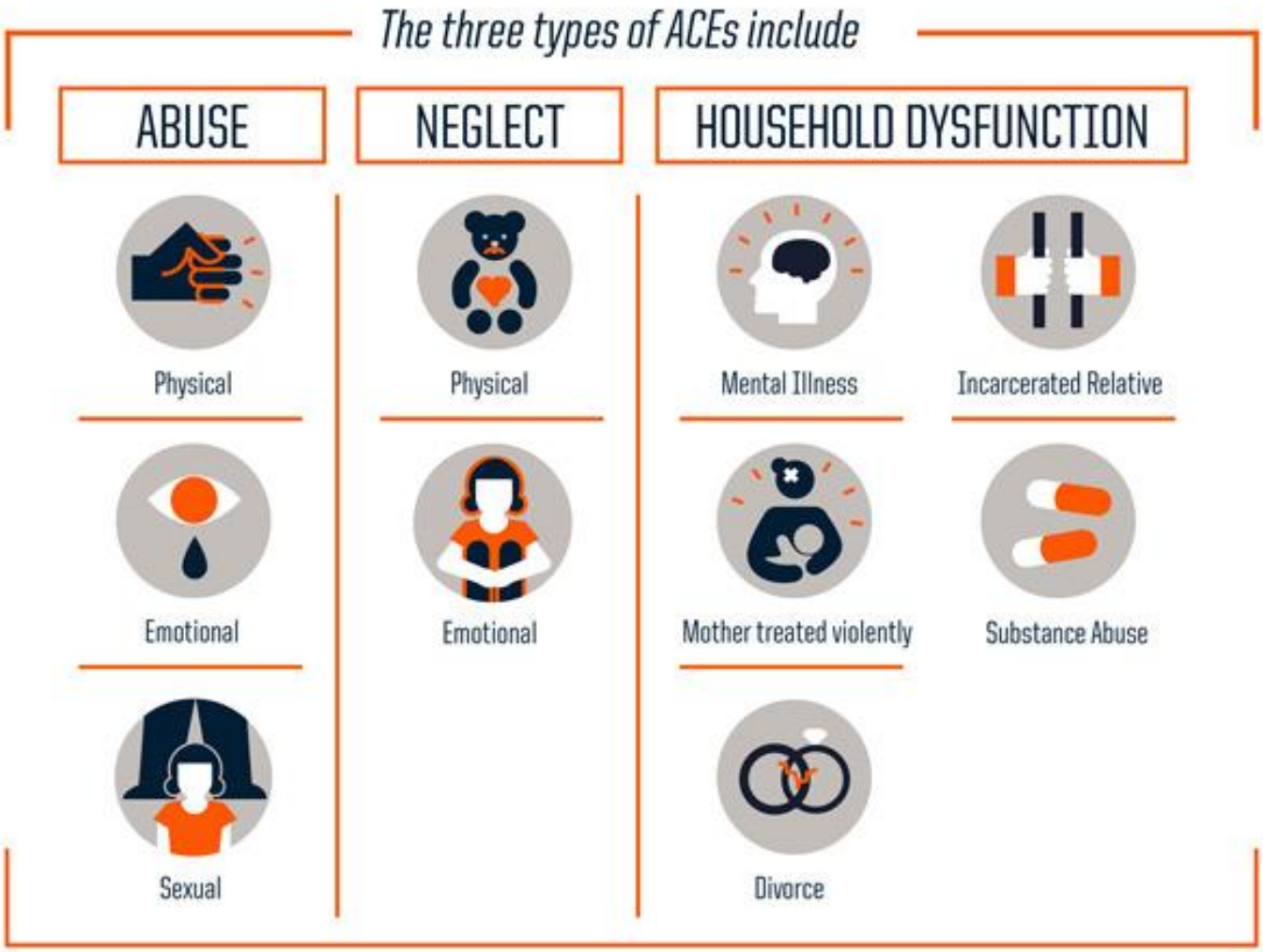
National Institute of Mental Health (2016). *Mental health medications.* U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

National Alliance on Mental Illness [NAMI]. (n.d.) *Tardive dyskinesia*. https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Tardive-Dyskinesia

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022). *Living well with serious mental illness.* Samhsa.gov. https://www.samhsa.gov/serious-mental-illness

d: Adverse Childhood Experiences

Childhood trauma has been shown to have strong correlations to the experience of an array of health and social conditions in adulthood. Childhood trauma is often referred to as adverse childhood experiences (ACEs). While the experience of trauma at any point in the lifetime has potential to disrupt occupational performance, the evidence for the association between childhood trauma and serious mental illness is strong (Merrick et al., 2017). Repeated exposures contribute to worsened mental health in adulthood, including increased rates of depression and attempted suicide rates up to 30 times higher for adults with four or more ACEs (Stumbo et al., 2015; Merrick et al., 2017). ACEs are defined as experiencing physical, emotional, or sexual abuse or neglect or exposure to a parent being physically or emotionally harmed, parental divorce or separation, parental incarceration, household member with substance use disorder, or a household member with mental illness (Merrick et al, 2017; Atchison & Suarez, 2021).



Robert Wood Johnson Foundation (2013). The three types of ACEs include [Online image] https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

Majority of what is known about the long-term effects of ACEs has been provided from the CDC-Kaiser Permanente Adverse Childhood Experiences Study and ACE data collected from the Behavioral Risk Factor Surveillance System (BRFSS) which is a health-related telephone survey (Merrick et al., 2017). Studies show that removal of an individual from a traumatic experience/environment does not immediately restore occupational performance, there are often lifelong challenges (Atchison & Suarez, 2021). Impaired occupational performance may be experienced in areas such as activities of daily living, rest and sleep, education, work, leisure, peer relationships, social relationships, and health management (Atchison & Suarez, 2021; American Occupational Therapy Association, 2020).

Half to two thirds of US adults have reported experiencing at least one ACE and those with four or more reported ACEs have exponentially heightened risk for chronic health problems, both physical and mental (Stumbo et al., 2015; Atchison & Suarez, 2021). Future violent behavior, health risk behaviors, earlier onset of mental illness, decreased life expectancy, premature death, and impaired stress response are some of the health problems commonly faced (Merrick et al., 2017). In addition to the physical health problems that can result from ACEs, individuals with increased exposures are more likely to experience increased feelings of shame and false guilt (Merrick et al., 2017). Outside of the home, exposure to violence within a community can limit feelings of security and positive emotions children may feel towards a caregiver with whom they otherwise have a positive and healthy relationship with (Willis & Ashcraft, 2021). This highlights the importance of OT practitioners examining the dynamics of both family systems and community environments and how they intersect and interact (Willis & Ashcraft, 2021).

The OTPF-4 (2020) suggests that OT practitioners can assist individuals with a history of trauma with symptom and condition management (American Occupational Therapy Association, 2020).

Additionally, cultural considerations must be factored in when assessing and treating different individuals. The intervention and assessment process should address individual, community, and larger population challenges as different cultures may perpetuate trauma in individuals through their widespread cultural acceptance of the actions that cause trauma (Atchison & Suarez, 2021).

Resources for more information:

CDC – ACEs: https://www.cdc.gov/violenceprevention/aces/index.html

NCSL – ACEs: https://www.ncsl.org/research/health/adverse-childhood-experiences-aces.aspx

ACEs and Toxic Stress: https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

Child Welfare - ACEs:
https://www.childwelfare.gov/topics/preventing/overview/framework/aces/

ACE Fact Sheet:
https://healthysafechildren.org/sites/default/files/ACE_Fact_Sheet_LA_ACE_Initiative.pdf

Unhoused population and ACE: https://nhchc.org/wp-content/uploads/2019/08/aces-fact-sheet.pdf

BRFSS: https://www.cdc.gov/brfss/index.html

Therapeutic Interventions to reduce effects of ACEs: https://www.acamh.org/app/uploads/2021/02/Therapeutic-interventions-to-reduce-the-harmful-effects-of-Adverse-Childhood-Experiences-%E2%80%93-ACEs-%E2%80%93.pdf

CDC- Kaiser ACE Study: https://www.cdc.gov/violenceprevention/aces/about.html

References:

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). American Journal of Occupational Therapy, 74(Suppl. 2), 7412410010. https://doi. org/10.5014/ajot.2020.74S2001

Atchison, B.J. & Suarez, M. (2021). Intro to trauma and the role of OT. In A. Lynch, R. Ashcraft, & L. Tekell (Eds.), *Trauma, occupation, and participation: Foundations and population considerations in occupational therapy* (pp. 3-18). AOTA Press.

Merrick, M.T., Ports, K.A., Ford, D.C., Afifi, T.O., Gershoff, E.T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. *Child Abuse & Neglect, 69*(1), 10-19. doi:10.1016/j.chiabu.2017.03.016

Stumbo, S.P., Yarborough, B.J.H., Paulson, R.I., & Green, C.A. (2015). The impact of adverse child and adult experiences on recovery from serious mental illness. *Psychiatric Rehabilitation Journal, 38*(4), 320-327. doi: 10.1037/prj0000141

Willis, B. & Ashcraft, R. (2021). Trauma across the lifespan and family systems theory: Considerations for occupational therapy. In A. Lynch, R. Ashcraft, & L. Tekell (Eds.), *Trauma, occupation, and participation: Foundations and population considerations in occupational therapy* (pp. 41- 51). AOTA Press.

e: Resources for De-escalating Aggressive Behavior:

This section is meant to provide information and resources on de-escalation strategies and their importance in preventing or addressing aggressive behavior when working with individuals in a healthcare setting. It must be noted that people diagnosed with a serious mental illness also face an increase of victimization both in and outside the mental health care system (Rossa-Roccor, Schmid & Steinart, 2020) The intent of this document is to avoid stigmatizing terms and stereotypes against people with a serious mental illness, as there is no specific diagnosis or patient demographic that can predict future violent behavior, but epidemiological studies have highlighted certain practice environments that present the highest risk: inpatient and acute psychiatric settings, geriatric long term care settings, urban emergency departments, and residential and day social services programs (Occupational Safety and Health Administration, 2016). Healthcare workers in general are four times more likely to be victims of workplace violence than workers in private industry (The Joint Commission, 2018). Approximately 75% of the nearly 25,000 workplace assaults that are reported each year occur in health care settings (The Joint Commission, 2018).

Aggressive behavior is defined as the use of physical violence towards oneself, property, or others or making specific targeted verbal threats (Gaynes et al., 2017). De-escalation, sometimes known as conflict resolution or conflict management, is the combination of strategies used to reduce a patient's agitation (The Joint Commission, 2019). Please see the "Understanding Agitation: De-escalation YouTube resource below). Common approaches for de-escalating aggressive behavior that have been used in the past involved seclusion or restraint, however, updated practice standards call for more patient-centered approaches that are less restrictive (Gaynes et al., 2017). Use of seclusion or restraints may produce a negative response from the patient, can be humiliating, and are emotionally and physically traumatizing for the staff and patient involved (The Joint Commission, 2019). Prevention of aggressive behavior and reducing aggressive behavior once it has begun using verbal techniques are the two main alternative approaches to de-escalation that have been discussed in the literature (Gaynes et al., 2017; The Joint Commission, 2019; Mavandi et al., 2016). Some examples of prevention strategies are risk assessment, staffing ratio changes, staff training programs, and peer-based interventions (Gaynes et al., 2017). A tool that can be used to evaluate training and education programs aimed at informing de-escalation practice is called the English Modified version of the De-Escalating Aggressive Behavior Scale (EMDABS). Mavandi et al.'s (2016) article provides further information on the seven items that the EMDABS is comprised of, including best practice descriptors for each. Reducing aggressive behavior that has already begun can be done through use of clear and calm verbal communication paired with non-threatening body language (The Joint Commission, 2019). According to the OTPF-4 (2020) occupational therapy practitioners must be aware of client factors that consider "regulation and range of emotions; appropriateness of emotions, including anger, love, tension, and anxiety; lability of emotions" (p.52). Showing respect and support while verbally de-escalating a situation with a patient are important as confrontational language and use of health care terms or non-accessible language may further agitate the individual (The Joint Commission, 2019). Because patients seldom outright state they are becoming increasingly agitated, it is important to be able to self-identify escalating and

aggressive behaviors. These behaviors can be present in a patient's tone/volume, their demeanor, the nature of their responses to questioning, and facial expressions (McKnight, 2020). In the event a patient becomes aggressive it is best to intervene right away for the best chance at defusing the situation (McKnight, 2020).

Recently, restraint and seclusion reduction initiatives have recognized sensory-based interventions as popular methods for assisting some individuals with self-regulation (Seckman et al., 2017; Champagne, 2020). Research has shown that the use of sensory-based interventions can greatly decrease an individual's distress, reduce the need for seclusion/restraint, and reduce overall aggressive behaviors (Seckman et al., 2017; Champagne, 2020). Additionally, this reduced use of seclusion/restraint and incorporation of these interventions saw improvements in sense of safety from both staff members and clients (Seckman et al., 2017). Individuals can work with OT practitioners to identify strategies that will help them feel safe and stabilized. This may involve educating the individual about how the nervous system responds to stimuli and identifying coping skills to help manage behavior in times of increased volume of sensory input (Champagne, 2020). Some examples of sensory-based interventions that can be utilized to de-escalate aggressive behaviors and reduce need for restraint/seclusion are: warm drinks (de-caffeinated tea), soothing-low intensity smells, rocking slowly in a chair, humming or singing quietly, swaying to soft playing music, swinging on a swing, sensory rooms, touching smooth soft textures, and slow-paced walk or movement in room (Champagne, 2020).

Below are links to additional resources containing information on de-escalation strategies relevant to healthcare workers.

Resources for more information:

6 Core Strategies for Reducing Seclusion and Restraint Use: https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

De-escalating Violence in Healthcare: https://sigma.nursingrepository.org/bitstream/handle/10755/17096/Chapter3.pdf?sequence=3

OTPF – 4: https://therapistsforarmenia.org/wp-content/uploads/2021/04/Occupational-Therapy-Practice-Framework_-Domain-and-Process-Fourth-Edition.pdf

United States Dept of Labor Resource: https://www.osha.gov/healthcare/workplace-violence

Guidelines for Preventing Workplace Violence: https://www.osha.gov/sites/default/files/publications/osha3148.pdf

De-escalation in Healthcare: https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-47-deescalation-in-health-care/

Workplace Violence Prevention: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/work-place-violence-prevention/compendium_update-01062022.pdf

Strategies to De-escalate Aggressive Behavior: https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/aggression_research.pdf

Understanding Agitation: De-escalation. https://www.youtube.com/watch?v=6B9Kqg6jFeI

References:

Champagne, T. (2020). Sensory modulation. In N. Carson (Eds.), *Psychosocial occupational therapy* (pp. 104-240). Elsevier.

Gaynes, B.N., Brown, C.L., Lux, L.J., Brownley, K. A., Van Dorn, R. A., Edlund, M. J., Coker-Schwimmer, E., Weber, R.P., Sheitman, B., Zarzar, T., Viswanathan, M., & Lohr, K.N. (2017). Preventing and de-escalating aggressive behavior among adult psychiatric patients: A systematic review of the evidence. *Psychiatric Services, 68*(8), 819-831. doi: 10.1176/appi.ps.201600314.

Mavandadi, V., Bieling, P.J., & Madsen, V. (2016). Effective ingredients of verbal de-escalation: Validating an english modified version of the 'de-escalating aggressive behaviour scale'. *Journal of Psychiatric and Mental Health Nursing, 23*(1), 357-368. https://doi.org/10.1111/jpm.12310

McKnight, S.E. (2020). Assessing an escalating situation for early intervention. In S.E. McKnight, *De-escalating violence in healthcare: Strategies to reduce emotional tension and aggression* (pp. 29-44). Sigma Theta Tau International Honor Society of Nursing.

Occupational Safety and Health Administration. (2016). *Guidelines for preventing workplace violence for healthcare and social service workers*. U.S. Department of Labor. https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Rossa-Roccor, V., Schmid, P., & Steinart, T. (2020). Victimization of people with severe mental illness outside and within the mental health care system: Results on prevalence and risk factors from a mulitcenter study. *Front. Psychiatry* 11:563860. doi: 10.3389/fpsyt.2020.563860

Seckman, A., Paun, O., Heipp, B., Van Stee, M., Keels-Lowe, V., Beel, F., Spoon, C., & Delaney, K.R. (2017). Evaluation of the use of a sensory room on an adolescent inpatient unit and its impact on restraint and seclusion prevention. *Journal of Child and Adolescent Psychiatric Nursing, 30*(2), 90-97. https://doi.org/10.1111/jcap.12174

The Joint Commission. (2018). *Take a stand: No more violence to healthcare workers.* https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_59_wpv_infographic_3_30_18_finalpdf.pdf

The Joint Commission. (2019). *Quick safety issue 47: De-escalation in health care.* https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-47-deescalation-in-health-care/

f: Suicide Prevention

In 2019 roughly 47,000 Americans died by suicide and there were approximately 1.3 million attempts (American Foundation for Suicide Prevention, 2021). These statistics account for the general population, when taking a closer look at rates of suicide in individuals diagnosed with a serious mental illness (SMI), we see that the rates of death by suicide increase. Adults diagnosed with mood disorders have death by suicide rates approximately 25x higher than the general population and adults diagnosed with schizophrenia have rates approximately 20x higher than the general population (SMI Adviser, 2020). When compared to individuals with other mental health disorders, those diagnosed with serious mental illness were younger, more likely to have previous suicide attempts, and more likely to have co-morbid substance use disorders (Schmutte et al., 2021). Risk factors and protective factors are present in each individual's life and can contribute to increased or decreased risk of death by suicide. Risk factors are anything associated with an increased risk and protective factors are associated with decreased risk (SMI Adviser, 2020). Some examples of risk factors in the general population are prior attempts, chronic disease and disability, social isolation, and lack of access to behavioral care (SMI Adviser, 2020). There are additional risk factors associated with individuals who have SMI such as, being unhoused, experiencing untreated psychiatric symptoms, perceived discrimination, and unemployment/low income (SMI Adviser, 2020). Protective factors for all individuals diagnosed with an SMI or not include access to consistent and effective behavioral healthcare, sense of social connection, sense of purpose in life, and development of coping skills or problem-solving skills (SMI Adviser, 2020). The most appropriate way to identify and support individuals who are at high risk and have expressed suicidal ideation is to know the warning signs, ask clear and direct questions about their suicidal ideation (to determine if it is passive or active), assess suicide risk using brief screening tools, provide support, and following up to reassess risk (Centers for Disease Control and Prevention, 2018; American Foundation for Suicide Prevention, 2021; SMI Adviser, 2020). Use of safety planning has also been shown to support individuals deemed to be at high risk for suicide. A safety plan is a prioritized list of coping strategies and sources of support to be used by individuals in time of need (American Foundation for Suicide Prevention, 2021; SMI Adviser, 2020).

Literature suggests that prevention efforts to decrease suicide attempts and deaths should be enacted on both larger community/population levels and on a smaller individual level. The following are strategies to prevent suicide suggested in the literature (Centers for Disease Control and Prevention, 2018; Thomas et al., 2018; Schmutte et al., 2021; Loos et al., 2017):

- Providing financial supports for individuals in need through unemployment benefits, housing stabilization policies, and other similar programs
- Strengthening access to and delivery of care by offering telehealth appointments for individuals who have to travel far for office visits, increasing coverage of mental health conditions in insurance policies, and addressing provider shortages in underserved areas.

- Creating protective environments by utilizing organizational policies aimed at reducing stigma, allowing for an environment where it is safe to talk about suicidal thoughts and seek help, and reducing access to lethal means to complete suicide (e.g., firearms)
- Promoting social connections through formation of peer lead groups and interventions promoting community engagement
- Teaching coping skills
- Recovery oriented interventions placing an emphasis on fostering empowerment and hope in individuals – with a focus on establishing collaborative relationships between mental health professionals, peer providers, and the individual with serious mental illness

Occupational therapy practitioners specifically can look to the *Occupational Therapy Practice Framework: Domain and Process (4th ed.)* (AOTA, 2020) to develop a clinical approach that maintains the client centered and holistic lens through which they view the patient hallmark to OT. Through combined use of the OTPF, models of practice, frames of reference, and activity analysis practitioners can facilitate evaluation and treatment of a client (AOTA, 2020; Novalis, 2017). Finding ways to re-engage in occupations of interest, sustain engagement in occupations, and find purpose/meaning in their lives are common themes seen when working with those at risk for suicide and those identified as suicide survivors (Novalis, 2017; Loos et al., 2017). Examples of interventions OT's can provide: client and family education, interventions targeting functional activities (activities of daily living or instrumental activities of daily living), interventions aimed to facilitate advocacy and bolster self-esteem as well as other interventions that consider the dynamic interactions of the environment, culture, occupations, and life roles of each individual (AOTA, 2020; Novalis, 2017).

Please note, if a client expresses suicidal ideation during an OT session, it is critical to refer the client to a crisis center and/or contact the client's physician or to call 911 if you feel the client is a danger to self or others. Clinicians or clients can also call the National Suicide Prevention Hotline 1-800-273-TALK (8255) and access resources at:** https://www.apa.org/advocacy/suicide-prevention **and https://www.apa.org/topics/suicide

Links for resources with more information*:*

National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/

Safety Plan Example: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

AOTA Article Suicide Prevention/Intervention: https://www.aota.org/publications/ot-practice/ot-practice-issues/2020/suicide-prevention-and-intervention

Suicide Prevention Resource Center: https://www.sprc.org/

ZERO Suicide: https://zerosuicide.edc.org/sites/default/files/Addressing%20the%20Intersection%20of%20Serious%20Mental%20Illness%20and%20Suicide%20in%20Healthcare%207.29.19%20Slides%20and%20Transcript_0.pdf

Patient Health Questionnaire – 9: https://nida.nih.gov/sites/default/files/PatientHealthQuestionnaire9.pdf

Recognizing/Responding to Suicide Risk: https://suicidology.org/training-accreditation/rrsr-clinicians/

Collaborative Assessment and Management of Suicidality: https://cams-care.com/about-cams/

Screening/Assessing Suicide Risk: https://zerosuicide.edc.org/toolkit/identify/screening-options

Ask Suicide Questions (ASQ): https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Suicide Assessment Five-Step Evaluation and Triage: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

Columbia-Suicide Severity Rating Scale (C-SSRS): https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

Using C-SSRS: https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

SAMHSA Suicide Prevention: https://www.samhsa.gov/find-help/suicide-prevention

APA Suicide Prevention: https://www.psychiatry.org/patients-families/suicide-prevention

Preventing Suicide: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

NIH Suicide Statistics: https://www.nimh.nih.gov/health/statistics/suicide

Suicide Safe Mobile App: https://store.samhsa.gov/product/suicide-safe

Understanding Suicide: https://www.verywellmind.com/suicide-4157253

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g: Workplace Stress, Burnout and Compassion Fatigue

Healthcare workers often experience work-related stress that impacts sleep, energy levels, mental and physical health and overall well-being (De Hert, 2020; Mental Health America, n.d.). The demands of the health care profession may include long shifts, exposure to emotionally charged patient experiences, comforting individuals in deep pain and responding to multiple demands throughout the day (Mental Health America, n.d.; Substance Abuse and Mental Health Services Administration (SAMHSA), 2020). If not properly addressed, work-place stress can escalate into burnout and/or compassion fatigue.

In 2019, the World Health Organization included burnout in the International Classification of Diseases, 11th Edition (ICD-11). It is defined as a "syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed" and is characterized by "feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism toward one's jobs and reduced professional efficacy" (World Health Organization, 2019). Burnout is understood to develop over time and common symptoms may include inability to focus, sleep problems, anxiety about work, avoiding decision making, growing resentful toward patients and workplace, chronic exhaustion, having a pessimistic outlook, doubting one's performance, apathy and social withdrawal (De Hert, 2020, Mental Health America, n.d.). In extreme cases, burnout can contribute to substance use and suicidal ideation (De Hert, 2020).

Compassion fatigue is described as "a state of exhaustion and dysfunction biologically, physiologically and socially as a result of prolonged exposure to compassion stress and all it invokes" (Cocker & Joss, 2016). It has been found that exposure to the trauma and stress of the individuals who seek services impact a practitioner's capacity for empathy and ability to cope with the everyday environment (Cavanagh et al., 2020; Cocker & Joss, 2016). Some common symptoms of compassion fatigue include feeling on edge, difficulty making decisions, extreme exhaustion, intrusive thoughts about workplace, feelings of disconnection from colleagues and clients, reduced ability to show empathy, feeling angrier and more irritable and reduced satisfaction with work (SAMHSA, 2020; Cocker & Joss, 2016)

Burnout and compassion fatigue can have negative effects on both the health care practitioners and the individual receiving care. For practitioners, burnout and compassion fatigue may result in poor physical and mental health, difficulty functioning on a team, impaired decision-making and overall job dissatisfaction (O'Connor et al., 2018; De Hert, 2020; SAMHSA, 2020). For individuals receiving care, burnout and compassion fatigue are related to impaired quality of care, lower patient satisfaction and an increased rate of medical error (O'Connor et al., 2018; De Hert, 2020).

Resources for more information related to workplace stress, compassion fatigue and burnout related to prevalence and symptoms:

Facing Burnout as Healthcare Worker: https://www.mhanational.org/facing-burnout-healthcare-worker

Well-Being Resources: https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources

SAMHSA Tips for Coping with Stress and Burnout: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-01-01-016_508.pdf

Healthcare Worker Burnout and Self-Care: https://www.providence.org/news/uf/625195886

Guide to Understanding and Coping with Compassion Fatigue: https://www.onlinemswprograms.com/resources/social-issues/guide-to-compassion-fatigue/

Compassion Fatigue: What is it?: https://www.youtube.com/watch?v=v-4m35Gixno

Emotional Wellness Toolkit: https://www.nih.gov/health-information/emotional-wellness-toolkit?utm_source=TWITTER&utm_medium=TWITTER&utm_content=100000297895443&utm_campaign=Engagement&linkId=100000003086217

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Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare emergency and community service workers: A systematic review. *Int Journal of Environmental Research and Public Health. 13*(6). https://doi.org/10.3390/ijerph13060618

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Substance Abuse and Mental Health Services Administration [SAMHSA]. (2020). *Tips for healthcare professionals: Coping with stress and compassion fatigue* [Fact sheet]. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-01-01-016_508.pdf

World Health Organization. (2019). *Burn-out an "occupational phenomenon": International classification of diseases*. World Health Organization. Retrieved from https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

h: Self Care and Coping Strategies for Practitioners

As noted above, the demands of being a mental health care professional may lead to workplace stress, compassion fatigue and overall burnout. Treating both burnout and compassion fatigue should be individualized and guided by the level of functional impairment the practitioner is experiencing (De Hert, 2020). Engaging in self-care activities can prevent and combat symptoms of workplace stress and promote a healthy work life balance. Some suggestions for addressing work-place stress includes prioritizing a work-life balance, striving to sleep and eat well, talking with loved ones, engaging in enjoyable activities outside of work turning to colleagues for support, relaxation strategies such as mindful movement, breathing or meditation, journaling, physical activity and engaging in spiritual practices (SAMHSA, 2020; De Hert, 2020).

In addition, seeking professional health and wellness resources within the employee's organization/work setting or outside of the organization is encouraged for additional support (SAMHSA, 2020; De Hert, 2020). The National Alliance on Mental Illness (2020) recommends that health care practitioners reach out for support when they are feeling irritable or angry, feeling anxious or constantly sad, isolating from others, spending time thinking about traumatic events, experiencing sleep difficulties or any physical issues that were not present previously. Multiple options for reaching out and seeking help exist, depending on an individual's comfort level and availability including, but not limited to professional mental health support, 24-hour helplines, peer support services and participating in workplace wellness opportunities. Often times, there is a financial barrier to seeking professional help. The Alliance on Mental Illness (2020) has identified a list of services that are free, virtual and confidential for health care professionals including:

- Therapy Aid: https://therapyaid.org/
- The Emotional PPE Project: https://emotionalppe.org/
- The Battle Within: https://www.thebattlewithin.org/frontline-therapy-network
- 911 At Ease International: https://www.nami.org/Your-Journey/Frontline-Professionals/Health-Care-Professionals
- Physician Support Line: https://www.physiciansupportline.com/
- PeerRxMed: https://www.peerrxmed.com/

Additional Resources for preventing burnout and compassion fatigue and engaging in self-care and coping strategies:

Compassion Fatigue for Crisis Counselors: https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors

Relieving Tension Breathing Exercises: https://www.ajc.com/lifestyles/relieving-tension-breathing-exercises-for-nurses/j55gw8rL6W0WyhhY8Hx0mN/

Mental Health and Resiliency Tools:
https://www.health.state.mn.us/diseases/coronavirus/hcp/mh.html

How Healthcare Workers can Take Care of Themselves: https://hbr.org/2020/05/how-health-care-workers-can-take-care-of-themselves

NAMI: https://www.nami.org/Your-Journey/Frontline-Professionals/Health-Care-Professionals

Here is an example of deep breathing strategies that can be done during times of stress at work.

Retrieved from Project X Factor: https://www.projectxfactor.com/post/the-3-most-effective-breathing-exercises-to-combat-stress

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National Alliance on Mental Illness [NAMI]. (2020). *Healthcare professionals.* https://www.nami.org/Your-Journey/Frontline-Professionals/Health-Care-Professionals

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2020). *Tips for healthcare professionals: Coping with stress and compassion fatigue* [Fact sheet]. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-01-01-016_508.pdf

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L: Additional Resources for Skill Development, Enhancement, and Information

This section includes additional resources for practitioners in the form of recommended texts and links to continuing education topics, certifications, and intervention/treatment tools. The resources provided are not meant to be an exhaustive list of all that is available to practitioners working in the field of mental health, they are meant to act as a starting point to provide additional guidance and direction.

Continuing education credits:

- Evidence for Interventions to Improve and Maintain Occupational Performance and Participation for People with Serious Mental Illness: A Systematic Reviews- https://myaota.aota.org/shop_aota/product/CEAJOT68
- A Trauma-Informed Approach Distinct to Occupational Therapy: The TIC-OT Model- https://myaota.aota.org/shop_aota/product/OL5140
- Acceptance and Commitment Therapy for Occupational Therapy Practitioners- https://myaota.aota.org/shop_aota/product/OL5166
- Role of Occupational Therapy in Case Management and Care Coordination with Complex Conditions- https://myaota.aota.org/shop_aota/product/CEAJOT23
- Suicide Awareness and Occupational Therapy for Suicide Survivors- https://myaota.aota.org/shop_aota/product/CEA1117
- Use the Occupational Therapy Practice Guidelines for Adults with Serious Mental Illness- https://myaota.aota.org/shop_aota/product/OL8301

Certifications:

- Mental Health First Aid- https://www.mentalhealthfirstaid.org/population-focused-modules/adults/; https://www.mentalhealthfirstaid.org/wp-content/uploads/2021/09/092321_Adult-MHFA-Flier.pdf
- Certified Psychiatric Rehabilitation Practitioner (CPRP): https://www.psychrehabassociation.org/certification; https://www.psychrehabassociation.org/certification/cprp-certification
- Question. Persuade. Refer (QPR): https://qprinstitute.com/; https://qprinstitute.com/individual-training
- Psychology First Aid (PFA): https://learn.nctsn.org/course/index.php?categoryid=11; https://www.apa.org/practice/programs/dmhi/psychological-first-aid/training

Texts:

Brown, C., Stoffel, V. C., and Muñoz, J. P. (2019). *Occupational therapy in mental health: A vision for participation, 2nd Ed.* FA Davis and Company, Philadelphia, PA. ISBN: 9780803659162

Cole, Marilyn B. (2018). *Group Dynamics in Occupational Therapy, Theoretical Basis and Practice Application of Group Intervention, 5th Ed.* Thorofare, NJ: Slack Inc. ISBN**:** 978-1-63091-367-0

Taylor R.R. (2020). *The Intentional Relationship*. Philadelphia, PA: FA Davis. ISBN: 13-978-0803669772

Links:

- Worksheets and activities for a variety of topics - https://www.therapistaid.com/
- Illness Management and Recovery Evidence Based Practice toolkit (SAMHSA) - https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4462
- Information on Peer-Support specialist training - https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Peer-Support-Training.aspx
- Occupational Therapy Toolkit (Patient handouts and treatment guides for adults) - https://www.ottoolkit.com/
- Information on Cognitive Behavioral Therapy - https://www.verywellmind.com/what-is-cognitive-behavior-therapy-2795747
- Information on Dialectical Behavior Therapy - https://www.verywellmind.com/dialectical-behavior-therapy-1067402
- Dialectical Behavior Therapy - https://dialecticalbehaviortherapy.com/
- Mindfulness - https://www.verywellmind.com/mindfulness-the-health-and-stress-relief-benefits-3145189
- Motivational Interviewing- https://www.psychologytools.com/professional/techniques/motivational-interviewing/

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