Occupational Therapy in The Mental Health Setting

A Quick Reference

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This document will provide the reader with an overview of the role of Occupational Therapy in mental health. Occupational therapists are concerned with clients' daily functioning and quality of life. In particular, how clients purposefully participate within their environments such as their home, work, school, and community. Occupational therapists focus on re-engaging clients into their normal life, and build client-centered approaches that are suitable to each client's needs.

According to the World Health Organization (WHO), 25% of people around the world might have a mental health problem. This might hinder their ability to participate within the environment and limit their productivity. Therefore, occupational therapists focus on evaluating all factors that affect a clients' quality of life and determine the right client-centred and occupation-based intervention to help prevent and recover from mental health problems.

Adapted from: Brown, C., Stoffel, V. C., & Munoz, J. (2019). Occupational therapy in mental health: A vision for participation. FA Davis.

	Symptoms and limitations	**Implication to function**	**What OTs can do**
Cognitive deficits.	Inability to multitask, or execute complex	Start to depend on procedural memory: only performing tasks	1. Evaluation: analysis of occupational performance, use of occupation-based

	activity; difficulty with new tasks and multistep processes; Poor working memory (depend on procedural memory to complete daily activities); Aphasia, Apraxia; inability to interpret sounds, visual object, or time sequence. Attentional problems, impaired memory, inability to learn, deficits in reasoning and problem-solving	that relays on procedural memory, more complex IADLs that require problem solving are harder. Experiences that demand complex thinking and new learning are proven to be challenging. (Ex: house repairs or driving alone in an unfamiliar place) Individuals are withdrawn from social activities requiring high-level cognitive skills or that are challenging to their safety. As language declines social participation declines. (Ex: attending and/or engaging in family gatherings, etc.) In mild cognitive deficits: Difficulties in work, leisure, social participation and complex IADLs. Severe cognitive deficits: Difficulty in ADLs, IADLs (including medication management), rest, and sleep. They become dependent for their ADLs (incontinence care, feeding	assessments (Ex: Kettle test, PASS or Weekly Calendar Planning Activity), identification of environmental and contextual supports and barriers. 2. Intervention: Determine appropriate environmental adaptations and supports that facilitate performance. Educate caregivers on adaptations. 3. Cognitive remediation: restoring cognitive skills (attention, memory, and problem solving). 4. Dynamic interactional approach: increase functional information performance capacity - generating strategies and self-monitoring skills that facilitates successful occupational engagement. (Ex: teaching a client to think about the problems that they might face during a complex daily task prior to initiating it and identifying strategies that might facilitate successful completion of that task) 5. Cognitive adaptation: adapting the environment and tasks to compensate for cognitive impairments (Ex: labeling cabinets, providing sample scripts for brushing teeth.)

		- they could show resistance or refusal).	
Cognitive beliefs (associated with mood disorders; depression, bipolar)	Negative beliefs about self, others, and the world that are affecting motivation to engage in occupations. Not finding meaning in engagement. Lack of motivation	Individuals become less motivated to engage in self-care activities, work, leisure or in social engagement. Individuals are then withdrawn and isolated from others.	Help engage clients in meaningful occupations that support personal performance successes to enhance self-efficacy beliefs while counteracting dysfunctional cognitive beliefs related to occupational performance. Offer interventions that combine belief-oriented individual and group CBT interventions with vocational training to enhance self-efficacy beliefs, reframe other dysfunctional beliefs, and improve work performance. (Ex: practicing self-monitoring that includes paying attention to thoughts and beliefs associated with each activity; rating pleasure from 0-10, helps the client create positive beliefs about mastery and ability to engage in activity.) 1. Use cognitive restructuring, behavioral experimentation and activation, performance successes, and social learning to target cognitive beliefs and achieve desired occupational goals (Ex: engaging in desired activities, assessing thought and beliefs about their engagement.) 2. Motivational interviewing to strengthen motivation for engagement.

			3. Promote engagement by educating caregivers and/ or staff to provide activities with social components to help individuals feel connected to a larger community.
Stress, and anxiety. (Associated with anxiety disorders, phobias, panic, and trauma disorders)	Fear response that is prolonged and inappropriate to the actual threat level.	Limit participation in activities away from family or home. Limit participation in activities with new people, like new employment, marriage, and education. Limited participation in desired activities due to fear. High arousal states can cause inability to concentrate on a task.	1. Use of occupation-based approaches to cope with stress: identifying, engaging in, and adapting occupations to master the environment. 2. Provide opportunities to express emotions related to personal experiences through activities (individual or groups). 3. Facilitate sessions for psychoeducation, relaxation and meditation, interpersonal skill training, exercise and wellness.
Obsessive compulsive behavior (Associated with OCD, body dysmorphic disorder, and hoarding disorder)	Excessive and persistent preoccupations and rituals. Persistent urges that are relieved through engaging in a behavior.	Significantly compromise quality of life. Inability to alter behaviors even with feedback. Spending time engaging in obsessive thinking or behavior can take time away from participation in other activities.	1. Time use and management: retraining to spend less time engaging in obsessive activity . 2. Cognitive behavioral therapy: identify sources of beliefs and providing evidence to the contrary.

		Avoid situations that may trigger their symptoms; like being around other individuals.	
Sensory processing (associated with Autism, ADD, ADHD)	Hyperresponsive or over responsive to self, others, environment. Sensory seeking (craving intense sensation consistently)	Appropriate behavioral responses to stimuli are important for successful interaction with others or with objects during occupational engagement. A person may have difficulty completing an occupation due to feeling over stimulated by the components of the task or by the environment. Or by continuously being unfocused or drawn away from activity due to under stimulation.	1. Sensory integration interventions to improve motor skills, sensory processing, and behaviors. 2. Using an alert-program to improve self-regulation strategies. 3. Providing activities that provide an appropriate type of sensory input for the individual and situation.
Communication and social skills. (associated with personality d isorders, Autism)	Decreased information processing, Poor planning skills, cognitive inflexibility, poor social judgment.	Decreased speed of information processing leading to difficulty comprehending information related to engagement in activities or engagement with others. Decreased goal oriented behavior leads to vague narrative discourse. Decreased cognitive flexibility and poor social and emotional	Prescribe or design Augmentative and Alternative Communication (AAC) systems and devices. Train individuals for the use of AAC. Social skills training to improve social function for individuals who tend to have negative views of themselves, and to increase social intelligence, for example, training individuals to read facial expressions and social cues.

		intelligence prevents the person from understanding others indirect requests, feelings, and thoughts, thus limiting social participation. Inability to communicate with others during activities can limit participation. An individual with limited social skills may miss opportunities for engagement due to inability to ask or contact others.	
Pain	Acute and chronic pain, pain behaviors.	Decrease occupational roles and occupational performance and participation, due to physical or psychological limitations from pain.	1. OT interventions address physical, psychosocial, and environmental factors that influence the experience of pain. 2. Biomechanical strategies: increasing or compensate for limited range of motion, strength, and endurance for occupational performance. Application of physical agent modalities. Use of exercise-based interventions. Adaptive equipment training, environmental adaptation. 3. Behavioral strategies: gradual increase in participation. Operate intervention to overt pain behaviors; enforcement of positive behaviour, and refraining from enforcing pain behaviors.

			(Ex: activity pacing, biofeedback reinforcement of well behaviors). 4. Relaxation and refocusing strategies: relaxation training, distraction from pain, progressive muscle relaxation, guided imagery, mindfulness.
Delusions, paranoia, hallucinations (associated with Schizophrenia and Schizoaffective disorder)	Disorganized or catatonic behavior.	Impaired cognition is usually associated with these disorders, thus causing functional dysfunction. Difficulty with working memory or manipulate information in the brain. Can't develop habit patterns for familiar situations. Unable to identify steps of specific tasks. The require more feedback to change their behavior.	1. Cognitive remediation: graded and repeated practice of cognitive oriented occupational tasks. 2. Environmental adaptation: reduce cognitive demands by adapting to the environment. 3. Social skills training: use repetition and feedback to gain new social skills. 4. ADL/IADL retraining: learning behavioral strategies to engage in daily activities.
Eating disorders	Changes in eating habits. Overeating or under-eating.	Difficulties with self-care due to bad self-image, productivity due to fatigue/ tiredness, and leisure occupations, specifically social events that involve eating. Challenges in eating skills (eating in a normal, safe, and healthy	1. Motivational interviewing: identifying reasons for change. 2. Building new healthy routines to facilitate healthy eating, and meal preparation

		matter), meal preparation, and independent living.	3. Behavioral therapy: challenging negative cognitive thoughts during eating or meal preparation.
Disruptive behavior disorder (associated with personality disorders)	Inability to self-control emotions and behaviors. Impulse control, excessive hostility.	Individuals are often excluded from engaging in activities due to conflict with others. Inability to control impulses can also prevent individuals from fully completing a task due to their emotions.	1. Cognitive Orientation to Daily Occupational Performance (COOP): Problem solving for an occupational goal through (goal-plan-go-check). 2. Zones of regulation: providing a system to identify state of alertness and create strategies to reach desired levels. 3. Community Retraining: retrain hospitalized individuals to reintegrate into the community through developing coping skills. 4. Sensory rooms: creating a room with calming stimulus that individuals can use when they feel agitated.
Drug and Alcohol use		Disruption of routines due to the constant need for consuming alcohol or drugs. Inability to complete wanted occupations, inability to fall asleep or stay asleep unless under the influence.	1. Cognitive behavioral therapy. 2. Motivational interviewing 3. Mindfulness meditation.

Occupational Therapy within a multidisciplinary team:

Multidisciplinary Care allows professionals from a range of disciplines to work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one umbrella and brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. The need to provide clients with multidisciplinary mental health care is supported by a large body of evidence that suggests it has a positive impact in promoting users wellbeing compared with the care provided in institutional settings. A multidisciplinary team (MDT) usually consists of psychiatrists, clinical nurse specialists/ mental health nurses, psychologists, social workers, occupational therapists, medical secretaries, and sometimes other disciplines such as counsellors, art therapists, advocacy workers, and care workers.

The table below gives a generalized view of what a multidisciplinary may consist of and their roles in the team.

Multidisciplinary Team Member	Duties Involved
Psychiatrist	Perform assessments once case is provided. provide talking therapies, prescribe medication, investigate for any physical illnesses.
Psychologists	Provide specialized talking therapies, perform in-depth assessments of aspects of brain functioning and behavior.
Psychiatric Nurse	Assess difficulties, administer and monitor medication.
Occupational Therapists	Provide skills assessments, formulate rehabilitation plan, which is delivered both individually and in groups, improve patients' independence and overall quality of life.

Social Worker	Provide support for families, provide talking therapies, advise in relation to housing, finance and supports.
Dietician	Screening patient, provide Nutrition Therapy, treatment and management of eating disorders.

When to refer to Occupational Therapy:

Occupational therapists focus on building functional living skills that allow clients to engage in safe self-care activities, social activities, and leisure activities. Being diagnosed with mental health disorders can impact the ability to engage in occupation. Limitations include physical limitations due to diagnosis or medication, or psychosocial due to lack of motivation or thoughts and beliefs. An occupational therapist works with clients to identify the occupational needs as well as the supports and barriers to the engagement. Therapists then, with the client, facilitate the return to occupational engagement through re-training and/or adaptations that increase the impact of the earlier identified supports and decrease or limit the impact of the barriers.

Whenever a diagnosis is impacting the person's engagement in wanted occupations, tasks, or roles a referral to occupational therapy is beneficial. If a patient presents to you with a lack of motivation to engage with others and socialize, inability to complete desired tasks (like self-care tasks or any other I/ADLs), or engage in important roles they hold, occupational therapy interventions could be beneficial. If the patient has the desire to get back into their roles and routines Occupational therapy should be recommended. OT's will work with clients experiencing limited occupational engagement due to any diagnosis regardless of their age or functional goal.

References

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