# Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice



The purpose of this statement is to describe the role of occupational therapy practitioners[1] in the promotion of mental health and in the prevention of and intervention for mental health disorders throughout the lifespan. This document describes the distinct contributions specific to the discipline of occupational therapy and the knowledge and skills occupational therapy practitioners share with other core mental health professionals. This document is intended for both internal and external audiences, including stakeholders in health care, education, and community and mental health services (e.g., clients, family members, policymakers) and mental health practitioners of all disciplines. The Appendix provides a glossary of terminology related to occupational therapy in the promotion of mental health.

## Background and Definitions

The roots of occupational therapy are grounded in psychiatry. The moral treatment movement, from which the profession evolved, sought to replace the brutality and idleness of earlier treatment of disorders of the mind with attention to establishment of healthy routines and participation in meaningful occupation (Christiansen & Haertl, 2014). In the early 20th century, the founders of and early writers in occupational therapy created a body of literature that supported the therapeutic value of occupation. They embraced the ideas of physician Adolph Meyer (1922), who articulated a holistic and practical emphasis on the importance of helping people with mental illness reorganize their daily habits and applied the therapeutic use of occupation across settings ranging from psychiatric hospitals to reconstruction hospitals for soldiers returning from war (Christiansen & Haertl, 2014).

According to AOTA (2014c), "Occupational therapy is founded on the understanding that active engagement in occupation promotes, facilitates, supports, and maintains health and participation" (p. S4). The term *occupation* is defined as life activities that people "engage in throughout their daily lives to structure time and give life meaning" (AOTA, 2014c, p. S43). The goals of occupational therapy are to promote physical and mental health and well-being in all people, with and without disability-related needs, and to establish, restore, maintain, and improve function and quality of life for people at risk for or affected by physical or mental disorders.

Occupational therapy practitioners contribute to the promotion of *mental health,* which is understood as a state of well-being in which a person realizes his or her abilities, copes with challenges, and is able to work and contribute to the community (World Health Organization, 2013). The profession brings a habilitation and rehabilitation perspective to mental health services in keeping with the increased emphasis on recovery and wellness directed toward participation in daily life occupations. AOTA supports the inclusion of the profession of occupational therapy in the federal definition of *behavioral and mental health professionals* found in the *Code of Federal Regulations* under the National Health Services Corps and as a qualified mental health profession defined by state statute and regulation (AOTA, 2014b).

[1]When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA American Occupational Therapy Association [AOTA], 2015a). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a, 2015b).

Occupational therapy's distinct contribution to the field of mental health is its grounding in occupation. Intervention may build new or enhance existing skills, create opportunities, and modify or adapt the environment or activity to enable participation in life (AOTA, 2013b). Occupational therapy practitioners use occupations that clients need and want to do and an understanding of the variables that influence the ability to successfully engage in occupations to help clients achieve goals for full participation in life.

## Occupational Therapy's Role in Mental Health

Through the use of activities, occupational therapy practitioners promote mental health and support full participation in life for people with or at risk of experiencing psychiatric, behavioral, and substance use disorders. Occupational therapy practitioners provide services to people throughout the lifespan wherever they participate in and carry out everyday activities, including in homes, schools, workplaces, and neighborhoods. Practitioners also serve people in institutions that address habilitative and rehabilitative needs, such as hospitals, outpatient clinics, skilled nursing facilities, adult day programs, clubhouses, transitional and residential living facilities, prisons, jail diversion programs, and other community settings.

In addition to providing distinct occupation-based evaluation and intervention services to clients, occupational therapy practitioners have skills to assume roles as case managers, care coordinators, group facilitators, skilled and licensed community mental health providers, qualified mental health professionals, consultants, program developers, and advocates. However, when occupational therapy practitioners assume these roles, they retain their focus and emphasis on what clients need and want to do (i.e., everyday occupations), with an emphasis on the practical matters of role performance and well-being, by assisting clients in retaining or developing interests and skills and removing barriers to competent and fulfilling participation. Thus, although an overlap in knowledge and skills with other professions is acknowledged, occupational therapy offers distinct contributions to mental health services provision by recognizing and emphasizing the complex interplay among client variables, activity demands, and the environments and contexts in which participation takes place. Occupational therapy practitioners are skilled in analyzing, adapting, and modifying tasks and environments to support goal attainment and optimal engagement in occupation so that clients can develop and maintain healthy ways of living (AOTA, 2011; Cohn & Lew, 2015).

Through the clinical reasoning process, occupational therapy practitioners select and apply different theoretical perspectives and approaches informed by evidence. These perspectives and approaches may draw from other fields and areas of practice, such as physical and psychiatric rehabilitation, psychology, school mental health, sociology, psychiatry, neuropsychiatry, and anthropology, but they are synthesized with frames of reference that are unique to occupational therapy and that reflect the profession's focus on occupation. This clinical reasoning process guides occupational therapy evaluation and intervention.

As in all occupational therapy practice, services in mental health are client centered. The client may be a person, a group, or a population (AOTA, 2014c). Occupational therapy practitioners collaborate with clients to determine what is currently important and meaningful and what they want or need to do. Together, practitioners and clients collaborate to identify factors that may be barriers or supports to healthy participation in desired and necessary daily occupations. Practitioners may partner with peer specialists to enable recovery services and supports that build on individual strengths to enable the four dimensions of health identified by the Substance Abuse and Mental Health Services Administration (SAMHSA): (1) health (well-being and symptom management), (2) home (maintenance of a safe and stable place to live), (3) purpose (meaningful daily activities), and (4) community (relationships and social networks; Stoffel, 2013).

## Education and Professional Qualifications

Entry-level occupational therapists need a master's degree in occupational therapy but may also enter the profession with a clinical doctorate. Accreditation standards for entry-level occupational therapy education programs include extensive requirements to support students' knowledge and skill development as mental health practitioners. In addition to the therapeutic use of occupation for people with mental health needs, education programs are required to demonstrate students' preparation in biological, physical, social, and

behavioral sciences, including abnormal psychology, sociology, therapeutic use of self, effective communication, group dynamics and facilitation, and interprofessional collaboration (Accreditation Council for Occupational Therapy Education [ACOTE], 2012). Moreover, both occupational therapy and occupational therapy assistant academic curricula address psychosocial, physical, cognitive, sensorimotor, and trauma-related issues that people with specific disorders may experience; the impact of lifespan and developmental issues; ethical and practical issues of social and occupational justice; and occupational deprivation and marginalization.

Master's-level occupational therapy education includes a range of supervised clinical and community-based experiences that begin during coursework and culminate in 6 months of full-time clinical internship. Internships may take place in traditional specialty mental health in acute psychiatric or community mental health settings, as well as in physical medicine, habilitation, or rehabilitation settings with a strong mental health emphasis, such as palliative care, peripartum care, forensic work with special populations, and other settings in which the focus of treatment is enabling mental health and successful adaptation to interruption in typical occupations.

Occupational therapy assistants have at minimum an associate's degree and work with occupational therapists to implement interventions. They use therapeutic occupations to address physical, cognitive, psychosocial, sensory, and other needs to enable clients to participate in everyday life activities (ACOTE, 2012). Occupational therapy assistants work under the supervision of and in partnership with occupational therapists to implement the intervention plan and to assist with ongoing evaluation of outcomes (AOTA, 2014a). Their educational coursework culminates in 4 months of full-time clinical internship.

Both occupational therapists and occupational therapy assistants have passed a nationally recognized entry-level examination. In addition, they have fulfilled state requirements for licensure, certification, or registration.

## Core Mental Health Professional Knowledge and Skills Applied to Occupational Therapy Practice

Occupational therapists are educated to apply knowledge of mental and physical health with a focus on participation and the role of occupation to help clients promote health, prevent disability, and overcome or manage health challenges. Occupational therapy practitioners apply a distinct perspective through the use of performance-based assessments and an emphasis on and understanding of the relationship between occupational participation and health and well-being. In addition to supporting client skill development and adaptive responses, occupational therapists analyze the complex interplay among client variables, activity demands, and the environments and contexts in which activity takes place, and they use their distinct skills to adapt or modify tasks or environments to support goal attainment and optimal engagement in occupation so that clients can develop and maintain healthy ways of living.

As required by ACOTE (2012), in the area of mental health, entry-level occupational therapists are educated in the following areas:

- Influence of neurophysiological changes, environmental factors, and contexts on mental health and the development of psychiatric conditions
- Human development and behavior throughout the lifespan, including how the emergence of mental illness influences development and the ability to participate in meaningful occupations
- Historical and contemporary perspectives on the promotion of mental health and on mental health disorders and treatment, including the consumer/survivor/ex-patient movement and concepts of resilience and recovery, trauma-informed care, social and emotional learning, peer-to-peer supports and services, and family-to-family supports and services (Brown & Stoffel, 2011)
- Current *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) taxonomy with regard to psychiatric diagnosis, etiology, symptoms, impairments, clinical course, and prognosis

- Common comorbidities with mental illnesses (e.g., diabetes, chronic obstructive pulmonary disorder, obesity, substance use, chronic pain, attention deficit hyperactivity disorder, autism spectrum disorder; Brown & Stoffel, 2011)
- Psychiatric medication actions, side effects, and effects on functioning (Brown & Stoffel, 2011)
- Therapeutic use of self and group processes (Cole, 2012)
- Evidence-based practices and service delivery models (e.g., assertive community treatment, illness management and recovery, supported employment, permanent supportive housing, school mental health, trauma-informed care, cognitive and dialectical behavioral therapies, social and emotional learning, positive behavioral interventions and supports, wraparound services; Bazyk & Arbesman, 2013; Brown, 2012; Brown & Stoffel, 2011)
- Public policies, programs, and procedures and related legal and ethical issues that influence mental health services delivery (e.g., involuntary treatment, insurance parity, advance directives, confidentiality)
- Payment systems and agencies and standards that influence mental health and rehabilitation service delivery (e.g., SAMHSA, Rehabilitation Services Administration, Centers for Medicare and Medicaid Services, Medicaid, Center for School Mental Health, state mental health authority, state vocational rehabilitation agency, private insurance, standards of practice, state licensure, certification, Joint Commission, Commission on Accreditation of Rehabilitation Facilities [CARF])
- Current applicable standards for service delivery and documentation (e.g., state mental health acts, Health Care Privacy and Accountability Act, confidentiality acts, licensure laws, CARF and Joint Commission requirements, criminal justice acts).

Occupational therapists apply the knowledge they have in common with other mental health professionals to their understanding of the variables that influence engagement, performance, and participation in the everyday occupations that are central to role performance, health management, inclusion, and community participation. Thus, occupational therapists are prepared to

- Assess mental health status (e.g., affect, cognition, insight, comprehension, impulse control, suicide risk) and incorporate findings in all phases of evaluation and intervention and determine the impact on engagement, performance, and participation in everyday occupations (Brown & Stoffel, 2011);
- Evaluate the influence of culture, diversity, socioeconomics, and values on a person's experience of mental health disorders, view of mental health treatment, experience of recovery, and participation in valued and meaningful daily activities (Crist, 2011);
- Use evidence-informed approaches and tools to perform comprehensive and targeted functional and performance-based assessments that lend themselves to the analysis of client, task, environmental, and contextual variables that influence efficiency and efficacy of occupational performance (Brown & Stoffel, 2011);
- Establish collaborative relationships that promote behavioral change in clients to facilitate successful participation in personally valued occupations (e.g., through therapeutic use of self, communication of hope, maintenance of ethical and interpersonal boundaries, motivational interviewing, active listening, primary and secondary accurate empathy, immediacy, confrontation, limit setting, group process, crisis and conflict resolution; Cole, 2012; Taylor, 2008);
- Integrate person-centered and recovery-oriented approaches to implementing interventions that facilitate goal development and attainment related to individually desired roles and occupations (Brown & Stoffel, 2011); and
- Design, execute, and apply individual and group intervention approaches used in mental health practice to facilitate increased performance and participation in everyday roles and occupations (e.g., cognitive–behavioral therapies, psychoeducation, psychodynamic approaches, behavioral approaches, social and emotional learning, recovery models, resiliency and strengths-based models,

psychosocial rehabilitation skills training, biopsychosocial approaches, dialectical behavior therapy, motivational interviewing, transtheoretical model of stages of change; Brown & Stoffel, 2011, Cole, 2012).

Examples of how occupational therapists apply these concepts include

- Using motivational interviewing and cognitive and environmental adaptations to assist a client in establishing daily habits and strategies to facilitate successful medication routines;
- Performing evidence-based assessments to identify sensory modulation deficits that may contribute to challenging behaviors and incorporate individualized emotional regulation or sensory strategies into a daily routine;
- Using a recovery-based approach to create and implement a plan for a client to reengage in meaningful activities that support a healthy and satisfying life;
- Collaborating to support achievement of a client's goals for increased independence by completing home-based functional assessments that identify current strengths and challenges and needed skills, resources, and modifications to achieve and maintain safe and independent community living; and
- Teaching skills to support client self-advocacy in achieving personal goals and improving quality of life.

Occupational therapy evaluation using this broad perspective often illuminates previously unidentified reasons why a client might find an activity challenging by taking into consideration physical and mental health, the environment, sensory processing, and cognition.

Occupational therapy practitioners engage in advocacy around social, economic, policy, and system factors that affect the health, well-being, and participation of people with serious mental illness (e.g., poverty, unstable housing, low education, unemployment, estrangement from family, inadequate insurance, lack of integration among service systems). Practitioners evaluate the dynamic interactions among the individual, family, community, and social system and their impact on the client's mental health, and they support policies that enable increased opportunities for meaningful participation (Wilcock & Townsend, 2014).

Practitioners have a history of collaboration with mental health stakeholder groups (e.g., consumers, family members, at-risk populations, employers, mental health providers, community programs, advocacy groups, legislators, third-party payers). They engage in activities to transform mental health service delivery systems to be consumer driven, family driven, youth guided, and community focused. Occupational therapy practitioners working with adults in the community understand the implications of the consumer/survivor/ex-patient movement for mental health services (AOTA, 2013b; Stoffel, 2013). Occupational therapists are integral team members in federal community mental health best practices for children, youth, and young adults such as the Early Detection, Intervention, and Prevention of Psychosis Program (McFarlane et al., 2010) and Systems of Care initiatives (Erdman, 2011). Occupational therapists are on the list of licensed and credentialed staff that may be included in the new Certified Community Behavioral Health Clinics, which are best practice exemplars that were funded in the Excellence in Mental Health Act (S. 264) passed in 2014 (National Council for Behavioral Health, 2016).

## Occupational Therapy Process in Mental Health

Led by their belief in the inherent drive of all people to engage in meaningful and purposeful occupations and their understanding of the influence of occupational engagement on health and recovery, occupational therapy practitioners use occupation and an understanding of the variables that influence clients' ability to successfully engage in everyday activities to facilitate achievement of occupational participation and recovery goals (AOTA, 2011). The underpinnings of occupational therapy evaluation and intervention rest in practitioners' understanding of the influence of neurophysiological changes, environmental factors, and contexts on both participation in everyday occupations and the development of psychiatric, behavioral, and physical health conditions (e.g., medical, physical and somatic, intellectual, cognitive, learning, other nonpsychiatric disabling conditions). This focused value on the impact of occupational engagement on health and recovery and the distinct in-depth understanding and ability to analyze factors that support or constrain performance, participation, and well-being separate occupational therapy practitioners from

other mental health professionals. (See Table 1 for case examples of occupational therapy evaluation and intervention for clients affected by mental health issues.)

**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues**

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
|---|---|---|
| **George** is a 40-year-old man with a diagnosis of schizophrenia involving significant impairment of cognitive functioning.<br><br>George had lived with his parents and worked as a dishwasher in a hotel for many years, until his parents died and the hotel closed. He ended up on the streets, and several attempts at getting him into housing failed because he hoarded clothing and did not maintain personal hygiene or medication routines. He is unable to work or sustain housing. | • Loss of support system (parents) for ADLs<br>• Inability to sustain housing because of poor hygiene and inability to care for a home<br>• Low safety awareness of physical danger of living on the streets<br>• Inability to manage regular medication routines<br>• Loss of productive roles<br>• Lack of autonomy and choice. | *Interventions*<br>• Complete performance-based assessment by observing George in his routines to identify strengths and needs, and provide interventions within a single-room-occupancy setting serving people who have been homeless.<br>• Work collaboratively with George to develop routines and supports for ADLs.<br>• Hire a peer in the setting to manage George's clothing and prompt his daily shower, provide clean clothes, and take away soiled clothing daily. Establish equitable co-occupations so that peers prepare meals and George does dishes and cleans up the kitchen. Hire another peer to clean George's room every week.<br>• Monitor George's satisfaction and skill development and help him identify what he wants and needs to do.<br><br>*Outcomes*<br>• With support, George is hired by the facility's soup kitchen to wash dishes. He is generally the first person in the building every morning!<br>• George experiences an increased sense of belonging, social participation, and productive roles (Fieldhouse, 2012). |
| **AbleDisAbled** is a drop-in group facilitated by OT faculty from the local university for people with mental health needs or homelessness who have limited community supports.<br><br>Some members have been asked to leave multiple support groups because of conflicts with other members. Members come to the group knowing their diagnoses and disabilities but with very little recognition of their strengths or capabilities.<br><br>When asked to develop goals for the group, members respond that they want to build productive occupations and advocate for the needs of low-income residents in the community. | • Decreased agency and autonomy<br>• Lack of awareness of their own capabilities<br>• Lack of leisure and productive occupations<br>• Limited social support systems<br>• Limited opportunities for self-expression<br>• Limited opportunities to experience themselves as contributing members of their community | *Interventions*<br>• Partner with group members to identify their goals for recovery, which are focused on building a meaningful life in valued roles regardless of symptoms or level of impairment (Myers et al., 2016).<br>• Use the group process to work through ineffective interactions and practice positive social participation.<br>• Develop productive occupations through an occupation-based group, which develops into a recycled crafts enterprise that occurs during a portion of the weekly group and on a drop-in basis throughout the week. |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
|---|---|---|
| | | • Develop a time bank with OT students in which proceeds are deposited into and then disbursed to members in exchange for time spent crafting, selling, or advocating.<br>• Facilitate effective member identification of priorities and concerns to enable the voice of experience when engaging with community coalitions, agencies, and government officials; provide training and mentoring for peer leaders (Swarbrick, 2011).<br>• Connect members with regional consumer-operated services and help them with initial grant-writing efforts and community outreach to enable them to build local peer-to-peer capacity.<br><br>*Outcomes*<br>Members report the following outcomes:<br>• Increased sense of belonging to a community and of safety and well-being<br>• Increased advocacy knowledge and skills; for example, increased capacity for empathy and understanding the perspective of others have made members better advocates<br>• Feeling valued for their strengths; increased hope and meaning<br>• Better coping mechanisms and skills<br>• Increased community advocacy: Members volunteer their time throughout the community; they sit on multiple community groups, bringing providers feedback on local needs. They are writing grants, developing product lines, and marketing. |
| **Lisa** is a 4th-grade student in a school district that assigns OT practitioners to schools and makes them available for all teachers and children in a school. Several federal initiatives support specialized instructional support services such as OT as resources to improve student skills beyond academics. OT may also be part of wraparound teams to remove barriers to learning and enable classroom participation (Every Student Succeeds Act of 2015 [Pub. L. 114–95]; U.S. Department of Education & U.S. Department of Health and Human Services, 2016). | • Hyperstable adaptive response (freezes or attempts to escape) when Lisa is faced with learning challenges<br>• Decreased opportunities for Lisa to experience herself as competent and build social capital with peers<br>• Limited use of Lisa's emergent drawing skills and other strengths<br>• Ineffective consequences for negative behaviors, resulting in Lisa being excused from completing required tasks<br>• Lisa's lack of functional writing skills to match demands | *Interventions*<br>• Observe Lisa's performance in different environments, attending to her sensorimotor, psychosocial, and cognitive systems and their impact on performance. Note the physical, cultural, and social demands in the school setting. Interview Lisa, and use a performance-based screening to identify problem and strength areas.<br>• Analyze assessment results: Lisa's written work is well formed but very slow, and her letters-per-minute keyboarding speed is even slower because of her limited experience. |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
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| When Lisa's teacher has difficulty with students in the reading group, she asks the occupational therapist to help her identify potential strategies. Lisa, in particular, demonstrates negative behaviors across several classes and states that she is "dumb" and that school is "stupid." The teacher also feels overwhelmed and poorly supported. | | • Help Lisa explore strategies to accommodate written expression, providing opportunities for her to experience success in composition tasks.<br>• Train the teacher on how to set up accommodations and strategies to practice keyboarding.<br>• Assist Lisa's teachers in building routines throughout the day that capitalize on her drawing ability (e.g., having her illustrate work, identifying her as an artist, assigning her drawing tasks in group work) to enable her to experience herself as competent and build social capital.<br>• Facilitate 10 twice-weekly after-school groups using meaningful activities to practice evidence-based strategies for increasing hopefulness. Use group process to support Lisa's successful adaptation in carefully designed community-based activities to build on strengths (e.g., art classes at local studio, photography class).<br>• Assist the teacher by using task analysis to identify seating, presentation of materials, and dyad changes to support increased student attention in the reading group.<br><br>*Outcomes*<br>• Lisa develops sufficient keyboarding speed to choose to type longer assignments. Her teachers report increased initiation and engagement in classroom tasks.<br>• Lisa demonstrates improved classroom performance with decreased negativity and increased efficiency in written expression. After 6 months of intervention, Lisa no longer requires support from OT.<br>• The teacher reports an increased sense of mastery with both Lisa and the reading group and an appreciation of OT as a resource. |
| **Ivan,** a 17-year-old high school student, was recently diagnosed as having first-episode psychosis. He lives at home with his parents and a younger brother. | • Declining grades at school<br>• Disengagement from extracurricular activities<br>• Strained social relationships with family and peers<br>• Social isolation<br>• Interpersonal conflict with his mom | *Interventions*<br>• Evaluate Ivan to determine strengths and needs as a member of the transdisciplinary early psychosis team (Early Assessment and Support Alliance, 2013; Melton et al., 2013); using the Adolescent/Adult Sensory Profile (AASP; Brown & Dunn, 2002) to determine Ivan's and his mom's sensory needs in response to the challenges they described. |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
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| Previously an A and B student, Ivan has been getting Cs and Ds and is at risk for failing some of his classes. Before the onset of his symptoms, Ivan was involved in school clubs and activities, but he recently quit all of his extracurricular activities.<br><br>Ivan's relationships with his family and friends have become strained because he has become suspicious of others and isolates himself in his room much of the time.<br><br>Ivan's mom complains that he often plays music at top volume in his room, which causes her distress, and that he becomes angry when confronted about the loud music and states that she just wants to control him. | | • Analyze AASP results, which reveal higher scores in low registration, sensory sensitivity, and sensation avoidance for Ivan (Roush, Parham, Downing, & Michael, 2014) and high scores in sensory sensitivity and sensory avoidance for his mom.<br>• Identify strategies for Ivan's IEP to enable him to meet his sensory processing needs to improve his school performance and resume participation in valued activities (Krupa, Woodside, & Pocock, 2010):<br>▫ Move Ivan away from windows and air conditioning vent to the front of the class where he can focus on the teacher.<br>▫ Obtain permission for Ivan to suck on sour sugar-free candy to help him stay alert and focused during lectures and quiet work time.<br>▫ With Ivan, identify an extracurricular activity, the chess club, in which Ivan has more control over his sensory environment so that he can participate comfortably.<br>• Work with Ivan and his mom to arrange areas in the house to meet their sensory needs and help them communicate their sensory needs to each other:<br>▫ Designate the living room as a neutral space with lights and sounds kept to a moderate level with no extremes.<br>▫ Designate Ivan's room as a place where he can turn up music and use bright decorations to meet his low registration needs.<br>▫ Keep the kitchen quiet with lower lighting to meet his mom's sensitivity needs.<br>*Outcomes*<br>• Ivan's grades improve.<br>• Ivan's successful participation in the chess club leads to him slowly reengage in other extracurricular activities.<br>• Ivan's relationship with his mom improves through understanding each other's sensory needs. |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
|---|---|---|
| **Caitlyn,** a 17-year-old 11th grader, was diagnosed 2 months ago by her psychiatrist with generalized anxiety disorder and major depressive disorder . Caitlyn's depression and anxiety started as a result of thinking about transitioning from high school to college and leaving home.<br><br>Caitlyn reports decreased energy and interest in activities she used to do, such as dancing and shopping at the mall with friends. She recently stopped seeing her only two friends. She reports decreased interest in school and is falling behind in her schoolwork; her grades have begun to deteriorate, although she has not failed any classes.<br><br>She reports feeling anxious all the time, with heightened anxiety around several specific issues in the occupations of student and young adult. In a meeting with her guidance counselor, Caitlyn expresses being fearful of attending college, a new and unfamiliar environment. She is especially anxious about living in a dormitory with roommates and eating unfamiliar foods. She refuses to participate in her school's employment preparation program, stating she is uncomfortable working and interacting with people in community work settings. | • Declining grades at school<br>• Social isolation<br>• Decreased interest in leisure activities<br>• Impaired organization and coping skills to complete school coursework<br>• Difficulty managing changes and new activities in her daily routine<br>• Anxiety regarding leaving school and pursuing adult occupations, including college, work, and independent living | *Interventions*<br>• Complete an occupational profile and, in collaboration with Caitlyn, design interventions to help her cope with depression and anxiety and reengage in meaningful occupations with her friends.<br>• Include Caitlyn in twice-weekly group sessions, led by an occupational therapy assistant, to promote social skills, ADLs, problem solving, stress management, and coping skills (Orentlicher & Olson, 2010; Precin, 2015; Stein & Smith, 1989).<br>• Recommend that Caitlyn attend summer school to reduce the course workload and manage stress during the school year; the small class size and individualized attention of summer classes will enable Caitlyn to participate in challenging subjects in a supportive setting.<br>• Work with Caitlyn to create a school schedule and to-do list, color coded by subject, to develop her skills in breaking large assignments into small manageable tasks and plot due dates on her new schedule, helping to reduce her symptoms of anxiety and depression and resulting behaviors (Beck, Guth, Steer, & Ball, 1997; Spitzer, Kroenke, Williams, & Löwe, 2006).<br>• Help create an opening in Caitlyn's weekend schedule to encourage her to engage in social leisure activities by spending time with her friends in relaxing activities that she enjoys, such as walking.<br>• As part of Caitlyn's transition team (transition specialist, teacher, school psychologist, and occupational therapist), meet with Caitlyn and her mother to review Caitlyn's transition plan and her strengths and goals for education, independent living, and employment (Orentlicher, 2015). |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
|---|---|---|
| | | ▫ *Education:* To ease Caitlyn's anxiety, she will attend the local community college with an established program for students with emotional and other disabilities. She will be supported by a special counselor and attend a weekly social and vocational skills program.<br>▫ *Independent living:* By attending the community college, Caitlyn will be able to live at home, which reduces her anxiety. Her mother agrees to provide Caitlyn with opportunities to shop for groceries and cook favorite meals. Caitlyn and her mother are encouraged to make connections with the local community mental health center, which can provide assistance with moving into a supported living apartment and offers weekly groups focused on independent living, social skills, and recreational programs.<br>▫ *Employment:* Because Caitlyn is having difficulty managing a full academic schedule, she decides not to attend the high school's employment program. To prepare for college graduation, Caitlyn will receive employment preparation services and vocational training from the community mental health center.<br>*Outcomes*<br>• Caitlyn demonstrates organizational skills by using her new calendar and colored-coded to-do list.<br>• Her grades improve, and she reports spending a few hours every weekend socializing with friends.<br>• Caitlyn states that she feels more at ease with the idea of eventually living on her own. |
| As an administrator in a state mental health system, an **occupational therapist** is responsible for maximizing prevention of ill health and disability and promoting wellness and community integration through productive and competent role participation. | • Decreased participation in meaningful and fulfilling healthy daily routines that include self-care and productive and social activities<br>• Avoidance of exertion and pain associated with walking, climbing stairs, grocery shopping, cooking, housekeeping, and exercise | *Interventions*<br>• Provide technical assistance and training of peer providers in the topics addressed in NEW–R classes:<br>▫ I can make a change<br>▫ ABCs of healthier eating<br>▫ Reading food labels and portion control<br>▫ Let's get moving |

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**Table 1. Case Examples of Occupational Therapy Interventions for Clients Affected by Mental Health Issues** *(cont.)*

| Description | Occupational Performance Challenges | Occupational Therapy Interventions and Outcomes |
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| The occupational therapist is aware that obesity is highly prevalent among people with mental illness and leads to medical conditions and related pain, lethargy, diabetes, and heart disease, which can be prevented or better managed with improved nutrition and physical activity (AOTA, 2013a).<br><br>As part of a statewide implementation of integrated evidence-based employment; nutrition, exercise, and weight management; and peer-led recovery interventions (Rebeiro Gruhl, LaCarte, & Calixte, 2016), the occupational therapist implements Nutrition and Exercise for Wellness and Recovery (NEW–R; Brown et al., 2015; University of Illinois at Chicago Department of Psychiatry, 2012), a revised, peer-led version of RENEW (Recovering Energy through Nutrition, Exercise, and Weight Loss), a weight loss and nutrition management program designed specifically for people with psychiatric disabilities (Brown, Goetz, & Hamera, 2011; SAMHSA, 2016). | • Historic exclusion from the workforce because of unfounded beliefs about the stress of work exacerbating mental illness<br>• Social isolation<br>• Diminished community integration and participation | ▫ Eating out<br>▫ Meal planning and thrifty shopping<br>▫ Let's get cooking without all the fat<br>▫ Celebrating accomplishments and keeping up the good work.<br>• Conduct 1.5-hour sessions that include inspirational quotes, experiential educational activities; a fitness activity; action planning; and sharing of results, strategies, successes, and challenges, followed by a healthy meal or snack prepared by classmates.<br>• Supervise occupational therapy students in collaborating with people in recovery to develop 20-minute exercise modules that facilitate preferred ways to exercise (e.g., dance, calisthenics, yoga, free weights).<br><br>*Outcomes*<br>• NEW–R is implemented statewide and integrated with evidence-based supported employment.<br>• Participants feel positive about making small changes in their dietary and exercise habits, losing weight, and getting and keeping employment.<br>• Health care costs secondary to disability and excess weight are reduced.<br>• Employment increases participants' community integration and decreases their poverty and social isolation. |

*Note.* ADLs = activities of daily living; IEP = individualized education program; SAMHSA = Substance Abuse and Mental Health Services Administration.

## *Evaluation*

Guided by occupational therapy theories, frames of references, and practice models, occupational therapists select relevant screening and assessment procedures to identify interests, priorities, strengths, needs, problems, and concerns regarding clients' occupational engagement and successful performance of daily life tasks. In addition to these personal factors, occupational therapists' assessments of performance and participation include an analysis of activities, occupations, contexts, and environmental characteristics to determine those that challenge or support clients' interests, skills, and performance (AOTA, 2014c). Occupational therapy assistants may assist in data collection but are supervised by occupational therapists, who are responsible for the evaluation process.

An occupational therapy assessment may establish medical necessity for habilitation and rehabilitation services directed toward functional impairments associated with psychiatric conditions by articulating how symptoms and underlying neuropsychiatric conditions interfere with performance of daily life tasks.

Occupational therapists synthesize this information with presenting medical, social–emotional, psychiatric, intellectual, and educational strengths, concerns, and diagnoses to work collaboratively with clients toward goal development and attainment through recovery-oriented approaches. Occupational therapy practitioners use a range of standardized and performance-based assessments to evaluate occupational performance factors, and these assessments contribute to discerning the effectiveness, adequacy, independence, and safety of performance and the client's satisfaction with and perception of his or her performance (e.g., the Allen Cognitive Level Screen–5 [Allen et al., 2007], Assessment of Motor and Process Skills [Fisher & Jones, 2012], Canadian Occupational Performance Measure [Law et al., 2014], Model of Human Occupation Screening Tool [Parkinson, Forsyth, & Kielhofner, 2006], Performance Assessment of Self-Care Skills [Holm & Rogers, 2008]).

Occupational therapy's emphasis on performance-based assessment frequently illuminates alternative strategies for behavioral activation and skill development by identifying challenges and barriers that may go unidentified or be seen as solely behavioral when environmental, contextual, and physical factors are not adequately considered (Krupa, Edgelow, et al., 2010). Thus, when intervention is not successful in helping a person achieve his or her personal goals or perform desired and needed occupations, an occupational therapy evaluation may help suggest alternative approaches.

### *Intervention, Promotion, and Prevention Strategies*

Occupational therapy practitioners promote mental health through enhancing clients' competency in valued roles and activities. This goal is accomplished through the manipulation of factors that influence participation and performance, such as identification and strategic and intentional use of strengths, skill development, task adaptations, environmental supports and modifications, emotional and sensory regulation strategies, cognitive adaptations, biomechanical interventions, and habit and routine development. Practitioners work in partnership with clients' natural support systems (e.g., caregivers, teachers, mental health workers, parents, family members, significant others, employers, landlords). For clients for whom natural supports are few, practitioners facilitate the development of resources and supports that enable successful and competent occupational participation.

Interventions can be provided to an individual or group as direct care or through consultation to populations or systems of care to promote and address mental health issues. Occupational therapy interventions to populations include program development, design, and implementation.

Because occupational therapy practitioners are broadly educated to examine all conditions that affect occupational performance and participation, they are distinctly equipped to bridge the divide among medical, educational, and social services delivery models. Practitioners integrate the client's physical and psychosocial rehabilitation needs into a comprehensive intervention plan that factors in medical and addiction comorbidities. With the widely recognized need to integrate physical and mental health care for people with behavioral health conditions, occupational therapy practitioners are emerging as distinctly equipped to work in integrated and primary care settings for psychiatrically at-risk populations and in settings with clients in need of integrated behavioral, medical, rehabilitative, and habilitative care. Interventions support desired changes in health and wellness, such as taking medications; getting enough sleep; developing and maintaining relationships; getting adequate physical activity; and performing routine daily activities such as self-care, school, work, volunteering, participation in community organizations, leisure and recreation, and caring for one's home.

### *Outcomes*

The *Occupational Therapy Practice Framework* (AOTA, 2014c) identifies eight outcomes as the goals of occupational therapy interventions: (1) occupational performance, (2) prevention, (3) health and wellness, (4) quality of life, (5) participation, (6) role competence, (7) well-being, and (8) occupational justice. Outcomes for people with mental health needs in occupational therapy may include a focus on improvement of individual skills and abilities that enable increased competence and participation in valued roles. Outcomes may also include increased health, wellness, and sense of well-being as a result of participation in meaningful leisure, volunteer, employment, or advocacy activities.

Occupational therapy interventions can produce pragmatic outcomes in the lives of people with mental health needs. Fieldhouse (2012) found that adults with mental health needs reported an increased sense of belonging, efficacy, and contribution in community roles when they were supported by occupational therapy practitioners who focused on occupations and engagement in the mainstream community. Occupational therapy interventions in the Action Over Inertia program with Assertive Community Treatment recipients experiencing extreme activity disengagement resulted in significant gains in time spent in activity after 12 weeks (Edgelow & Krupa, 2011). People with severe mental illness participating in forensic occupational therapy demonstrated increased motivation for occupation, process skills, and communication and interaction skills (Taylor & Chia-Wei, 2015). Veterans with posttraumatic stress disorder, depression, and traumatic brain injury demonstrated significant improvements in symptom reduction and occupational performance and satisfaction after participation in programming that included both occupational therapy and trauma-focused cognitive–behavioral therapy (Speicher, Walter, & Chard, 2014). Older adults can benefit from strategies that target building healthy habits and routines to promote wellness and participation and prevent decline, such as Lifestyle Redesign (Chippendale, 2014).

In a systematic review of the literature, Arbesman, Bazyk, and Nochajski (2013) reported strong evidence for occupation- and activity-based interventions for children at schoolwide, targeted, and individual levels. Outcomes included improved prosocial behaviors and self-management; decreased problem behaviors; increased participation in play, leisure, and recreational activities for children with disabilities; and improved academic performance. MacFarlane et al. (2010) demonstrated a dramatic reduction in the development of psychosis in youth with prodromal symptoms after involvement in an intensive community-based program that included occupational therapy as a core component.

## Summary

Occupational therapy practitioners' support of the mental health of clients transcends settings and diagnoses (AOTA, 2016). Practitioners use themselves, activities, occupations, and groups therapeutically across settings, supporting effective adaptive responses to illness, injury, and disability, whether those conditions are psychiatric or originate in other parts of the body. Occupational therapy practitioners have rigorous training and preparation in the treatment and support of people with mental health disorders and have a unique focus on building habits and routines that support mental health and positive outcomes.

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*Adopted by the Representative Assembly Coordinating Council (RACC) for the Representative Assembly 2017*

*Revised by the Commission on Practice 2016*

**Acknowledgments**

The Commission on Practice acknowledges the authors of the 2010 version of this document: Cynthia Barrows, MS, OTR/L, CPRP; Katherine A. Burson, MS, OTR/L, CPRP; Cathy Clark, MS, OTR/L; Jyothi Gupta, PhD, OT(C), OTR/L; Jamie Geraci, MS, OTR/L; Lisa Mahaffey, MS, OTR/L; and Penelope Moyers Cleveland, EdD, OTR/L, BCMH, FAOTA.

This revision replaces the 2010 document *Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice,* previously published and copyrighted in 2010 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy, 64*(Suppl.), S30–S43. https://doi.org/10.5014/ajot.2010.64S30



*Citation*. American Occupational Therapy Association. (2017). Mental health promotion, prevention, and intervention in occupational therapy practice. *American Journal of Occupational Therapy, 71*(Suppl. 2), 7112410035. https://doi.org/10.5014/ajot.2017.716S03

## Appendix. Glossary of Terminology for Mental Health and Occupational Therapy

**Early Assessment and Support Alliance (EASA)**
Community organization in Oregon that advocates for early identification and treatment of psychosis.

**Every Student Succeeds Act (ESSA)**
Legislation replacing provisions of the No Child Left Behind Act of 2001 (Pub. L. 107–110).

**Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub. L. 104–191)**
Legislation protecting individuals' medical records and other personal health information.

**Joint Commission: Accreditation, Health Care, Certification (JCAHO)**
Nonprofit organization that accredits and certifies health care organizations.

**Positive Behavior Interventions and Supports (PBIS)**
U.S. Department of Education technical assistance center that applies a public health model in K–12 education with universal, targeted, and intensive levels of support.

**recovery**
Effective management of symptoms of mental illness to enable health, well-being, stable housing, relationships, and purpose; a specific philosophy of service delivery that includes respect, hope, self-direction, and individualized and strength-based services and supports and that recognizes the importance of peer-to-peer supports, responsibility, and a nonlinear process.

**Social and emotional learning (SEL)**
process by which schoolchildren learn and apply social and emotional knowledge for effective coping and relationships.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**
Branch of the U.S. Department of Health and Human Services that administers initiatives and grant funds to support policy shifts toward best practices.

**wraparound**
Intensive, strengths-based, family-driven, youth-guided, community-based intervention that frames least restrictive support for children with significant behavioral health needs who would otherwise be treated in residential treatment centers.