UNIVERSITY of INDIANAPOLIS®

School of Occupational Therapy

An Occupation-Based Approach for Program Development within an Acute Mental Health Setting

Ashley Scheidler

May, 2018

A capstone project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

Under the direction of the faculty capstone advisor:

Sally Wasmuth, PHD, OTR

A Capstone Project Entitled

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By

Ashley Scheidler, OTS

Approved by:

Faculty Capstone Advisor	**Date**
Doctoral Capstone Coordinator	**Date**

Accepted on this date by the Chair of the School of Occupational Therapy:

Chair, School of Occupational Therapy	**Date**

Abstract

Acute psychiatric facilities serve individuals with serious mental illnesses in hopes of providing adequate care to promote a successful community reintegration, although many facilities lack having an occupational therapist on staff to help in the recovery process. In this doctoral capstone experience (DCE), an occupational therapy (OT) student from the University of Indianapolis advocated for the OT profession by creating and implementing a seven-week occupation-based program with adult patients at LaRue D. Carter Memorial Hospital, as there was no OT practitioner on staff. The participants were chosen through a convenience sample and to measure outcomes, the OT student utilized structured and unstructured assessments. The program focused on activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that were deemed meaningful during the completion of the needs assessment. Through the results of a pre-post survey and participant feedback, there was an increase in knowledge of the OT scope of practice. The Goal Attainment Scale (GAS) was an outcome tool used to measure the effectiveness of the program, which met the expected level of outcome. The results of the program showed the need of an OT practitioner at this specific site, as OT provides holistic, occupation-based therapy. For future practice, the need for more OT practitioners within the mental health setting, especially acute care facilities, is evident and vital during these individuals' recovery process.

Introduction

Serious Mental Illnesses

Individuals with serious mental illnesses are viewed differently in society, yet there is little light shed on the underlying physiological aspects that are affecting these individuals. In a report from 2015, The National Institute of Mental Health reported 10 million Americans over the age of 18 are living with a serious mental illness, but many do not receive treatment (2018). A serious mental illness is defined as individuals 18 and older either living with or diagnosed within the past year with a mental, behavioral, or emotional disorder that results in serious functional impairment (APA, 1994; SAMHSA, 2013). According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2013), common serious mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, borderline personality disorder, major depressive disorder, and psychotic disorder. The exact cause of a serious mental illness is unknown; however, environmental, biological, and psychological factors play a role. Individuals may have altered brain chemistry due to substance abuse, family history of mental illness, and/or difficult upbringings involving trauma. These factors increase the chances of having a serious mental illness (SAMHSA, 2013). Individuals with serious mental illnesses have decreased motivation, poor self-care, limited social skills, and the biggest burden is unemployment (Dewa, McDaid, & Ettner, 2007; Harvey, Green, Keefe, & Velligan, 2004). The goal is for the individuals to learn to lead a productive life while managing symptoms to promote successful community reintegration.

A Gap in Healthcare

According to Mental Health America, Indiana is ranked 48 out of 51 states overall, indicating higher prevalence rates and lower access to care for those with a mental illness (2017). Across America, 56% of American adults with a mental illness do not receive treatment and there is up to a 6:1 ratio of individuals with a mental illness to mental health professionals (MHA, 2017). There is an obvious shortage of professionals available to help individuals with these diagnoses, however many do not take the necessary steps for treatment, as showcased above. There are an estimated 26% of homeless adults that are living with a serious mental illness (U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2011). Within the department of corrections, 20% of state prisoners and 21% of county jail prisoners have a mental health condition with 2 million that are incarcerated each year (Glaze & James, 2006; NAMI, n.d). At least 83% of individuals do not receive the appropriate help and care within the jail system causing their symptoms to worsen (NAMI, n.d.). There is an evident gap in healthcare between various populations within the United States. Individuals with a serious mental illness have an increased risk of having a chronic medical condition and these individuals on average die 25 years earlier than others (Colton & Manderscheid, 2006). This unimaginable statistic is related to the access to healthcare. All of these statistics produce staggering numbers that indicate serious concerns and issues relating to healthcare and quality of life for individuals with mental illness. The National Institute of Health (n.d.) discussed the 21st Century Cures Act passed in 2016 is monumental in the recovery of individuals with mental illnesses. It allows more opportunity for research to have clinical trials in hopes of new therapies for these individuals (NIH, n.d.). This advance in healthcare may be eliminated due to political changes; however it is still important to advocate for changes in the mental health setting to advance opportunities.

Recovery Model

SAMHSA has defined recovery as "the process of change which individuals improve their health and wellness, live a self-directed life, and strive to reach their highest potential" (SAMSHA, 2017, para 2). The recovery model is utilized to assist individuals with leading a successful daily life while managing symptoms. The four dimensions included in this model are health, home, purpose, and community (Duckworth, 2015). The recovery process is client-centered and is supported through various treatment services, community-based programs, peers, and family (SAMSHA, 2017). Ten components are discussed within the model to support individuals during the recovery model, such as, hope, respect, relational, culture, peer support, holistic, many pathways, person-driven, strengths/responsibilities, and trauma (SAMSHA, 2013). The fundamental aspects of the recovery model coincide with the philosophy of occupational therapy (OT). Many principles of the model are reflected in the Model of Human Occupation (MOHO), a model utilized in OT practice to integrate volition into the individual recovery process (Cole & Tufano, 2008).

Model of Human Occupation

According to Cole & Tufano (2008), the MOHO is an open system that focuses on a holistic and systemic approach for individuals of all ages with various needs. The open system consists of multiple factors that work together, which all effects an individual's motivation, behavior, and performance. This model emphasizes both internal and external aspects of an individual's life and how they are connected. The MOHO divides the person into three sub-categories, which are volition, habituation, and performance capacity. Volition includes values, interests, and personal causation. Habituation is habits and roles that become routines for the

client. Lastly, performance capacity is the ability to act with the appropriate skills needed. The MOHO is a client-centered model; however, the environment can play a role in the outcome of the performance (Cole & Tufano, 2008). Wimpenny, Forsyth, Jones, Matheson, and Colley found that when theory is used and health professionals collaborate with one another, the implementation of the theory, specifically the MOHO, will advance practice and the intervention process (2010). The MOHO is commonly used within the mental health setting because it is client-centered. Individuals with mental illnesses have decreased self-esteem and a loss of self-worth, so putting the person at the center of the OT process will potentially increase the individual's volition and overall quality of life.

Occupational Therapy in Mental Health

According to the American Occupational Therapy Association (AOTA), OT practitioners work collaboratively with individuals with mental illnesses to increase motivation, empowerment, and to foster hope, in order to increase participation and satisfaction in meaningful occupations. OT practitioners also hope to help individuals be as independent as possible in their daily lives through evaluation and intervention tools. Interventions include identifying healthy habits and routines, learning coping strategies, identifying personal values, needs, and goals, and even making a recovery action plan (AOTA, 2016). Intervention sessions take place individually or in groups. The OT Practice Framework suggests individuals must have appropriate client factors, performance patterns, and performance skills in order to be successful in completing the occupation (2014). In mental health settings, OT practitioners need to be client-centered to allow the individual to make goals and individualized choices during the OT process in order to increase participation and have positive outcomes (Arbesman & Logsdon, 2011). OT can serve individuals through community-based programs, inpatient facilities,

schools, forensic centers, outpatient facilities, and skilled nursing facilities (AOTA, 2016). According to the Occupational Therapy Compensation Workforce Study, only 2.9% of OT practitioners work in a mental health setting (AOTA, 2010). There is an obvious shortage in the mental health setting of OT practitioners and there are many reasons as to why this is. According to Buchmueller, Cooper, Jacobson, and Zuvekas, the shortage is due to a larger crisis where services may not be reimbursed within the mental health setting (2007). With this shortage, OT practitioners need to become members of state and national organizations, conduct research to show evidence of how important OT is within the mental health setting, and practitioners need to advocate to administrators on the important role of OT (Gutman, 2011).

Inpatient Mental Health Facilities

According to Mental Health America (MHA), hospitalization becomes necessary for an individual with a mental illness when their illness becomes serious enough that they are at risk for harming themselves and/or others (2016). LaRue D. Carter Memorial Hospital is a state psychiatric hospital that has been serving individuals with serious illnesses since 1948 (IN.gov, 2018). These patients are treated through an interdisciplinary approach that focuses on a holistic, client-centered basis. The hospital has a three-fold mission of providing research, education, and treatment to patients. There are two service divisions within the hospital that provide treatment to adults age 18 and over such as, journey to recovery and channel for change (IN.gov, 2018). The pathway to healing is the division for children and adolescents with severe emotional disturbances (IN.gov, 2018). There are various professions on the treatment teams, such as physicians, psychologists, social work, dietitians, and recreational therapists; however there is no OT. The role of OT within the mental health setting, especially on the inpatient level, is vital to the individual's recovery and reintegration into the community in order to lead a productive life.

This experience will look into the effectiveness of the OT process through group treatment sessions within the acute mental health setting.

Methods

Participants

The occupation-based program took place on an adult unit at LaRue D. Carter Memorial Hospital in a nutrition room. All participants had a serious mental illness diagnosis that had impacted their daily life to the extent of having a court order to be patients at this hospital. The participants' ages ranged from 19-60 years old. The program was conducted in person between the leader (OT student) and patients throughout the entire process. The individual portion was held during the screening and evaluation process, while the group portion was held during the intervention phase. Group therapy in the acute mental health setting is a core part of OT, which is the reason the program at LaRue Carter had multiple participants (Cole, 2008).

Study Design

Screening.

A mixed methods approach was utilized throughout the screening and evaluation process, which was reflected by tools that included quantitative and qualitative data. The screening process determines individual strengths and limitations through existing data, observations, and tools to determine the need for additional assessments (Hinojosa & Kramer, 2014). The screening process is an essential part to determine what evaluations are needed; therefore, leading to a productive intervention phase. Without the supervision of a registered occupational therapist (OTR), there could not be any OT specific standardized screening and/or evaluation

tools used. The Mini Mental State Examination (MMSE) is a generalized screening tool used throughout healthcare. It was created for adults who have psychiatric, neurological, and other conditions (Folstein & Folstein, 2010). The MMSE screening tool is used to determine the individual's cognitive function (Ong et al., 2016). This screening tool is important in the mental health setting to not only plan for productive treatment sessions, but also to promote cognizance of the participant's cognition. Ong et al. (2016) reported cognition is a key impairment in individuals with schizophrenia. Decreased levels of cognition can affect an individual's functional ability, such as completing self-care tasks, independence, social skills, and work skills (Lepage, Bodan, & Bowie, 2014). AOTA encourages OT practitioners to focus on the relationship between the individual's cognition, functional performance, and environmental context (AOTA, 2017). Therefore, it was essential to address these areas in the screening and evaluation process.

Evaluation.

According to Cole & Tufano (2008), the evaluation process should be client-centered and thoroughly done. Utilizing data to learn more about the individual from an outsider looking in and understanding how individuals perceive themselves are two steps in the evaluation process that ensure adequate information is obtained (Cole & Tufano, 2008). Since there were no OT standardized assessments used, it was imperative to include various levels of structured and unstructured assessments in order to consider all aspects of OT that were meaningful to the individual. Clinical observations were conducted on the unit and during various groups to observe individual's actions and behaviors in different situations. Areas focused on during the observation period included appearance, mood, eye contact, orientation, etc. Structured interviews and patient checklists were also a part of the evaluation process. Interview questions

included occupational profile questions to build rapport with the participants. Questions highlighted sensory processing, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and triggers that bought on certain behaviors. Since the MOHO guided this experience, it was imperative to base the program off the client's needs and wants. The participant completed a short checklist to allow some control during the evaluation process. These questions determined meaningful occupations for each participant. Scanlan and Novak (2015) found that sensory approaches are essential in mental health because it can help individuals regulate behaviors through self-direction and empowerment. Through this process, there has been a reduction in restraints and seclusion (Scanlan & Novak, 2015). Therefore, it was important to include sensory-based questions. Edelow and Krupa suggested individuals with serious mental illness have limited participation in meaningful occupations, personal growth, and social participation, indicating the importance of addressing these issues during the evaluation process (2011). The data collected determined the structure for the intervention process.

Compare/Contrast Areas of Occupational Therapy

Throughout the scope of OT, the goal for the screening and evaluation process is to gain valuable information about the individual in hopes of creating a client-centered intervention process. The difference is the various screening and evaluation tools, specific to a population or setting, that gather this information. OT is unique in its own way because practitioners address an individual's mental health needs in all practice settings (AOTA, 2016). Specifically in mental health, the goal is for the client to live a productive life while managing his/her symptoms through meaningful interventions. Simpson, Bowers, Alexander, Ridley, and Warren (2005), conducted research on an acute mental health floor and found OT practitioners assessed patients

and provided group therapy, which was similar to the occupation-based program at LaRue Carter. However, the OT practitioners focused more on ADLs, whereas the program completed in this study focused on IADLs (Simpson et al., 2005). Spence, Schwarzschild, and Synovec (2015) reported OT practitioners at John Hopkins Hospital on the psychiatric floors conducted various therapeutic groups that focused on IADLs. The groups specifically focused on one IADL throughout the program, which was based on cognition and community reintegration goals for each patient. The practitioners had eight or less participants in each group, which is similar to the program at LaRue Carter (Spence et al., 2015). The program at Johns Hopkins focused on one IADL at a time, whereas the program at LaRue Carter focused on both ADLs and IADLs. In acute mental health settings, it is common to have group therapy that focuses on IADLs, such as money, time, and medication management, and activities that motivate the clients to have a healthy life to promote purposeful and meaningful skills.

Needs Assessment Results

A convenience sample was utilized during the screening and evaluation process, which resulted in eight participants. Based on the results from the MMSE, one participant scored in the moderate cognitive impairment range, three in the mild cognitive impairment range, and four in questionably significant impairment range. Some participants did require assistance with reading and writing. During the interview, all participants reported their biggest problem was being a patient at LaRue Carter and their goal was to be discharged. All participants reported the desire to hold a job. Seven participants reported the need to increase self-esteem and skills for money management. Four participants reported difficulty in completing daily self-care tasks. Three participants reported loud sounds and certain clothing bother them. The participants were observed on the unit during recreational therapy groups. Seven participants had appropriate

behavior, however; one participant did voice negative comments at times. All participants needed reminders to stay on task at least once and most had flat affect. All participants were oriented appropriately and some participants were observed wearing the same clothing on consecutive days. Six participants were chosen to be a part of the program through a treatment team decision after compiling results. The treatment team included a physician, pharmacist, social worker, registered nurse, and a recreational therapist.

Outcome Measures

Participants completed a pre and post-test survey during the first and last session to determine the effectiveness of the program through their lens. The survey was five questions that included multiple choice, true and false, and short answer questions. The questions were based off of information presented to the participants throughout the duration of the program. The goal was for the participants to gain knowledge in these various areas by the time the post-test survey was administered.

The Goal Attainment Scale (GAS) was utilized as an outcome tool to determine the effectiveness of the program through goal writing. The level of attainment was laid out through numbers and expectations. The present level was scored as a -2, meaning it was much less than expected. There was no OTR on staff, so there were no occupation-based programs before the OT student arrived and the staff had not been educated on the role of OT at LaRue Carter. The next level was -1, which meant the goal was somewhat less than expected. This goal was met during the progression of the doctoral capstone experience (DCE). Zero was the expected level of outcome, meaning it was the annual goal. The expected goal of the program was to plan and implement a seven-week occupation-based program on an adult unit that focused on various

ADLs and IADLs. The second goal was to educate staff and patients on the role of OT at this site through in-services or handouts. The next level was +1, which meant it was somewhat more than expected and it exceeded the annual goal. The highest level of attainment was +2, which meant much more than expected and it far exceeded the annual goal. The OT student strived to meet the expected level of outcome, but was satisfied with any score higher. The leader of the group determined if the goal was met at the end of the program.

Procedure

Implementation

The program at LaRue Carter, led by an OT student, took place one day a week for 45 minutes for seven weeks. Throughout the entire program, the title and goals of the program were reviewed weekly. Each session included a purpose, educational concepts, instructions, a sharing component, and questions for discussion. All sessions were led by the OT student; however, there were times when the participants were encouraged to lead the group.

During the first session, each participant filled out a pre-test survey. The same survey was completed again during the last session to determine the effectiveness of the program. The first session highlighted self-esteem and confidence through an activity and openly sharing with the other participants. The activity focused on the participants and how they viewed themselves in society. The participants were asked to pick words from a pile that described them, and at the end of the session, participants went around and discussed the reason for the words chosen. The goal for this session was to build rapport with the participants' and increase their comfortability levels within the group dynamic.

The second session focused on social participation and interaction. On the unit, many participants tended to sit alone and did not interact with others often. Participants completed a worksheet that highlighted meaningful occupations and items. Once completed, the participants' were asked to openly share. Participants then role played social scenarios with one another on how they would react if they were in certain situations. The goal was for the participants to branch out of their comfort zone and interact with one another.

The third session focused on money management. Participants filled out a money log to track their spending and also discussed wanted versus needed items. Participants were educated on the difference between the two terms. Participants then were divided into groups based on where they were sitting to complete a next dollar up activity that included fake money and printed off items with prices on them. The participants worked together on how much money was needed to purchase the item. Based on the results from the needs assessment, participants tended to spend money on unnecessary items, so the goal was for the participants to keep track of their money and what they buy.

The fourth session addressed self-care routines and the participants created their own daily checklist. The checklist not only focused on hygiene, but self-care for the body, mind, and soul. Participants were shown examples of other individual's self-care checklist and then were asked to create their own. The participants' were able to fill out their checklist with important items that they wanted to complete on a daily basis regarding this topic. There was also a reward system with the checklist to add a motivating factor for the participants. The goal was for the participants' to be aware and responsible for completing self-care tasks on a daily basis.

The fifth session focused on creating a sensory diet for the participants in order for them to have optimal arousal levels. The participants were given examples of calming and energizing activities and even examples of various sensory diets. Participants created their sensory diet for different parts of the day and examples included, washing face with cold water, pacing, listening to music, wrapping up in a blanket, and eating crunchy foods. After interviewing staff, many participants did not know how to control their behaviors in an appropriate manner, so this was an opportunity for them to address self-control and emotional regulation. The goal for this session was to increase the participants' self-control and emotional regulation on a daily basis.

The sixth session addressed cognitive remediation through purposeful activities that addressed selective and working memory. The participants' filled out word searches, comprehension worksheets, and sequencing worksheets in order to stimulate their brain. The participants' had a discussion on the importance of completing these activities and why it was important within their daily life. The results from the MMSE indicated cognitive impairments for multiple participants, so completing this activity activated and hopefully increased various parts of the participant's memory. The goal for this session was to address any cognitive deficits and learn how to adapt to any challenges that arise on a daily basis.

The last session included the post-test survey and addressed the participant's successes in life. The post-test survey included the same questions and format as the pre-test survey. The participants then completed a success worksheet about their life. The purpose of the worksheet was to end the program on a high note where the participants felt an increased sense of worth. At the end of the session, the OT student and participants reflected on the program. The goal of the last session was to wrap up the program and complete the post-test survey in hopes that the participants gained more knowledge throughout the program.

All session topics were determined through the results of the needs assessment and input from the treatment team. The overarching goals for the program were to improve and address self-esteem, self-care, social participation and interaction, money management, sensory-based concerns, and cognitive remediation in order for the participant to have a productive daily life. All activities chosen were designed to help the participants' reach the program goals.

Leadership Skills and Staff Education

Since there were no OT practitioners at this site, it was essential to demonstrate effective leadership skills to advocate for the profession and the importance of creating the program. Many professionals do not fully understand OT's scope of practice, so educating these individuals is key to the growth of OT in mental health. The OT student demonstrated effective communication skills, responsibility, and confidence when advocating for the importance of the program. Meetings with the rehabilitation director, treatment team professionals, and various staff led to the creation of the program. Discussions with multiple recreational therapists about the overlap with OT and the distinct value of OT took place to determine potential session topics. Throughout this experience, strategies that were identified were the vision and mission of LaRue Carter. Advocating and educating staff on the OT program was rooted from these distinct statements. During the implementation phase of the program, the OT student demonstrated various leadership skills in order to lead an effective program. The OT student was confident, yet personable during sessions. The OT student maintained ethical standards throughout sessions, as there were many contraband items and discouraged verbiage when interacting with participants. Contraband items were prohibited due to safety concerns for the participants, which included scissors, sharp objects, strings, etc. To promote OT, handouts were distributed to staff and patients on the role of OT at this site and the overview of the completed program during

April for OT month. During monthly rehab meetings, progress of the program was presented and feedback with potential ideas from other professionals were accepted to promote interprofessional care. Any additional strategies and skills were introduced as the program progressed.

Discontinuation

Outcomes

As the program progressed, changes arose that were addressed by the OT student. During the first week, participants were shy and did not openly share unless called on. Even with explanation, some participants were confused on the purpose of the program. Although, all participants did fill out the pre test and did complete the assigned activity. The OT student's approach changed in order to continue building rapport and ensure participants' success throughout the program.

During week two, social participation and interaction were addressed. The activities chosen were meant to move participants out of their comfort zone, as many did not interact with one another regularly. It was evident some participants did not feel comfortable, so the OT student allowed for a more open session and did not require any participant to answer something they did not want to. Participants seemed to like this idea through communication and facial expressions. Some participants then shared with one another and volunteered throughout the session with prompting.

During week three, the session focused on money management. Participants practiced the next dollar strategy with fake money and printed out items with prices on it. One participant became agitated, stating "I already know how to count money," and had to be verbally redirected

by the OT student. Other participants voiced how beneficial this session was. After week three, one participant dropped out of the program due to treatment plan changes, leaving five participants in the program.

During week four, self-care was addressed utilizing a checklist. Participants were asked to write down self-tasks they completed on a daily basis. A reward was given to four participants, who brought back the checklist the following week with it filled out. Many participants enjoyed this idea and were successful in sharing ideas with others and completing the activity. The same self-care checklist was given to the participants who wished to continue this weekly after this session.

Week five focused on creating a sensory diet. Participants were confused at times, but with additional direction, were able to fill out the chart. The OT student had to help most participants on an individual basis in order for them to correctly fill it out. The challenges were mainly due to the participants not understanding the purpose of this session, even with some verbal redirection. The OT student did want to challenge the participants since many do not have a grasp on their self-control. At the end of the session, most participants liked this chart and said they would use it on a daily basis.

During week six, the session focused on cognitive remediation, also known as cognitive rehabilitation. The session was cut short due to a routine fire drill. The participants enjoyed completing the various sequencing and crossword activities. The participants voiced that they would enjoy doing these activities on a daily basis to stimulate their brain. The sequencing worksheet was comprised of 16 steps for having a dinner party. The participants took more time than expected to get started, but they were all able to complete it independently. It was

interesting how the participants freely completed these types of activities, when others have been a struggle for them to participate in.

The last session focused on the five remaining participants filling out the post-test survey. One participant needed help reading the questions, while the other four participants were independent when completing the survey. The participants were also asked to complete a success worksheet, in order to end the session and program on a high note. One participant was disruptive during the session by saying inappropriate things and had to be verbally redirected several times by the OT student. Four participants were willing to share at the end of the session. When asked about the program as a whole, one participant voiced how positive this group was. Four participants said they would be in this group again if it was offered and they liked how the group was small.

Challenges arose throughout the sessions due to participants' underlying diagnoses and behavioral difficulties. The OT student was mindful when these times occurred and worked with the participants to address the situation. Participants required more direction and time than anticipated in order to complete activities, so session outlines were modified to meet the participants' needs. The goals of each session did not change; however there were fewer discussion questions and activities provided during sessions to ensure productive sessions for the participants. Being mindful of feedback from the participants was important to ensure quality improvement. Providing holistic care is an approach used throughout the scope of OT, so changing the program as needed was essential to meet the participants' needs, especially within the mental health setting. At the conclusion of each session, questions and feedback were welcomed by the participants.

To measure the outcome of the program, the GAS was utilized. Refer to Appendix A for detailed goals and objectives. All goals started off at the present level, which was -2. As the DCE progressed, the goals kept increasing in the level of attainment, which will be discussed below. Goal 1 was for the occupation-based program, which was to plan and implement a seven-week program on an adult unit. The expected level of outcome (0) was met at the cession of the DCE, which can be seen in Appendix A. Goal 2 discussed advocating for the role of OT at this site through either an in-service or handouts. The outcomes of this goal were somewhat more than expected (+1), as there was an in-service and handouts given to staff. Both goals were outcomes that provided positive support with the idea of having an OT practitioner on staff at this site. Goal 3 was completed during a different part of the DCE, which was not discussed in this paper.

The pre-test survey was given to the participants to gain information on their knowledge of OT during the first session. All participants identified at least one correct ADL; however, only one participant knew what OT was. All participants were able to at least identify one correct coping strategy. No participants were able to correctly identify an IADL from a list of options. Three participants needed assistance with spelling. The post-test surveys were administered during the last session to see if the participants had gained any knowledge throughout the entire program. Four participants were able to correctly identify at least one IADL. All participants were able to identify at least one ADL. Only one participant was able to correctly write out what OT meant. Three participants were able to identify more than one coping strategy. The OT student reviewed the surveys and determined that the program was successful and the participants did know more information on the post-test survey, even with behavioral difficulties during the last session.

Sustainability/Societal Needs

Sustainability was difficult to address since there were no OT practitioners on staff at LaRue Carter. The OT student compiled information into a binder that included session protocols, session worksheets, and a curriculum for sustainability of the program when there is an OT practitioner on staff. The OT student was a self-advocate, as well as an advocate for the role of OT at the site. The OT student provided education to staff on ways to provide an optimal environment for specific participants and other patients in the hospital in order to have a productive daily life. As the program evolved, staff voiced the need for an OT practitioner at this site. The rehabilitation director advocated to other staff members at various meetings to create an OTR position at LaRue Carter. Individuals throughout the hospital witnessed the benefits of OT within this population and setting.

Even though mental health is the root of OT, there are few OT practitioners actually working in this field, as discussed in the introduction. With no OT practitioner on staff, the OT student took on a leadership role during this experience in order to make necessary changes without overstepping any boundaries of other staff. According to MHA, individuals with mental health diagnoses have unmet health needs (2017). In order to assist in a successful community reintegration, individuals in an acute mental health setting would benefit from OT services in order to lead a productive daily life. The occupation-based program at LaRue Carter helped advocate for the role of OT and educated staff and patients on the benefits of occupation-based programs.

Discussion

Overall Learning

LaRue D. Carter Memorial Hospital is one of many acute psychiatric facilities in the state of Indiana that do not have an OT practitioner on site. This exploratory DCE looked into the benefits of having an OT practitioner on site and what occupation-based programs would look like. There were positive outcomes from the occupation-based program and advocating for the profession of OT that took place. The participants voiced improved knowledge through the pre-post surveys of what OT is and noted increased participation and success rates through daily activities, which in turn led to a more productive daily life. Staff was educated on the role of OT at this site and how beneficial it was to have an OT practitioner on staff. Overall, this experience captured what the OT student wanted to accomplish and an OT position at LaRue Carter will soon be open for applicants.

Many limitations were present during the experience, with no OT practitioner on staff as the biggest one. The OT student was limited in the way the OT process was completed during the DCE. Standardized assessments could have been utilized during the needs assessment to help individualize the program better. The number of participants was limited due to other groups going on at the same time and many patients not wanting to participate. The intervention process activities were limited due to patient population and risks for the participants, themselves, and staff. The program was still beneficial; however, it was limited due to multiple reasons.

Throughout this exploratory DCE, all routes of communication were kept professional by the OT student, participants, staff at LaRue Carter, and professors from the University of Indianapolis. Communication varied from face to face, emails, and phone conversations. The beneficial outcomes of this experience have been influenced from the effective communication between every individual involved.

Implications

After witnessing the positive effects from the occupation-based program, the OT student has more respect for mental health facilities because of the patient population. The OT student has a better understanding and knowledge of how to interact with individuals with serious mental illnesses in order to provide meaningful, effective therapy. The OT student has seen the evident need for an OT practitioner at this site through leading the program. Going forward, it is imperative to have OT practitioners on staff at acute psychiatric facilities. These facilities have various reasons as to why they do not hire an OT practitioner; however, it is our responsibility to advocate for the profession. OT practitioners are trained and licensed professionals who have the ability to provide therapy to individuals with serious mental illness to learn to cope and lead a productive daily life through the use of meaningful occupations. After this experience, the hope is for other professions and sites to see the benefits of hiring an OT practitioner and will do so in order to help in individuals with serious mental illness in their recovery process.

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Appendix A

GOAL ATTAINMENT SCALE FORM

Level Of Attainment	Goal 1:	Goal 2:	Goal 3:
-2 Much less than expected *(Present Level)*	Did not plan or implement an occupation-based program on an adult unit	Did not educate staff or patients on role of Occupational Therapy	Did not educate or give staff a handout on a potential sensory room for the youth unit
-1 Somewhat less than expected *(Progress)*	Plan an occupation-based program, but do not implement the program	Educate the RT staff on role of Occupational Therapy through handouts	Give staff a handout on a potential sensory for the youth unity, but do not educate staff
0 Expected level of outcome *(Annual Goal)*	Plan and implement a 7 week occupation-based program on an adult unit that focuses on ADLs and IADLs	Educate staff and patients on role of Occupational Therapy through in-services or handouts	Educate and give staff a handout on a potential sensory room for the youth units
+1 Somewhat more than expected *(Exceeds annual goal)*	Plan and implement a 7 week occupation-based program on 2 adult units	Educate all staff and patients on adult units on role of Occupational Therapy through in-services and handouts	Educate and give staff multiple resources and create a handout on a potential sensory room for the youth unit
+2 Much more than expected *(Far exceeds annual goal)*	Plan and implement a 7 week occupation-based program on 3 adult units	Educate 75% of hospital staff and patients on role of Occupational Therapy through various in-services and multiple handouts	Design, educate, and give staff multiple resources and create a handout on a potential sensory room for the youth unit