Occupational Therapy in Acute Inpatient Psychiatry: An Activities Health Approach

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Key Words: activities of daily living evaluation • activity therapy program • mental health services • milieu therapy

This article discusses some of the challenges that occupational therapists working in acute psychiatric inpatient settings commonly face. There is often a lack of sufficient time available for treatment as well as limitations inherent in addressing functional problems in the artificiality of a hospital environment. A theoretical framework is introduced from which the role of occupational therapy and realistic objectives for acute short-term care can be identified. This framework for inpatient occupational therapy practice is based on the concept of activities health, which provides a definition of health in functional rather than medical terms. The importance of emphasizing the patient's competence in roles assumed in community living is emphasized. A step-by-step approach to program development with specific examples is also provided.

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This article was accepted for publication February 2, 1990.

The activities that we do every day provide a foundation for our lives. Psychiatric illness often interferes with a person's ability to perform the activities that are part of everyday living. When one considers the kinds of symptoms that psychiatric patients exhibit (e.g., disturbances in thinking, judgment, reality testing, and communication; social withdrawal, anhedonia, and dysphoria), problems in daily functioning are not surprising. Functional difficulties are most severe when symptoms are exacerbated to the extent that hospitalization is required.

It is a widely accepted assumption in the mental health field that psychiatric illness has an impact on day-to-day functioning. It has been observed that in the course of patient assessments professionals from virtually all of the disciplines involved in the treatment of psychiatric inpatients comment on the degree to which these patients are able to carry out daily activities. Reasons for hospitalization are often described in terms of the person's inability to function adequately in the community, and improvement in psychiatric status is often first noted in improved hygiene and grooming, improved orientation to unit routines, a greater ability to keep one's hospital room orderly, and more appropriate social interactions.

The gradual shortening of lengths of stay for psychiatric inpatients has raised important questions about the role of occupational therapy in acute, short-term hospital settings. Occupational therapists, who are concerned with the improvement of daily functioning, are often frustrated by the lack of time available for treating long-standing functional problems (Jackson, 1984; Short, 1984). Given the realities of briefer stays in inpatient settings, how can the role of the occupational therapist best be defined? What kind of program would meet the overall occupational therapy objectives for patients at the acute stage of psychiatric care?

In this article, we will address these questions by briefly reviewing the changing patterns of service provision affecting inpatient psychiatry and by discussing the implications for the practice of occupational therapy in short-term hospital settings. We will then describe a model for occupational therapy practice in short-term, acute inpatient psychiatry that is in its early stages of development at the 100-bed inpatient service of the Department of Psychiatry at St. Vincent's Hospital and Medical Center of New York. Included is a step-by-step approach to program development that can be applied to a variety of inpatient psychiatric settings.

Changing Patterns of Inpatient Hospitalization

Since the deinstitutionalization of chronic psychiatric patients began in the 1950s, there has been a move-
ment toward shortening lengths of stay in most psychiatric facilities. With lengths of stay hovering at 30 days and under, diagnostic assessment, control of acute symptoms, and early discharge planning have logically assumed the greatest priority. The implementation of a prospective payment system in inpatient psychiatry (Scherl, English, & Sharfstein, 1988) will probably shorten hospitalizations even further. The results of a survey of New Jersey psychiatrists who have worked with a diagnosis-related groups system indicate that the primary impact on practice has been the increased pressure to discharge and refer. The psychiatrists noted that the inpatient milieu treatment model is being replaced by a model focused on crisis intervention, management of symptoms, and discharge of patients who are often at lower levels of functioning than previously (Sargent, Scherl, & Muszynski, 1988). Even in states where prospective payment systems have not yet been instituted, the priorities of short-term inpatient settings are quite similar.

Reasons for reductions in length of stay go beyond economics. Outcome research has suggested that patients resume adult roles in the community more quickly following short-term hospitalizations, perhaps because the person’s identity is maintained (Talbott & Glick, 1988). Length-of-stay studies have demonstrated no advantage for chronic schizophrenic patients treated for 30 to 90 days as compared with treatment periods of under 30 days (Talbott & Glick, 1988). However, it is noted in the literature that although the evidence suggests that there are advantages to briefer hospitalizations, follow-up outpatient treatment in day programs is seen as an important factor in the promotion of successful outcomes with this chronic psychiatric population (Talbott & Glick, 1988). This finding underscores the importance of careful assessment of the kinds of outpatient services the chronic psychiatric patient needs, in order to effectively address more long-term functional problems.

Dilemmas Inherent in Inpatient Occupational Therapy Practice

The acute exacerbation of chronic psychiatric illness often results in the deterioration of the patient’s ability to adequately fulfill roles assumed in everyday living. Because the physical environment, sociocultural surroundings, and pattern of activities of an inpatient psychiatric unit bear little resemblance to everyday living, and because the very nature of each activity changes when separated from its natural context, hospitalized patients lose contact with the familiar activities associated with life roles, which compounds the role dysfunction that is often triggered by the exacerbation of symptoms. Addressing issues of daily functioning in an inpatient setting therefore presents a fundamental challenge to the occupational therapist.

Guiding Principles and Overall Objectives

The approach to inpatient occupational therapy programming presented in this article incorporates the concept of activities health, which is based on the premise that health in an activities sense (or function) is possible even in the presence of a chronic illness. Activities health has been defined as a state of being in which a person is able to perform the activities of everyday living in ways that are comfortable, satisfying, and socioculturally acceptable (Cynkin & Robinson, 1990). The distinction between an activities health approach and more traditional approaches may be difficult to discern at the start. The primary difference lies in the degree of emphasis on diagnosis and symptoms. In a more traditional approach, the amelioration of symptoms is often a major focus of intervention. In an activities health approach, symptoms are of concern only insofar as they interfere with the patient’s ability to achieve activities health. For a particular patient, for example, a traditional approach might be to identify symptom-specific needs such as increased concentration, socialization, and self-esteem. In an activities health approach, the therapist would assess the patient’s ability to perform activities needed for the particular roles to be assumed in particular environments after discharge, in ways that are comfortable, satisfying, and socioculturally acceptable. Thus, an activities health approach emphasizes the importance of understanding both the typical patterns of activities as they occur in the patient’s everyday life and the inextricable connections that exist between the activities and the natural contexts in which they take place (i.e., time, place, and sociocultural surroundings).

Given the hospitalized person’s need to remain in contact with familiar activities associated with life roles and the limitations that are present when addressing activities-related problems out of context, the objectives of occupational therapy in acute, short-term inpatient treatment are as follows:

1. Provide the patient with a normalizing, structured routine, integrating meaningful activities from the various aspects of daily living (i.e., self-care, chores, work, leisure, sleep).
2. Provide opportunities for the patient to participate in daily simulations of activities associated with his or her roles outside of the hospital, to maintain partial contact with the roles to be resumed after discharge.
3. Monitor the degree to which treatment interventions (e.g., medication, behavioral management) are affecting the patient’s ability to
manage everyday activities in the milieu. The treatment team can use this information as one of many indicators of the patient’s recovery from an acute episode.

4. Obtain information about the patient’s roles and daily routine outside the hospital. This includes the identification (with the patient) of those aspects of his or her activities life that are in need of change.

5. Make recommendations to the treatment team regarding the kinds of services the patient will need upon discharge to improve everyday functioning, and convey assessment findings and long-term occupational therapy goals to the agency to which the patient is referred.

The inpatient occupational therapy program is viewed as a point of entry into a long-term progression toward a more desirable state of activities health—a progression that is likely to extend well beyond the inpatient stay if the goal is to be fully achieved. The patient’s ability to manage activities in a hospital situation does not necessarily indicate an ability to do similar activities within the context of everyday living. Recognizing this fact helps the inpatient therapist provide more accurate functional assessments, because it brings a clearer understanding of what can and cannot be inferred from observations of patients on an inpatient unit. Once what can and cannot be accomplished in a hospital setting is understood, it becomes incumbent upon the therapist to consider and make provision for the steps that need to be taken after discharge to help the patient integrate gains made in treatment into everyday life outside the hospital. Thus, functional assessment and participation in discharge planning are integral parts of the inpatient occupational therapist’s role.

The Programming Process

The following is a step-by-step approach to inpatient program development for an acute setting, to be followed once the objectives of occupational therapy at this level of care have been established.

**Step 1: Assessing the Population and Setting**

The patient population can be systematically assessed from two general perspectives: (a) characteristic lifestyles and (b) level of functioning (i.e., the degree to which the patients’ psychiatric disturbance is affecting their performance of everyday activities).

First, the commonalities and variations of lifestyle within the group are examined to determine what aspects are characteristic of the population as a whole. Such information can be gathered from a variety of sources, including historical information from current and previous hospital records, verbal reports from other team members, and informal or formal interviews with the patient. All of this information is used together to determine the demographics of the population, the range of roles that the patients in any given setting are likely to assume outside the hospital, the specific activities required for these roles, and the prevailing norms and expectations of the sociocultural groups to which the patients belong. The Activities Health Assessment (Cynkin & Robinson, 1990) can be adopted to provide a means of eliciting information about commonalities and variations in the patients’ activities lives.

The group’s clinical status must also be assessed, including range of diagnoses, severity of symptoms, and level of functional abilities. Assessments administered by other team members (e.g., psychological reports, mental status examinations, nursing and social work assessments) can be used in conjunction with occupational therapy assessments designed to measure cognitive skills (Allen, 1988), social interaction skills (Mosey, 1986), and other specific components of activities performance.

**Step 2: Assessing the Clinical Setting**

In addition to analysis of the patient population, the characteristics of the clinical setting are examined, so that the programs that are planned can realistically be implemented given the existing unit structure and interdisciplinary goals. The therapist specifically investigates unit routines, the potential for modifying components of the routines (e.g., mealtimes, wake-up times, and procedures), and opportunities and limitations regarding the use of a variety of hospital and community environments.

Once all of this information has been gathered, efforts can be directed toward planning a program in collaboration with other disciplines that is meaningful to the patients, socioculturally relevant, realistic in view of the patients’ levels of functioning, and feasible in view of the resources and limitations of the clinical setting.

**Step 3: Determining the Overall Structure**

In the context of everyday living, activities occur not as isolated events but in rhythms and patterns that are typical of each person. Therefore, to provide patients with an “orderly rhythm in the atmosphere . . . [to help them] become attuned to the larger rhythms of night and day” (Meyer, 1922/1977, p. 641), it is critical for milieu activities to be sequenced and timed in ways that are representative of out-of-hospital living. Similarly, it is important that opportunities be available for patients to participate in activities both alone and with others—again, in keeping with general patterns of everyday activities.
The unit schedule is best conceptualized as a 24-hr, 7-days-a-week sequence of activities. Consequently, it takes into account the patient’s activities around the clock, even beyond the limits of the occupational therapist’s workday. Collaboration with the nursing staff in designing the unit program is therefore an essential ingredient in this programming approach. The activities program in the milieu can be seen as a simulation of a group (or sociocultural) activities pattern, in which activities are arranged in rhythms and patterns that are typical of their at-home schedules. This provides opportunities to interweave activities in socioculturally relevant sequences. Such an activities pattern can be used to restore a sense of balance, structure, and variety in the patients’ daily routines, while also providing opportunities for the assessment of each person’s performance of activities.

Because virtually all patients carry out activities that fall into the general categories of self-care, chores, work (or its analogue), leisure, and sleep, the program can be designed so that patients are expected to carry out familiar, relevant activities from each of these areas of everyday living, timed and sequenced whenever possible in keeping with life outside of the hospital. Examples will be described later in this paper.

Obviously, it is impossible to create a program that is representative of the specific activities pattern for each patient. Therefore, in addition to structuring communal activities that are relevant to the population as a whole, the occupational therapy program must also include means of examining the activities life of each person, including the exploration of the degree to which and ways in which each patient’s psychiatric symptoms interfere with the performance of routine activities outside of the hospital. The rapid turnover of patients that is characteristic of short-term settings requires that the methods selected be efficient ones. Examples are discussed under Step 4.

Thus, the two major program components described above—providing opportunities for involvement in normalizing activities in the milieu and gathering life-style information from each patient—can be used together to achieve the overall occupational therapy objectives discussed earlier. Ultimately, it is the occupational therapist’s job to systematically put all of this information together to make predictions about each patient’s readiness to return to the demands of everyday living and to identify the kinds of supports and services that will be needed for successful functioning in the community.

Step 4: Determining Program Specifics

Once the program’s overall structure has been established, appropriate activities can be selected and integrated into the schedule. Selected portions of the occupational therapy program at St. Vincent’s Hospital are described as an example. These program developments are not in their final form; they represent the beginning of efforts to program activities in ways that specifically address the overall occupational therapy objectives identified. The descriptions are included for purposes of illustration and are not intended to be a blueprint for successful inpatient programming. As indicated earlier, it is important to arrive at a program design that is specific to the population of patients in each unique clinical setting.

Functional assessment. To assess each patient’s degree of activities health, the occupational therapist gathers information from a variety of sources. Information presented on admission helps the occupational therapist begin to formulate a picture of the person’s activities pattern, both at his or her optimal level of functioning and immediately prior to admission. As information is collected from the patient and significant others by various team members after admission, it can also be used to identify the roles that the patient has assumed by choice or necessity and the factors influencing success in carrying out these roles (Barris, Kielhofner, & Watts, 1983; Miller, 1988).

From this information, the occupational therapist can then identify the performance components required for each of the activities needed for successful daily living (Mosey, 1986).

The patient is a necessary source of information for the assessment of activities health. The Activities Health Assessment provides a graphic pattern of the patient’s activities life, which is used to explore the person’s own perception of his or her life-style. The assessment begins with the graphic reconstruction of the patient’s weekly activities schedule when at baseline and before admission. Once the pattern has been obtained, the patient is asked to categorize each activity (i.e., work, leisure alone, leisure with others, sleep, chores, self-care) and color-code it. This graphic pattern is used as the point of reference for an interview about the patient’s activities life, which culminates in the patient’s rating of his or her degree of overall satisfaction, overall comfort, and sense of sociocultural fit. Thus, the Activities Health Assessment is used to (a) identify those activities that are part of everyday living, (b) explore the patient’s perception of specific activities, and (c) determine his or her degree of activities health.

The milieu program. Each patient is given a

\[\text{Some will note that the Activities Health Assessment bears a resemblance to the Barth Time Construction (Barth, 1978), in that they both use an activity configuration as a point of departure. An analysis of both instruments, however, reveals differences in purpose, design, and kind of information elicited.}\]
schedule at the time of admission, including all pre-scheduled appointments, groups, and meetings he or she is expected to attend. Staff members from other disciplines are asked to refer to the patient’s schedule when discussing appointment times, thereby reinforcing the importance of the schedule. The schedules are used as a point of departure for a Time Management Group, where the patients address difficulties in organizing time in concrete, specific terms, rather than in an abstract, hypothetical way. The ability to use a daily schedule, which is actually a representation of the various appointment books on which so many people passionately rely, is one important predictor of the patient’s ability to return to work or participate in a day program following discharge.

Patients’ ability to care for themselves and for their environment is monitored by observing them as they carry out their sequence of self-care activities and as they perform chores to maintain order in the environment. Such observations have traditionally been part of the nursing staff’s assessment. To complement the nursing assessment, occupational therapy cooking groups are used to provide opportunities for patients to participate in yet another set of activities associated with a universal activity—eating. Information obtained during cooking groups is used to assess a patient’s ability to assume partial or complete responsibility for the preparation of meals after discharge. Whenever feasible, cooking groups are held at mealtime, so that they retain as much reality as possible. Cooking, like many other activities, is both preceded and followed by a sequence of other related activities, so these related activities are also incorporated to the extent possible. Meal planning, budgeting, shopping for supplies, setting the table, eating, clearing the table, and washing the dishes are some of the antecedent and consequent activities inextricably tied to the activity of meal preparation.

Depending on each patient’s living situation in the community, he or she may assume anywhere from no responsibility to total responsibility for preparing meals at home. Patients who live with their families may not prepare the whole meal, but may be responsible for a related task like setting the table or cleaning up. On the other hand, a patient who lives in a group residence may not be involved in any of the meal preparation activities, but may simply be served food and be expected to eat meals with other residents. The therapist focuses on each patient’s ability to engage in the activity in the way that will be required of him or her in the community.

Some of these related activities are rather easily simulated; others, like shopping, present logistical problems. More realistic activities will be substituted during the outpatient stage of treatment.

The use of leisure time is frequently an area in which dysfunction is evident. To address this aspect of everyday living, both group and individual activities are used. Supplies for individual pursuits are made available (e.g., books, needlecrafts, stationery, games) so that the ability to plan leisure activities and follow through on such plans can be assessed. Leisure-planning groups conducted by the recreational therapist are used both for the planning of leisure time while the patient is in the hospital and for formulating long-term leisure plans that the patient can pursue after discharge. To obtain accurate leisure assessment information, it is critical that the materials supplied be relevant to the patients’ lives outside the hospital. Trivial trivets and ashtrays that unfortunately have proliferated in psychiatric settings are, therefore, to be avoided.

Physical exercise, which is widely viewed as a valuable activity for psychological and physical well-being, is also integral to the program. For some, exercise is perceived as self-care; for others it is considered leisure; still others classify it as a chore. Regardless of individual perceptions, exercise experiences are structured and conducted in much the same format as the classes that are popular in the community, although they are markedly less physically demanding. An adapted exercise program (Avallone, 1986) can either provide an introduction to an activity that may be of benefit upon discharge or can help reacquaint a patient with an activity that is, or has been, a part of everyday living for him or her.

Finally, the expressed interest of some patients in returning to a previous job or seeking new employment upon discharge must be reality-tested. Assessment of vocational readiness is particularly difficult in an inpatient setting, because it is impossible to replicate in a supportive institutional setting the kinds of pressures and environments that are characteristic of the workplace. Therefore, the patient’s work history is used as the primary means of predicting whether or not the person will be able to work once acute symptoms are relieved. For those patients who express the desire to work immediately after discharge, group activities (such as unit bake sales and patient-run thrift shops) can be used to supplement the examination of the patient’s work history. These vocationally oriented groups are also valuable for patients for whom work is a long-term goal; they serve as preliminary work simulations for such patients and are used to monitor the patient’s work-related and interpersonal skills, activities, habits, and attitudes.

Summary

This approach to occupational therapy in short-term psychiatric inpatient settings has been developed in response to questions that we and other occupational
therapists have grappled with regarding our role in acute settings. Many persons, both inside and outside the field of occupational therapy, have an ample knowledge base yet have difficulty articulating the contribution that can be made at this level of care.

This approach is not revolutionary; clearly, some occupational therapists have already been assuming some of these roles and functions in their practice, and some occupational therapists have included therapeutic activities similar to those we have described. What is unique about this approach, however, is its emphasis on incorporating into treatment programs an understanding of activities as phenomena in and of themselves, paying attention to how, when, why, where, and how they occur in the course of everyday life. Also distinctive is the lack of emphasis on psychiatric diagnosis and symptoms per se; they are of concern only as they relate to the person's capacity to achieve activities health. This kind of perspective on activities helps the therapist to design simulations of everyday activities that are representative of the contexts in which they naturally occur and focus individual functional assessments on the activities required to fulfill roles assumed outside the hospital. Efforts are directed toward structuring the inpatient milieu to (a) have as normalizing a routine as possible, (b) promote engagement in everyday activities, and (c) provide a means of assessing the person's ability to resume everyday life roles following discharge.

By maintaining an awareness of the inextricable connections between activities and the contexts in which they occur, the therapist can also be clear about the conclusions that can and cannot be drawn about the patient's functioning in the hospital. Functional assessment in an inpatient setting provides a valuable starting point, but cannot be seen as a definitive predictor of functioning after discharge. Because the ultimate goal is to produce changes in patients' activities patterns, it is critical that discharge plans for those patients in need of further occupational therapy services include means for assessment of actual functioning in their everyday environments and means for helping patients carry over into the community gains made in the hospital.

Thus, if occupational therapy services in acute inpatient psychiatric care are understood as the initial steps of what is often a long-term progression toward greater activities health, both the therapist and the patient can direct their efforts toward attaining objec-

tives that are meaningful and attainable within a brief stay. The role of the inpatient occupational therapist is a vital one, because the therapeutic process sets the stage for the postdischarge phases of treatment that ultimately can help the patient achieve a better quality of everyday living, even in the presence of chronic psychiatric illness.

Acknowledgments
We credit Simme Cynkin, MS, OTR, FAOTA, for many of the ideas that underlie this approach, and we thank her and Linda Silber, MA, OTR, for their valuable feedback during the writing of this article.

References


