Roles and Functions of Occupational Therapy in Mental Health

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Historical Perspective

The "moral treatment" movement of the eighteenth and nineteenth centuries brought a disciplined and humanistic philosophy to the care of the mentally ill. Work, exercise, games, and arts and crafts were prescribed as regular therapeutics. The founding of occupational therapy in the early 1900s had historical roots in the noted healing potential of activities. During the twentieth century, the work of Adolph Meyer, a neuropathologist, identified a more substantive rationale for the use of socially acceptable work and leisure involvements. His emphasis on the direct involvement in the performance of activity or "occupation" had a marked impact on the philosophy and theory of occupational therapy.

During World War I, occupational therapists were sent overseas to provide injured soldiers with the therapeutic benefit of activity. The return of World War II veterans further demonstrated the benefits derived from activity. Beginning in the 1950s, psycho-dynamic concepts facilitated the emergence of activities as catalytic agents. This gave impetus to an emphasis on the use of relationships and intrapsychic experiences to prevent, eliminate, or alter behavioral deficits and to promote functional performance. A commitment to nonverbal communication, emphasis on nonhuman object relationships, and a more thorough attention to the properties of activity and activity analysis emerged. In the 1960s, correlations between the sensory integration deficits of the minimally brain damaged/learning disabled and the mentally ill were identified, which enabled further growth of treatment theory in occupational therapy. In more recent years, the study of occupation and how it relates to mental health is once more receiving attention and being incorporated into the theory and practice of occupational therapy in mental health.

This roles and functions paper reflects the recommended practice in this area but is not binding. Occupational therapy personnel need to be informed about organization codes and policies; federal, state and local laws; and professional licenses and regulations. Any of these codes or regulations may negate or revise the content in this paper.

Philosophical Base

Occupational therapy is based on the belief that performance of an activity which has purpose and meaning to the individual promotes learning, adaptation, and change. Occupation, or that which engages time or attention, is used by the occupational therapy personnel to prevent and mediate dysfunction and to promote maximum adaptation and function (1).

When the independent functioning of an individual is disrupted, improvement measures must begin at the patient's level of receptiveness to learning and provide for practice over a period of time. Occupational therapy personnel facilitate development of interpersonal relationships and promote a balance between work, play/leisure, and daily living skills. Primary to the practice of occupational therapy is the selection of activities that simultaneously provide successful motivating experiences and the modification of nonfunctional performance.

The analysis, adaptation, synthesis, and selection of an activity are based on the needs of the individual and on identifiable frames of reference and theoretical assumptions. Contemporary frames of reference used by occupational therapy personnel include, but are not limited to, developmental, biomechanical, psycho-dynamic, neurobehavioral, adaptive performance, and occupational behavior models. The last three are currently generating the most interest in occupational therapy in mental health. Based on the commitment to individually selected and goal-directed activity, "The underlying constancy of values within the profession transcends any theoretical bias" (2).

Education and Qualifications

Academic and clinical preparation acknowledges the biopsychosocial components of performance and adaptation. The basic sciences, the behavioral sci-
Occupational therapy theory and application involve studies of human performance and health care systems form the foundation of all academic programs. Occupational therapy theory and application involve studies of human performance and development of the following biomedical, sensory, motor, cognitive, psychological, and social components: the meaning and impact of activity on normal states as well as illness; the application of these theories to neonatal, pediatric, adolescent, and adult and geriatric populations; and the therapeutic use of activities in daily living, leisure, social, prevocational and vocational activities, tests and measurements, and a range of creative-expressive and craft modalities. Baccalaureate, master's degree, and doctoral programs provide basic and advanced professional education. An occupational therapist has graduated from an accredited curriculum and has passed the AOTA certification examination and is certified. A minimum of six months of supervised Level II fieldwork experience is required. Licensure is required in many states.

A certified occupational therapy assistant completes either a certificate course or an associate degree program approved by the American Occupational Therapy Association. Didactic course work provides an orientation to basic and behavioral sciences and emphasizes techniques and procedures for using the media and modalities of occupational therapy. Certification involves graduation from an approved program, completion of two months of supervised Level II fieldwork, and successful completion of the assistant level certification examination. Licensure is required in many states.

Screening

The occupational therapist screens individuals using such procedures as observation and interview, or the administration of a screening tool to identify the need for occupational therapy intervention. Brief data are collected related to past performance and current skills, abilities, and interests. Through the screening process the need for further assessment is determined.

Referral

In some settings all patients are referred for assessment and possibly treatment, whereas in other settings an individual referral method is used that can be initiated by the patient, the family, the therapist, the physician, or other health care professionals. Mental health settings operate under a variety of referral systems depending on reimbursement policies and characteristics of target populations. State licensure laws, accrediting agency standards, reimbursement regulations, and policies of individual facilities may require a physician referral for assessment and/or treatment.

Assessment

Occupational therapy assessment consists of systematic, individualized evaluation of past and current performance of work, independent daily living skills, play, and leisure. Data are gathered through structured and unstructured activities, projective techniques, individual or group tasks, standardized tests, interviews, and activity histories. Sensomotor, cognitive, and psychosocial components are assessed in terms of the patient's education, work, play, leisure, independent daily living skills and time management.

An individual's functioning determines the patient's abilities and deficits related to performance of basic life tasks and fulfillment of roles within work, family, home, play, leisure, and community settings. Performance areas assessed include the psychosocial, sensomotor, cognitive, and independent daily living skills needed to fulfill work, play, and leisure roles.

Program Planning

When the collection and interpretation of data are completed, assets and problem areas in occupational performance are identified. Short-term and long-term goals are established in collaboration with the treatment team and the patient/client, when possible. By analyzing and adapting activity, the occupational therapist designs a program to address the needs, interests, and abilities of the individual. Treatment matched to the individual's unique characteristics, receptiveness to learning, age, and cultural background is designed to maintain or restore function; compensate for loss or impairment; or facilitate maturation, development, and skill acquisition. The program may focus on sensomotor, cognitive, psychosocial, and independent daily living skills.

Program Implementation

Program implementation may be quite varied due to the complexity and diversity of individual patient needs. The type of setting and the frame of reference of that particular setting will also guide the selection of treatment methods. "For example, while short term acute care settings cannot provide lengthy remedial experiences promoting ambitious rehabilitative outcomes, occupational therapists serve a particularly important and versatile role with regard to functional assessment, symptom reduction, mobilization for rapid return to community living, and discharge planning" (3).

Program implementation in settings with longer length of stay is aimed at engaging the individual in purposeful experiences that require development of new abilities and the use of existing skills and interests to achieve or maintain maximum independence. The experience or activities may be used both for remediation of specific performance components or in the development of independent daily living skills, work,
play, leisure, and interpersonal interactions. “For example, a given activity may be chosen to provide appropriate sensory alerting stimuli, improve the ability to organize responses, clarify cause and effect, alter disorders of thinking and problem solving, provide structure and external control, encourage self-expression and exploration, or reinforce work skills and independent function in activities of daily living” (2).

The experience should also contribute to development of appropriate interpersonal relationships, allow for expression of feelings, provide intrinsic gratification, and meet basic needs for acceptance, achievement, creativity, autonomy, and social interaction. The occupational therapy personnel’s ability to facilitate behavior change through use of structure, cues, “intervening objects,” and interpersonal contacts inherent in activity-oriented experience constitutes key mechanisms for successful implementation of therapy.

In a program directed toward maintaining or restoring function, activities are selected to provide practice in the skill and to reinforce success. Practice enables the individual to improve the performance of existing skills. Activities designed to compensate for loss or impairment focus on alternative methods of accomplishing a task. The individual can be taught to compensate through the use of cognitive, sensory, or motor activities that are similar to those lost through impairment. When the program is one of remediation, task analysis determines the order in which the activities are presented to the patient to promote acquisition of skills in a developmental sequence.

All areas of program implementation are directed toward performance of skills in the areas of work, play, leisure, and self-maintenance and the balance among these. Specific skills might include attentiveness, expression of feelings, cooperation, grooming, time or money management, use of public transportation, work habits, and leisure skills. Techniques might include the use of creative media, games, or simulation, or actual skill practice. The program may involve group or individual activity and environmental manipulation, depending on the assets or limitations of the individual.

**Discontinuation of Service**

The decision to discontinue service occurs when established treatment goals have been met or the service is no longer indicated. The occupational therapist reviews the case and assesses current performance strengths and environmental strengths and needs to assist in developing a discharge plan. This plan might include recommendations regarding a living environment in which the individual is most likely to succeed at a maximum level of independence. Referrals to other agencies and/or service professionals might be included.

**Indirect Services**

Administrative, educational, and consultative responsibilities are critical components of the occupational therapist’s professional role. Administrative roles include service development for occupational therapy departments; participation in planning for units or agencies; supervising of staff, volunteers, and students; preparing budgets; ordering and maintaining supplies and equipment; writing policies and procedures for reimbursement; and assuring quality and appropriateness of care. Educational activities include programs for staff, students, other professionals, community agencies, and consumers. Consultancy services are provided to hospitals, nursing homes, community agencies, leisure programs, and industry. Such services may include service development, education of staff, adaptation of equipment and environments, and family education or counseling.

**Legal/Ethical**

The profession and its Association have shown evidence of concern for quality of care and service by extensive involvement in the development of professional ethics and formal Standards of Practice. Priority has been placed on quality assurance as a means of monitoring practice. More than 70 seminars teaching retrospective, concurrent, and prospective patient care evaluation systems were sponsored by the Association from 1976 to 1983. Sample quality review criteria for specific diagnosis have been prepared by the Association.

The Association has supported licensure for occupational therapists to ensure quality provision of occupational therapy services. At present, occupational therapists are licensed in more than half the states.

Confidentiality of records and reports must be maintained by occupational therapy personnel in conformance with local, state, and federal laws and regulations, policies of the institution or agency, and AOTA Principles of Occupational Therapy Ethics (4).

**Summary**

Within the scope of general psychiatry, occupational therapy personnel work in a broad range of practice areas and settings. Services are provided to children, adolescents, adults, and the elderly of all functional levels and diagnostic categories, in institutional, community-based, partial hospitalization, residential treatment, and forensic psychiatry programs. In all programs, the focus is goal-directed use of time, energy, interest, and attention to foster adaptation and productivity, minimize pathology, and promote the maintenance of health.

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I certify that the statements made by me above are correct and complete. (Signed) Jaclyn J. Alexander, Managing Editor.

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