Illness management and recovery: the role of occupational therapy

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Illness Management and Recovery: The Role of Occupational Therapy

by

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Advisor: Sonia Zimmerman, Ph.D., OTR/L

A Scholarly Project

Submitted to the Occupational Therapy Department

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University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master’s of Occupational Therapy

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APPROVAL PAGE

This Scholarly Project Paper, submitted by Crystal Brecht and Jenna McGregor in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Date
PERMISSION

Title: Illness Management and Recovery: The Role of Occupational Therapy

Department: Occupational Therapy

Degree: Master’s of Occupational Therapy

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ABSTRACT

Purpose

The Illness Management and Recovery (IMR) model is a collaborative program that focuses on living with a chronic mental illness by educating the client on management techniques that will facilitate goal setting toward recovery (Mueser et al., 2006). The purpose of this scholarly project was to review the occupational therapy (OT) literature and determine the role of OT in IMR programs.

Method

A comprehensive review was conducted on occupational therapy interventions appropriate for inclusion in the IMR modules. Sources utilized for the review included: United States and international OT journals, OT textbooks, and other publications authored by OTs from the years 2002 to 2011. The strength of the literature within each module was evaluated and the determination made that a need exists for a guide establishing and supporting the role of OT in IMR implementation.

Results

The review of the literature indicated limited researched evidence showing implementation of OT in the IMR model; however, there were indications and evidence to suggest OTs may have a role within the IMR model. There is evidence supporting the role of OT within each modules, however there is limited support within ‘Using Medication Effectively, Reducing Relapse, and Getting Your Needs Met in the Mental Health System.’ The lack of evidence can limit the role of OT within the mental health system. This can also be problematic for OT practitioners and managers as there will not be a clear understanding of the role of OT and the profession’s scope of practice. Therefore, two guideline documents were developed for OT practitioners and non-OT managers to define the role of OT in IMR model programming.
Conclusions

The guideline documents justify the need for OT services to managers who may or may not be OTs; further, the documents provide direction to OT practitioners as service providers in IMR model programming. The guidelines serve to enhance support for the role of OT in IMR implementation and provide guidance during the intervention process within the 10 modules for practicing OTs who are members of the IMR recovery team.
Chapter I

INTRODUCTION

Illness Management and Recovery (IMR) is an evidence-based model supporting the health and wellness of individuals diagnosed with severe mental illness (Mueser & MacKain, 2006), which was developed by the Substance Abuse and Mental Health Services Administration. Occupational therapists (OT) working in mental health settings are implementing services based upon the IMR model. Initial review of the literature indicates limited researched evidence showing implementation of OT within the IMR model; this can be problematic for OT managers and practitioners as there is not a clear understanding of the direct role of OT.

Due to the limited amount of literature showing direct OT implementation within the IMR model, the role of OT is not well defined; however, the student authors believe the OT literature will indicate evidence to suggest OTs may have a role within the concepts of each IMR module. Occupational therapy specific literature and textbooks supporting the role of OT within mental health will be explored. The concepts addressed within the IMR model are believed to be comparable to strategies that are implemented by OTs working in mental health settings.

The purpose of this scholarly project is to review the OT literature and determine the role of OT within the IMR model programs. The results of the literature review are
expected to inform development of tools supporting the role of OT as part of the IMR model programming team.

For the purpose of this scholarly project, key terms have been defined. The key terms include mental health OT, IMR modules, motivational interviewing, and psychoeducation.

**Mental Health OT**

Within the *Managers Guide* mental health OT includes information about intervention strategies OT’s are utilizing within mental health settings of practice.

**IMR Modules**

The IMR modules include a description of the concepts of each module as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). There are 10 modules within the IMR model program.

**Motivational Interviewing**

Motivational Interviewing is an intervention strategy used in correlation within the IMR modules. Occupational therapy practitioners use motivational interviewing to empower individuals to set personal goals and be the primary contributor during the intervention process (Stoffel & Moyers, 2005).

**Psychoeducation**

Psychoeducation is also used within the concepts of the IMR modules, as well as within the practice of OT. Occupational therapy practitioners use psychoeducation strategies to teach clients about mental illnesses and the treatment approaches available (Gutman et al., 2005).
The scholarly project is presented in the following four chapters. Chapter II includes the review of the IMR model and OT literature. Chapter III includes the methodology used to guide and develop the literature review and subsequent tools developed to support OT practice in IMR model programming. Chapter IV presents tools designed specifically to support OT practice in IMR model programming as well as instructions for implementation. Chapter V includes the conclusions, future recommendations, and limitations of the scholarly project.
Chapter II

LITERATURE REVIEW

Introduction to Illness Management and Recovery Model

Illness Management and Recovery (IMR) was introduced between 2000 and 2002 by the National Implementing Evidence-Based Practices Project (EBPs), the model has been supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Mueser et al., 2006). The IMR model published by SAMHSA (2009b) is designed to “give states, communities, administrators, practitioners, consumers of mental health care, and their family members resources to implement mental health practices that work (SAMHSA, 2009b).”

According to Mueser & MacKain (2006), IMR is an evidence-based model supporting the health and wellness of persons with a severe mental illness. The IMR model incorporates educational materials on how to manage mental illness symptoms, as well as allowing the client to personalize recovery (Mueser & MacKain, 2006). According to SAMHSA (2009a), strategies that are enforced within the model provide clients with insight into personal triggers that help prevent re-hospitalization and a plan to manage signs and symptoms. The model highlights the client’s role in treatment by emphasizing establishing goals through self-directed decision-making. The IMR model assists clients with understanding their illness, effectively using coping skills to prevent relapse, improving management of symptoms, and using medications as prescribed. The
model can be implemented in a variety of mental health settings and is noted to support practice interventions for persons with schizophrenia (SAMHSA, 2009a).

According to Mueser et al. (2004), IMR encompasses treatment that is focused on the client’s individualized goals. Clients are in charge of the treatment process and become the primary agent of change. Mueser et al. (2004) expresses the importance of educating clients about coping with stress, managing mental illness, and recovery. Experiencing severe symptoms of a mental illness can decrease a client’s quality of life and lead to avoidance of personal and social situations. Helping clients understand symptoms, as well as encouraging learning techniques to manage a mental illness can provide the client with more energy to focus on achieving personal goals rather than worrying about symptoms (Mueser et al., 2004). There are 10 modules within the IMR model (see table 1). The modules encompass the four core components of IMR: psychoeducation, behavioral tailoring, relapse prevention, and coping skills training (SAMHSA, 2009a). The four core components are utilized within the IMR model as a guide to designing the interventions in a way that will improve the client’s ability to overcome the barriers of their illness. In addition, techniques such as motivational interviewing, educational strategies, and cognitive-behavioral approaches are utilized within the modules to fulfill the concepts of the core components (SAMHSA, 2009a).
Table 1. Illness Management and Recovery (IMR) Modules

<table>
<thead>
<tr>
<th>Module</th>
<th>Topic</th>
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<tbody>
<tr>
<td>Module 1</td>
<td>Recovery Strategies</td>
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<tr>
<td>Module 2</td>
<td>Practical Facts about Mental Illness</td>
</tr>
<tr>
<td>Module 3</td>
<td>The Stress-Vulnerability Model</td>
</tr>
<tr>
<td>Module 4</td>
<td>Building Social Support</td>
</tr>
<tr>
<td>Module 5</td>
<td>Using Medication Effectively</td>
</tr>
<tr>
<td>Module 6</td>
<td>Drug and Alcohol Use (and its effects on mental health)</td>
</tr>
<tr>
<td>Module 7</td>
<td>Reducing Relapses</td>
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<tr>
<td>Module 8</td>
<td>Coping with Stress</td>
</tr>
<tr>
<td>Module 9</td>
<td>Coping with Problems and Persistent Symptoms</td>
</tr>
<tr>
<td>Module 10</td>
<td>Getting your Needs Met in the Mental Health System</td>
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</tbody>
</table>

Whitley, Gingerich, Lutz, & Mueser, 2009

Psychoeducation is utilized within the IMR modules as an educational strategy for clients to learn about mental illnesses (SAMHSA, 2009a). This strategy gives clients the opportunity to learn factual information about mental illnesses and how it can affect performance in occupation and fulfillment of a quality life. Psychoeducation also provides clients with a basic overview of the treatment options available for mental illness (SAMHSA, 2009a).

Another core component defined in SAMHSA (2009a) is behavioral tailoring. This strategy helps clients with understanding medications and how it impacts symptoms of the mental illness. This includes education on medication regimes and how important it
is to manage persistent symptoms. Behavioral tailoring also helps facilitate strategies for incorporating medication management within the daily routine (SAMHSA, 2009a).

SAMHSA (2009a) states that relapse prevention is a core component of IMR that helps clients with the recovery process. The approach incorporates education on triggers that lead to substance abuse and how the early warning signs can result in relapse. Relapse prevention guides clients through the process of identifying reasons that lead to substance abuse along with preparing for the future by developing a relapse prevention plan (SAMHSA, 2009a).

Lastly, SAMHSA (2009a) describes coping skills training as a core component for the IMR model. The approach aids clients in identifying the current coping skills they have that are positive and influential in their lives with a mental illness and how the use of the skills can be increased. Coping skills training also includes education on new coping strategies and how the strategies will influence the recovery process (SAMHSA, 2009a).

**IMR Team Members**

According to SAMHSA (2009a), IMR is a model that involves an interdisciplinary team of mental health professionals working together to implement the model. The team includes a leader, who can dedicate his or her time to the model and is at the managerial skill level. The leader is responsible for developing the rest of the team, creating policies and procedures for the model, and managing referrals and implementation of the model. The other team members may include social work, occupational therapy (OT), counseling, case management, nursing, and psychology.
Team members need a particular set of skills to be effective facilitators of the IMR modules. The practitioners should have background knowledge in mental health, as well as the ability to empower and motivate clients to make their own decisions and set personalized goals. Skills that a practitioner can use to empower clients include effective listening, eye contact, empathy, providing positive feedback, and using shaping to work on personal goals. Practitioners must feel confident in applying clinical and rehabilitation skills and possess a personality that easily enables rapport with clients. Practitioners are encouraged to work independently as well as part of a multidisciplinary team to help clients with multiple diagnoses (SAMHSA, 2009a).

**Diagnoses**

Illness Management and Recovery (IMR) can be used with persons having a wide range of diagnoses, specifically mental illnesses. Levitt et al. (2009) conducted a randomized control trial on the effectiveness of IMR in multiple-unit supportive housing and found that IMR assisted individuals to develop and utilize coping skills, manage symptoms, and engage socially. Study participants included individuals with schizophrenia, schizoaffective disorder, psychotic/delusional disorder, bipolar disorder, depression, mood disorder, and anxiety disorder (Levitt et al., 2009).

Roe, Hasson-Ohayon, Salyers, and Kravetz (2009) conducted a randomized control trial with a one year follow-up from an IMR program. The participants’ diagnoses included schizophrenia, psychosis, bipolar disorder, anxiety disorder, and personality disorder. After a year since engaging in the IMR program, participants reported continued
use of coping skills, social support, self-management, and retaining the learned information about mental illnesses (Roe et al., 2009).

Similarly, Mueser et al. (2006) included diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, and delusional disorder in an outcomes study of a nine-month IMR program (with a three-month follow-up). The program included coping skills training, medication management, coping with stress, and goal setting. After the follow-up, the individuals showed increased program retention. The individuals were better able to manage symptoms, establish, and achieve personal goals (Mueser et al., 2006).
Settings

According to SAMHSA (2009a), IMR model has been implemented in a variety of settings with a multitude of demographic backgrounds. Evidence for the model includes practice areas such as hospital based (inpatient and outpatient), community-based, and criminal justice settings (see table 2). The model has been implemented in the United States, Canada, Germany, and England (SAMHSA, 2009a).

Table 2. Overview of Illness Management and Recovery (IMR) Implementation Settings

<table>
<thead>
<tr>
<th>Settings</th>
<th>Focus of Therapy</th>
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</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Understanding mental illness facts</td>
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<tr>
<td></td>
<td>Medication use</td>
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<tr>
<td></td>
<td>Developing coping and social skills</td>
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<tr>
<td>Outpatient</td>
<td>Self-directed goal development</td>
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<td></td>
<td>Competency in managing the illness</td>
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<tr>
<td>Community-based</td>
<td>Social development</td>
</tr>
<tr>
<td></td>
<td>Medication use</td>
</tr>
<tr>
<td></td>
<td>Coping skills for stress management</td>
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<tr>
<td></td>
<td>Getting needs met in mental health system</td>
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<tr>
<td></td>
<td>Community re-integration</td>
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<tr>
<td></td>
<td>Relapse prevention</td>
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<tr>
<td>Jails</td>
<td>Understanding mental illness facts</td>
</tr>
<tr>
<td></td>
<td>Empowerment in goal development</td>
</tr>
<tr>
<td></td>
<td>Managing the illness with coping skills</td>
</tr>
<tr>
<td>Prisons</td>
<td>Development of long-term goals</td>
</tr>
<tr>
<td></td>
<td>Managing the illness with coping skills</td>
</tr>
</tbody>
</table>

Mueser & MacKain, 2006; Salyers, M. P., Rollins, A. L., Clendenning, D., McGuire, A. B., & Kim, E., 2011; Whitley, Gingerich, Lutz, & Mueser, 2009
The IMR introduction continues with an analysis of each of the 10 modules. The modules are presented by the primary focus and core strategies utilized to achieve the module focus. In addition, OT literature provided supporting OT utilization of the identified core strategies and module topics.

Module 1: Recovery Strategies

Focus

According to SAMHSA (2009c), the module ‘Recovery Strategies’ focuses on having the client create a personal definition of recovery. The recovery process can include, but is not limited to, taking steps towards forming and maintaining good relationships, managing mental illness symptoms, moving forward from the past, and gaining hope. Recovery involves setting personal goals, as well as staying active within enjoyed occupations. Creativity, leisure, social supports, and spirituality are believed to facilitate the recovery process for the individuals involved (SAMHSA, 2009c). Whitley, Gingerich, Lutz, and Mueser (2009) describe supports needed to guide the recovery process including peer and community supports and utilization of holistic interventions that incorporate the clients mind, body, and spirit (Whitley et al., 2009).

OT Support

The OT literature supports the use of ‘Recovery Strategies’ within practice. The literature supports OTs using coping techniques, community integration, social skills training, and providing education as guiding factors to successful recovery. Providing the client with a positive environment facilitates motivation and increases confidence. Occupational therapists can aid the client in establishing routines, which also provides a
sense of self and promotes independence after discharge. The following review of literature provides evidence related to OTs using ‘Recovery Strategies’ in facilitating independence by using therapeutic skills which promote positive recovery outcomes.

The systematic literature review by Gibson, D’Amico, Jaffe, and Arbesman (2011) supports the use of coping tools, as well as social and life skills training during the recovery process. According to Gibson et al. (2011), using client-centered interventions was correlated to positive outcomes within the profession of OT. Educational opportunities provided in therapy guide positive client outcomes and positive community integration. Positive outcomes include improved self-management skills which resulted in confidence in managing a mental illness (Gibson et al., 2011).

Through semi-structured interviews Kelly, Lamont, and Brunero (2010) found that engagement in satisfying occupations can direct the recovery process. Occupational therapists can be involved in recovery by providing education, evidence-based programs, and empowering clients to find meaning within life. Providing clients with a safe, supportive environment can also facilitate a positive recovery when the client is integrating back into the community. Kelly et al. (2010) concluded that the client involved must have enough insight into meaningful occupations, have the ability to re-establish a self-concept, and recognize possible barriers in engagement of occupations during recovery (Kelly et al., 2010).

Swarbrick (2009) outlined a descriptive framework for OTs in wellness and recovery in a state psychiatric hospital setting. It was expressed that individuals who have experienced severe mental illness have the capability to be independent. Promoting
wellness in recovery can facilitate client participation and motivation. Establishing routines during therapy can promote control within an individual’s daily life after discharge. The OT should provide the client with a positive environment that respects the client’s needs and values during recovery. Wellness strategies that promote recovery are outlined by Swarbrick (2009) and include “physical, spiritual, emotional, social, occupation/leisure, intellectual, and environmental” strategies. Within each strategy, examples are provided on how an OT might use each of the strategies to promote recovery (Swarbrick, 2009).

According to the literature review performed by Rebeiro Gruhl (2005), OT has a role during the mental health recovery process. During therapy, OTs focus interventions on identification of personal strengths, utilization of coping strategies, learning or re-learning occupational roles, and community integration. The components of therapy promote recovery and quality of life for individuals seeking services and help. The recovery process is individualized and OT can empower clients to make self-directed decisions and goals (Rebeiro Gruhl, 2005).

**Module 2: Practical Facts about Mental Illnesses**

**Focus**

According to SAMHSA (2009c) the ‘Practical Facts About Mental Illness’ module focuses on educating the client about the process of diagnosing a mental illness and what causes a mental illness to develop. The module presents facts related to mood disorders, depression, bipolar, and schizophrenia. Stigmas associated with having a mental illness and strategies in confronting a stigma are also addressed (SAMHSA,
Providing psychoeducation is not only a piece in the IMR modules, but it is also one of the core components that form the basis of IMR (Whitley et al., 2009).

**OT Support**

Occupational therapy practitioners use psychoeducation as a basic method for teaching clients about mental illnesses and the treatment approaches available within different contexts. Psychoeducational programs are a form of treatment and can be beneficial for the client’s family as a way to understand the client’s experience. In addition, psychoeducation provides clients with the knowledge of their mental illness and the empowerment to live with that illness and still engage in meaningful occupations.

Gutman et al. (2009) described how OT provides educational services in the public school system through a randomized control study. The program, Portland Identification and Early Referral Program, provided a better understanding of the mental illness to those suffering from an illness, as well as education to the families. As a result, individuals enrolled in the Portland Identification and Early Referral Program were more likely to complete secondary education and continue with postsecondary education or join the work force. Another educational program with the same objectives and OT influence is Pathway to Success. Pathway to Success is provided to adults with a mental illness who have a desire to return to school. Within educational programs, OTs use activity analysis to separate the demands of an activity into cognitive and psychosocial skills. This process helps the enrolled individuals learn each skill component in the hopes of compiling the skills to complete the activity (Gutman et al., 2009).
Gutman et al. (2009) also described the skill set possessed by the OT profession appropriate to provide educational services. Occupational therapists have the skills to make accommodations or apply compensatory strategies to promote occupational performance. The OT profession also helps individuals enrolled in educational programs find new roles of interest or resume meaningful roles through engagement in routines and habits (Gutman et al., 2009).

Eaton (2002) used a pilot study of a 12-bed women’s ward in an acute mental health unit that referred to psychoeducation as a promotion of learning which focuses on coping skills, support, and structure. Components of psychoeducation are present in OT programs, which are provided to clients and families. Programs include mental illness education, the opportunity to work with the families of those with a mental illness, and provide access to resources and supports. OT-based psychoeducation programs are goal-directed and often incorporate life skills training. The OT’s application of psychoeducation programs is enhanced by preparatory education of group process and use of activity to facilitate the learning process (Eaton, 2002).

From a philosophical perspective, Padilla (2002) agrees that OT interventions use psychoeducation to develop components of performance before trying to master the tasks. Similar to Eaton (2002), Padilla (2002) states that enrollment in psychoeducational programs promotes outcomes such as better daily living skills and relationships with family and mental health professionals. The teaching approaches described by Padilla (2009) that aim at achieving mastery include executive, therapist, and liberationist. Each teaching approach strives to achieve a relationship with the client, but the liberationist
teaching approach relates the most to OT implementation of psychoeducation. The liberationist approach uses experience as a way to obtain knowledge and apply it in a meaningful manner. The executive and therapist approaches seek to encourage development of the client’s potential and shape the client based on societal norms. Padilla (2002) stated, “Man is an active being whose development is influenced by the use of purposeful activity.” In order to learn a skill, the individual must engage in an activity that uses that skill (Padilla, 2002).

Module 3: The Stress-Vulnerability Model

Focus

According to SAMHSA (2009c) ‘The Stress-Vulnerability Model’ addresses how vulnerability can be influenced by stress, medications, and substance abuse. ‘The Stress-Vulnerability Model’ is designed to help individuals understand how to decrease effects associated with a disorder, as well as to identify coping strategies that help reduce and manage stress (SAMHSA, 2009c). Mueser et al. (2006) discusses stress-vulnerability as a process of helping individuals develop the foundational skills of illness self-management. The IMR model goal is to disrupt the pattern of stress, biological factors, and substance abuse that facilitates relapse and poor occupational performance. By learning to manage medications, utilize social supports, develop coping skills, and engage in meaningful occupations, individuals are able to improve their outcomes (Mueser et al., 2006). Treatment options within the module include solving personal problems with assistance, improving communication and relationships, and getting involved through work or activities (SAMHSA, 2009c).
OT Support

Occupational therapy helps clients dealing with a mental illness cope with the illness through supported activities, such as supported education or employment. A program that implements this concept is vocational rehab. This provides clients with the opportunity to social with others while getting their needs met of managing stress. Establishing a social network promotes confidence in the clients, which will lead to more interactions with others, and implementation of skills learned to manage the stress from living with a mental illness.

In a systematic review of OT interventions for consumers with a serious mental illness, Arbesman and Logsdon (2011) state supported education and employment as sources of vocational exploration that incorporate social skill development and cognitive training to facilitate goal achievement. Clients that engage in dynamic occupations have an improved sense of accountability, character, and dignity. Support groups can also be beneficial for those looking to advance their level of education, such as choosing a major, learning active study habits, and creating a class schedule. Occupational therapy can help individuals with compensation to the activity demands of a vocational or educational task so they can achieve their vocational goals (Arbesman & Logsdon, 2011).

Through a review of the literature on psychiatric disabilities in adolescents, Lloyd and Waghorn (2007) agreed with the social component of work as it provides an opportunity for social contact and connectedness, social identity and development of self-esteem. Vocational engagement promotes self-empowerment, sense of independent identity, and self-esteem. When handling a mental illness in early adulthood, areas of
development such as relationships, independence, and social skills can be negatively influenced. When there is a lack of interpersonal skills, the individual may have difficulties achieving vocational goals. The individuals engaged in vocational rehabilitation need motivation and the ambition to reach their goals, as well as the belief in their ability to complete the demands of the activity. Occupational therapists use skills training to enhance work performance and personal goal achievement, which can result in better management of and reduction of symptoms (Lloyd & Waghorn, 2007).

Lloyd and Waghorn (2007) further discussed social skills training as a common strategy utilized by OTs for client identified goal achievement. Individuals seeking vocational opportunities need social skills for job interview questions, communicating with co-workers/peers, engaging in group tasks, and asking questions to supervisors. In addition, learning social skills allows individuals to obtain resources about vocational opportunities such as the activity demands for the task, job or course availability, and completing applications (Lloyd & Waghorn, 2007).

As discussed by Lloyd and Waghorn (2007), social networking is another source of social support for individuals that can positively impact vocational and educational outcomes. Networking gives a person a sense of association and belonging to the community. By improving availability to education, volunteerism, and employment, individual’s dealing with a mental illness are able to develop social relationships that promote a sense of wellbeing and social confidence that make vocational goals and symptom management achievable. Lloyd and Waghorn (2007) state coping skills is another training strategy used by OTs for vocational achievement. Learning coping skills
prepares individuals for the unexpected situations that may occur in the workplace or educational setting. Managing stress, utilizing relaxation strategies and problem-solving can help individuals cope with a job application rejection or difficulties with peer or co-worker interactions (Lloyd & Waghorn, 2007).

Inman, McGurk, and Chadwick (2007) utilized a qualitative research method to focus on recovery and its relationship to vocational rehabilitation. Clients engaging in vocational rehabilitation had the opportunity to learn work skills, search for employment, improve work performance, and maintain employment. Engaging in work included a combination of measures, such as functioning in vocation and influential factors of the environment, primarily focusing on social. The importance of the connection between social skills and work was acknowledged, as well as self-efficacy. At the conclusion, the participants identified a transition from negative to positive in regards to belief in their abilities, confidence in work skills, and a desire to engage in vocation (Inman et al., 2007).

According to an OT textbook chapter focusing on vocational programming, skills training is a staged process that occurs over a period of time in different contexts (Auerbach & Jeong, 2005). Occupational therapists start with an introduction to the skill and focus on learning and building upon it. This step often occurs in partial hospitalization or day treatment facilities where the individuals are just beginning to learn about managing their illness and symptoms. The process continues with role-play and practicing using the new skills. The skills are often addressed in the mental health community, which is a safe environment for learning with the support of peers and the
medical staff. The opportunity to apply the new skills occurs in vocational settings such as volunteering. Individuals are able to take the skills learned during treatment and apply it to everyday experiences. Skill enhancement and reworking occur at this stage when individuals are able to generalize the skills learned and apply it to other areas of life. By breaking up the demands and learning the skills in a process, individuals with a mental illness are able to retain the information and apply it to all areas of their life in a meaningful manner (Auerbach & Jeong, 2005).

**Module 4: Building Social Supports**

**Focus**

According to SAMHSA (2009c), the module ‘Building Social Supports’ includes building a support system composed of a variety of people. Support groups are individualized and can include, but are not limited to friends, peers, significant others, colleagues, support groups, and practitioners. The educational material within the module ‘Building Social Supports’ encourages clients to strengthen existing relationships that are positive, as well as to try to meet new people. Meeting new people can be difficult for clients, so the module outlines places to meet people including work, school, parks, coffee shops, museums, or concerts. The client is encouraged to think of places where they would be most likely to go and meet people (SAMHSA, 2009c).

**OT Support**

Literature and textbooks support the role of implementing interventions related to ‘Building Social Supports’ in OT. Social engagement and having a positive support system is related to positive self-esteem and overall quality of life and health. Therapists
can engage clients in meaningful occupations through education, work, volunteer, or participation in leisure activities.

Cook and Chambers (2009) conducted a qualitative study of the effectiveness of OT services for individuals living with a mental illness. Cook and Chambers (2009) found that clients felt barriers related to social participation due to their mental health diagnoses. Clients experienced loss of valued roles within work, leisure, and volunteer experiences. Interventions provided by OTs addressed social engagement and occupational participation including promoting increased self-esteem, establishment of daily routines, and social networking. The OT’s were able to engage the clients in meaningful occupations such as educational opportunities, community outings using public transportation, work, volunteer opportunities, and engagement in leisure (Cook & Chambers, 2009).

According to Dowling and Hutchinson (2008), the group-based service in collaboration with a recovery-focused approach supports OTs in having the knowledge and educational background to empower clients and encourage them to first identify interests. After the client has identified interests, collaboratively the OT and client identify a group within the community that supports personal interests. Engaging in meaningful occupations within the community supports recovery and overall well-being. “Recovery begins with social and leisure activities in community settings and ends with full employment” (Dowling & Hutchinson, 2008). The OT has the ability to assess job performance and perform activity analysis’ to determine which activities and jobs the client will be most successful in (Dowling & Hutchinson, 2008).
An ethnographic study conducted by Mynard, Howie, and Collister (2008), focused on the experiences of individuals involved in a community-based football team. Interviews were conducted to explore experiences and personal meanings of involvement, as well as the sense of occupational identity within a social group. Occupational therapy was involved in promoting interventions that were community-based and supported personal leisure interests. The participants expressed positive outcomes and the findings can be related to improvement in self-esteem and overall health (Mynard et al., 2008).

In a research study assessing 103 participants and the daily occupations that are affected by persistent mental illness, Eklund (2006) identified that social networking is an important aspect to successful recovery, community integration, and adaptation thus influencing participation in valued occupations. It was concluded that clients who are diagnosed with a mental illness have smaller social networks. Engagement in occupations was related to feelings of social inclusion, rather than the diagnosis itself. Occupational therapists can understand client’s occupational values through interview techniques and observation (Eklund, 2006).

The second edition of *Occupational Therapy Practice Framework: Domain and Process*, (American Occupational Therapy Association [AOTA], 2008) identifies instrumental activities of daily living (IADL) that facilitate independent living. “The *Framework* was developed to articulate occupational therapy’s contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation” (AOTA, 2008, pp. 626). The knowledge and background
supporting OT’s role in interventions directed towards building social supports is outlined in the *OT Practice Framework* related to promoting social participation (table 3). The IADL’s below are also be used in OT interventions to support the development of social networks.

**Table 3. Areas of Occupational Performance**

<table>
<thead>
<tr>
<th>Area of Occupational Performance</th>
<th>Activities Supporting Development of Social Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADL - Community Mobility</td>
<td>Moving around in the community by using public or personal transportation methods.</td>
</tr>
<tr>
<td>IADL - Shopping</td>
<td>Planning shopping tasks; selecting, purchasing, and transporting items.</td>
</tr>
<tr>
<td>Education</td>
<td>Participating in formal education.</td>
</tr>
<tr>
<td></td>
<td>Participating in informal personal education. (examples: classes, programs, and activities that provide training in an area of interest).</td>
</tr>
<tr>
<td>Work</td>
<td>Identifying and/or participating in employment interests based upon likes, dislikes, and limitations.</td>
</tr>
<tr>
<td></td>
<td>Exploring or participating in volunteerism.</td>
</tr>
<tr>
<td>Leisure</td>
<td>Exploring and participating in leisure activities.</td>
</tr>
<tr>
<td>Social Participation</td>
<td>Engaging in activities with family, peers, and friends.</td>
</tr>
<tr>
<td></td>
<td>Engaging in community activities and interactions.</td>
</tr>
</tbody>
</table>

AOTA, 2008
Module 5: Using Medication Effectively

Focus

According to SAMHSA (2009c), ‘Using Medication Effectively’ is designed to educate clients regarding the advantages and disadvantages to taking medications. Medications are used to promote a chemical balance in the brain, thus reducing signs and symptoms of having a mental illness resulting in reduce chance of relapse. The module takes into consideration personal beliefs about medications and side effects that may be experienced by a client. The module provides educational information about different medications such as antidepressants, mood stabilizers, antipsychotics, antianxiety, and sedatives. The client is encouraged to describe personal experiences, good and bad, when taking certain medications. Taking medications can be confusing to clients and the module outlines strategies that can help manage daily medications (SAMHSA, 2009c).

OT Support

There is little OT literature specifically supporting the role of OT within the module ‘Using Medication Effectively.’ However there is support published in the second edition of the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2008). Medication management is addressed under OT’s role in supporting participation in the IADL, ‘health management and maintenance.’ There is also support provided in the opinion of others that medication management can be applied within OT theory.

According to AOTA (2008), Occupational therapy practice framework: Domain and Process, the IADL of ‘health management and maintenance’ includes developing,
managing, and maintaining a medication routine. According the expert opinion of Cole (2011), some OT professionals believe that medication management is outside of the role of the profession of OT. Others believe that occupational performance is affected by proper medication management and occupational performance is addressed in OT interventions. In Cole’s (2011) opinion, OTs may not be qualified to handle medications, but OTs are qualified to address adaptive approaches to taking medications; for example, learning to use a medication box to remember to take medications (Cole, 2011).

Cole (2011) also considers the practice of applying medication management in relation to the Model of Human Occupation (MOHO). Questions about the effectiveness of medications, as well as the personal beliefs of the client, need to be considered pertaining to the client’s volitional status. Times medications need to be taken, forming a routine, and medications effect on occupational performance are related to habituation. In MOHO, performance capacity related to medication management includes increase or decrease energy, coordination, strength, visual deficits, or comprehension of taking medications. Environmental considerations include safe storage, lighting, and adequate temperature to maintain medications (Cole, 2011).

**Module 6: Drug and Alcohol Use**

**Focus**

According to SAMHSA (2009c), the ‘Drug and Alcohol Use’ module focuses on identifying the advantages and disadvantages to substance abuse and its impact on persons with a mental illness. The client is encouraged to identify the positive and negative aspects of substance abuse and use this information to guide the decision-
making process of choosing to reduce substance use or eliminate the substance. A sobriety plan is an opportunity to reach recovery goals for those who chose to stop abusing substances (SAMHSA, 2009c).

**OT Support**

Occupational therapy and substance abuse intervention is a process of accepting the need for change and wanting to achieve sobriety through the recovery process. OT consists of educating clients on the impact substance abuse has had on occupational performance and the loss of identity that comes along with it. Therapy can include re-introducing clients to once meaningful occupations in order to promote role identity and a sense of purpose. Clients are able to establish healthy occupations to incorporate into a new lifestyle along with knowing how to deal with past occupations that lead to relapse.

In an OT textbook chapter on substance-related disorders, Haertlein Sells, Stoffel, and Plach (2011) discuss the impact substance abuse can have on individuals with a mental illness. Occupational role performance is negatively impacted due to the decrease of engagement in once meaningful occupations to make more time for substance abuse activities, such as earning money to pay for the substance or finding a source to the substance. Other areas impacted by substance abuse include sleep and school/work. Those abusing drugs have a lower quality of rest and have a more difficult time falling and staying asleep. In addition, missing days, lack of attention and poor performance are also a result of substance abuse (Haertlein Sells et al., 2011).

According to Haertlein Sells et al. (2011), individuals need guidance and support to achieve sobriety. This includes motivating the individual to identify leisure activities to
participate in that have a non-abusing environment that will be supportive of their recovery. The lives of these individuals have focused on substance abuse and the activities associated with it that they are not aware of activities that do not revolve around using. Guidance needs to be provided in identifying routines and habits that will be supportive of the recovery. As substance abusing takes effect of all areas of occupation, it is important to guide the individual in rebuilding a healthy lifestyle and routines. Motivational therapies that address an individual’s readiness to change are important to personal motivation in substance abuse and mental illness treatment (Haertlein Sells et al., 2010).

Moyers and Stoffel (2010), in an OT textbook chapter focusing on substance abuse prevent in adolescents and adults, elaborated on the stages on change outlined in the Transtheoretical Model of Behavior Change (DiClemente & Prochaska, 1998) and its relationship to substance abuse treatment. Unless a client is willing to change the lifestyle previously lived, teaching coping skills and life skills will not be as effective. Change is separated into five stages including: pre-contemplation, contemplation, preparation, action, and maintenance. The focus of each stage shifts from becoming invested in the idea of change to maintaining the new healthy behaviors and routines. In the middle of that, the client receives education on developing a belief in one’s ability to change, identifying barriers and facilitators within the environment, using decisional balance to determine the pros and cons to a healthier lifestyle, recognizing alternative occupations, and implementing the newly identified occupations in the routine of a healthier lifestyle. With the possibility of recurrence in unhealthy occupations, the stages of change is
reversible and a client can be revert to a prior level of change in order to develop the skills to handle the situation next time it occurs (Moyers & Stoffel, 2010).

Thompson (2007) distributed surveys to OTs in all practice settings to determine whether the practitioners were assessing substance use disorders. Interventions being utilized by OT practitioners included education on harm reduction, importance of support groups, assessing community resources, learning life skills and coping skills. It is important to determine what stage of change the client is at when designing the intervention plan. Interventions are to be presented to the client, but client’s readiness to change and live in sobriety will determine the outcome (Thompson, 2007).

McQueen, Allan, and Mains (2006) conducted a pilot study reviewing the use of brief motivational counseling with clients who abused alcohol. Motivational counseling allows the client to be a dynamic contributor to the treatment process. Empowerment gives the client the opportunity to attain self-identified goals leading to a lifestyle sustained with healthy routines. The approach is successful because the client has helped to develop a personal lifestyle plan, which makes the experience more relevant and meaningful (McQueen, Allan, & Mains, 2006).

Stoffel and Moyers (2005), in an OT textbook chapter focusing on OT with substance-abuse disorders, discussed how meaningful activities are replaced with activities important to upholding the addiction. These addiction activities eventually become habits, patterns of behavior, and routine. Cognitive-behavioral and psychodynamic are interventions in promoting a healthy lifestyle. The OT guides the client with identification of environmental, interpersonal, and emotional factors of the
context that are connected with using behaviors. This includes social establishments that the client previously used in as well as the individuals with which the client used. Part of the process of sobriety includes determining which coping skills the client can use to avoid relapse in this particular situation along with other occupations that revolved around using substances. In order to develop the coping skills, the client must first stop using substance abuse as a mechanism to avoid difficult situations rather than confronting them. The client needs to be invested in abstinence in order to effectively use the newly developed coping skills to replace substances as a defensive mechanism (Stoffel & Moyers, 2005).

Stoffel and Moyers (2005) also present motivational interviewing as an effective strategy. Motivational interviewing is a process between the therapist and client which includes the use of open-ended questions, reflective listening, and summarization to gather an understanding for the individual’s addiction. Through motivational interviewing, the therapist emphasizes the individual’s role in personal goal setting and treatment progress. Providing empathy and self-efficacy will promote change and the motivation to live a higher quality of life. It is important to not challenge an individual who is resisting change, but rather to acknowledge that change is difficult and that the individual’s strengths and values will make change achievable (Stoffel & Moyers, 2005).

Module 7: Reducing Relapse

Focus

According to SAMHSA (2009c), the ‘Reducing Relapse’ module focuses on the causes of relapse and how to diminish relapse in the future. This module gives the client
the opportunity to review past experiences with relapse to develop a prevention plan. The client identifies triggers and early warning signs noted in previous relapses as a way to prevent future relapse (SAMHSA, 2009c).

**OT Support**

Reducing relapse involves putting new skills learned in earlier modules into application. Occupational therapy strives to guide the client towards a healthy lifestyle by using the coping skills and life skills and applying the skills to the client’s personal life. This includes identifying individualized signs of relapse and developing a plan to handle the situation. Clients are encouraged to apply the skills training to their personal life. This requires clients to use problem solving and critical thinking skills because therapy will not be able to role play each possible situation that may arise. In addition, OT helps clients develop confidence in the ability to change by emphasizing the client as the agent of change.

In an interdisciplinary evidence-based review, Stoffel and Moyers (2004) discussed intervention methods that encourage the client to become the agent of change in obtaining sobriety; one of them being the previously discussed motivational interviewing. Additional identified evidence-based methods include brief interventions, cognitive-behavioral therapy, and 12-step treatment programs. Brief interventions are used to learn from the client what areas of occupational performance are of concern and what the client can do to make changes. Through the interview, the OT utilizes motivational interviewing techniques to acquire an understanding of how the client self-evaluates the impact of substance abuse on occupational performance. Gathering this
foundational information will give the OT an understanding of the client’s ability to change in order to engage in that occupation so that there can be continued growth in developing healthy habits and routines. This method allows the client to reflect back on the changes already made and how the skills learned then can be used in new areas of growth (Stoffel & Moyers, 2004).

Stoffel and Moyers (2004) stated that the use of cognitive-behavioral therapy allows the individual to use coping skills to change the way of thinking and behaving in high-risk situations. Occupational therapists guide distorted thinking towards change by facilitating the client’s self-efficacy and identification of alternative solutions to coping (other than abusing substances). Individuals can then learn the appropriate coping skills to reinforce relapse prevention and develop positive occupational behaviors. By giving the individual control of the intervention process, the individual is able to generalize the skills learned into other areas of their life; identify new coping strategies, and develop valuable self-monitoring skills (Stoffel & Moyers, 2004).

Stoffel and Moyers (2004) stated that the use of 12-step programs gives those dealing with substance abuse a sense of connectedness and social support. This method gives the client an opportunity to develop a personal meaning of sobriety. The 12-step program also helps incorporate the healthy routines of the new lifestyle. By having this resource in the community, the client will be able to identify the 12-step program as part of a new lifestyle which will facilitate development of new habits and routines. In addition, habits can also be established through this method. The program provides clients with activities which are supportive of the recovery process to sobriety, such as
workshops, conventions, or community events that incorporate family and friends (Stoffel & Moyers, 2004).

Tayar (2004) describes a relapse prevention program and states that clients are able to learn techniques and skills to allow self-growth in living a life free of drugs. Relapse prevention programs encourage clients to learn assertiveness when in stressful situations, how to problem solve in everyday life, and the ability to recognize risky situations. As stated by the substance abuse relapse prevention model, addictive behaviors are learned habit patterns and therefore can be unlearned. By learning personal triggers and awareness for high risk situations, clients are able to anticipate and prevent relapse before it spirals out of control. Self-efficacy development is important for this to occur because a client needs to have trust in one self’s ability to overcome the addiction and make a change (Tayar, 2004).

Module 8: Coping with Stress

Focus

According to SAMHSA (2009c), the ‘Coping with Stress’ module includes worksheets and information outlining the origins of stress. Two concepts that are presented are life events and daily hassles. Examples of each stressor that the client has experienced in the past year or on a daily basis are identified. The module ‘Coping with Stress’ outlines personal signs of stress, coping with stress, and techniques to use in preventing stress. The use of coping techniques such as deep breathing, muscle relaxation, and mental imagery are recommended. Identifying current techniques that
work, practicing strategies, and exploring other coping skills can help the client manage symptoms more effectively (SAMHSA, 2009c).

**OT Support**

Occupational therapy literature and OT textbooks have been reviewed to support the role of OT in ‘Coping with Stress.’ Literature indicates that OTs have the knowledge to use a variety of techniques with clients to promote effective coping based on research and education. Techniques include but are not limited to; yoga, writing, art, exercise, nutrition, and breathing exercises. The following literature reviews techniques that OTs are using in practice and provides support for OT’s role in incorporating coping techniques into practice.

Stoller, Greuel, Cimini, Fowler, and Koomar (2012) conducted a randomized control trial and reported that techniques such as yoga can be effectively used in OT to reduce stress. With proper training, OTs can implement the concepts of breathing and body movements into stress management techniques. According to Stoller et al. (2012) yoga can be used to increase self-regulation and decrease symptoms of stress. Even though the randomized control trials primarily focused on individuals in the military, Stoller et al. (2012) believe that the findings can be applied across other populations.

According to Haertl and Christiansen (2011) in *Occupational Therapy in Mental Health: A Vision for Participation*, coping is a person’s response to a situation in which a potential threat is addressed. Interviews should be used by occupational therapists to understand the client’s goals and perceptions of stress. Stress diaries are used by client’s to track stressful situations that are encountered, initial response to the situation, and the
coping strategy that was used during the event. Using a stress diary helps the client, as well as the therapist, prioritize goals and track stressful events. Clients and therapists incorporate coping skills such as writing and creative expression into interventions. Writing interventions allow the client to express thoughts openly; the therapist collaborates with the client to explore common themes within the writings. Creative expression includes art, role play, or media. The client can then reflect on the experience in relation to coping (Haertl & Christiansen, 2011). According to Haertl and Christiansen (2011), OT’s also suggest progressive muscle relaxation and deep breathing to clients when exploring coping strategies.

In a study of the effectiveness of coping strategies, Crouch (2008) studied the use of strategies such as relaxation, nutritional education, and exercise. The individual must be able to identify personal signs and triggers to begin utilizing coping skills. Whether the stressful events can be controlled or happen spontaneously, stress is challenging for most individuals. Identifying and utilizing successful coping strategies can provide an individual with motivation and a sense of fulfillment. Results showed that the individuals who were involved in the intervention group sustained stress alleviation by using skills developed in OT (Crouch, 2008).

In the OT text *Occupational Therapy Evidence in Practice for Mental Health*, Rigby and Wilson (2006) identified coping strategies that can be used for persons diagnosed with a mental illness. Strategies identified include monitored breathing, medication, social engagement, goal setting, mental imagery, and listening to music. Clients should be encouraged to rate coping strategies based upon personal effectiveness.
and identify which strategies can be used in different situations. Therapists encourage the use of strategies to help the individual get involved in meaningful occupations which also decreases stress (Rigby & Wilson, 2006).

**Module 9: Coping with Problems and Persistent Symptoms**

**Focus**

According to SAMHSA (2009c), the module ‘Coping with Problems and Persistent Symptoms’ addresses planning for situations in which coping strategies are necessary. The module also incorporates the use of social supports and setting goals to address problems. The module includes personal testimonials of people using coping strategies to reduce relapse and encouragement for others to take control of problems and symptoms. Experiencing persistent symptoms can lead to a lack of emotional expression and withdrawal from social situations, problems should be addressed to decrease stress. Identifying early warning signs of relapse is different than experiencing persistent symptoms. Identifying early warning signs is discussed in module seven ‘Reducing Relapse.’ Persistent symptoms are described as constant, yet the symptoms experienced usually do not lead to relapse (SAMHSA, 2009c). According to SAMHSA (2009c), problems related to symptoms are categorized as the following; “thinking problems, mood problems, negative and psychotic symptoms, or drug and alcohol use” (pp. 310).

**OT Support**

Occupational therapy interventions are able to incorporate ‘Coping with Problems and Persistent Symptoms.’ It is important for OTs to understand symptoms that clients may be experiencing; the best way to fully understand a client is to build a therapeutic
relationship. Application of coping strategies discussed in module eight ‘coping with stress’ can be used in correlation with managing symptoms.

Edgelow and Krupa (2011) conducted a multisite, randomized control trial of 24 community-dwelling individuals diagnosed with a severe mental illness. Results indicated individuals who do not have occupational balance are more likely to disengage from participation in meaningful occupations. Experiencing significant symptoms can limit a client’s ability to engage in occupations; barriers to engagement are both internal and external. Internal factors include positive and negative symptoms; positive symptoms can include hallucinations and negative symptoms can include affective blunting. External factors affecting participation include supportive services, community integration, and social stigma. Edgelow and Krupa (2011) concluded it is important for clients to find an occupational balance when experiencing barriers related to either internal or external factors.

According to Rigby and Wilson (2006) in the OT textbook *Occupational Therapy Evidence in Practice for Mental Health*, journaling can be used to record coping strategies that were used for symptoms experienced during a particular event. Keeping a journal or diary of events can help the client understand and identify triggers, symptoms, and situations that cause distress. Clients can then practice coping strategies within different contexts; practicing coping strategies consistently becomes part of the client’s routine. Using coping strategies consistently as part of a routine is important in learning to manage symptoms and reduce relapse (Rigby & Wilson, 2006).
A secondary analysis of the quality of life of 154 persons with severe mental illness by Chan, Krupa, Lawson, and Eastabrook (2005) discussed the importance of involvement in understanding symptoms experienced by clients. Quality of life was found to be affected by subjective mental illness symptoms and can be related to objective clinical measures, as well. Occupational therapists who address stress management enable clients to increase symptom management. Quality of life includes managing symptoms, as well as sense of belonging within the community (Chan et al., 2005).

In the OT textbook *Psychosocial Occupational Therapy: A Clinical Practice, 2nd Ed.*, MacRae (2005) indicates that OTs should understand the pathology of an illness and the symptoms a client may experience. The best way to understand a client’s symptoms is to get to know them. Clients who experience symptoms should engage in activities to divert attention away from the symptoms being experienced and/or employ coping strategies to alleviate the stress. Clients who are experiencing strong symptoms can either benefit from highly structured activities, or activities that allow exploration, depending upon personal learning styles. Structured activities allow the client guidance if they are unable to manage symptoms, the structure allows them to think more clearly because they are focused on another task. Activities that allow exploration allow the client the ability for a greater scope of self-expression and this helps alleviate symptoms as well. Interventions that focus on social skills, activities, time management, and allow the client to make personal decisions promotes positive coping with symptoms (MacRae, 2005).
Module 10: Getting Your Needs Met in the Mental Health System

Focus

SAMHSA (2009c) states the module ‘Getting Your Needs Met in the Mental Health System’ gives clients the opportunity to learn about the local mental health system and the range of programs within the system that are beneficial to the recovery process. The clients can learn from the services they currently utilize and express interest in other available services. In addition, this module educates clients on how to be self-advocates as members of the mental health system. Self-advocacy is valued because consumers have different needs as well as financial benefits. Self-advocacy allows the consumer to know what services are available and the qualifications for financial assistance (SAMHSA, 2009c).

OT Support

According to AOTA (2008, pp. 663) self-advocacy is an occupational therapy outcome defined as “actively promoting or supporting oneself or others.” This includes being aware of individual assets and areas of growth along with being able to identify and pursue goals. Occupational therapy helps individuals attain knowledge and resources of their legal rights and the ability to confidently communicate these rights to others (AOTA, 2008).

Cottrell and Langzettel (2005) conducted a mixed method study of the process of empowering consumers of psychiatric services. Quantitative data was collected to explore the perceived level of empowerment from consumers of the psychiatric services; qualitative data was use to gain a profound understanding of how consumers view
empowerment in their daily lives. Open-ended questions for the survey portion of the study looked into the individual meaning of empowerment and how it impacts quality of life while living with a mental illness. From the results, the consumers of psychiatric services identified five dimensions of empowerment: self-esteem/self-efficacy, power/powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger (Cottrell & Langzettel, 2005).

As for the term of empowerment, Cottrell and Langzettel (2005) defined it as a process which includes the qualities of self-directed decisions, access to resource, and confidence in ability to grow and advocate in the public domain. The values of empowerment include wellness, acclimation, proficiency, and the innate responsibility to help are comparable to the domain of OT. In order to achieve these values, individuals are guided through the barriers of mental illness by obtaining education on skills to overcome the barriers that limit community integration (Cottrell & Langzettel, 2005).

Cottrell and Langzettel (2005) included the implications of empowerment within OT. Empowerment is a skill that is within someone; power cannot be given to you. In order to achieve self-empowerment, the individual needs to become aware of the innate ability to empower oneself. The client needs to be the agent of change and demonstrate competency through occupational engagement. OT can be helpful for clients who are learning the skills to find empowerment within them and use it effectively to influence quality of life. This can also help give clients a voice in advocating for the services they prefer to receive in order to promote recovery (Cottrell & Langzettel, 2005).
**Problem Statement**

The IMR model is an evidence-based program supporting the role of healthcare professionals such as OT (SAMHSA, 2009a); however currently there is no OT literature or textbooks that support OTs role in the implementation of the IMR model. There is current literature and textbooks that do support the role of OT in mental health. Within a mental health setting OTs support and educate clients on a variety of skills, skill implemented include coping strategies, identifying goals, and increase group participation and support (Champagne & Gray, 2011).

According to SAMHSA (2009a) there are four core components that make up the IMR model. The four components include psychoeducation, behavior tailoring, relapse prevention, and coping skills training (2009a). According to Eaton (2002) OTs are involved in psychoeducation programs that are provided to the client, as well as to the families. Psychoeducation programs are goal-directed. OTs have the educational background to apply activities within interventions which support the client’s goals and overall learning process (Eaton, 2002). According to Rigby and Wilson (2006) using coping strategies consistently as part of a routine is important in learning to manage symptoms and reduce relapse.

According to the research conducted there is evidence in OT literature in textbooks supporting OT’s role in providing services related to SAMHSA’s four core components. The evidence related to OT justifies the professions role within each individual component, rather than SAMHSA’s overview of the whole program. There is a
need for evidence specific to OT to guide implementation of the IMR model as a program in relation to the professional role of OT.

Summary

This project aims to develop support for OT’s inclusion in mental health delivery systems utilizing the IMR model programs. Review of the OT literature reveals the role of OT within IMR programs is supported by professional OT literature and textbooks. The core concepts and strategies addressed in each of the 10 IMR modules were identified. Evidence of the OT application of the concepts and strategies in practice was explored in OT professional literature and textbooks. The review suggested the role of OT was supported within each module. The strongest evidence was found for OT involvement in IMR model programs in the following modules: ‘Recovery Strategies, Practical Facts about Mental Illness, The Stress-Vulnerability Model, Building Social Supports, Drug and Alcohol Use, Coping with Stress, and Coping with Problems and Persistent Symptoms.’ Evidence was more limited in the modules addressing ‘Using Medication Effectively, Reducing Relapse, and Getting Your Needs Met in the Mental Health System.’ The review of literature informed development of two guideline documents, one for non-OT managers and another for OT practitioners to educate regarding the role of OT within each module of IMR, as well as OT’s supported role as part of the IMR team.
Chapter III

METHODOLOGY

A systematic review of occupational therapy (OT) literature supporting the role of OT in IMR model programming was conducted for this project. In an effort to reflect contemporary practice in occupational therapy, inclusion/exclusion criteria were applied to the review. Criteria included professional OT articles published from 2002 to 2011 and OT-authored textbooks published from 2005 to 2011. The literature included professional national and international OT journals, as well as manuscripts published by OTs in other venues.


The first step of the literature review included a review of the IMR model to explore general information regarding the model, professions involved as part of the IMR
team, the diagnoses served, settings in which the model is implemented, the purpose of
the program, and the expected outcomes of the interventions provided. The next step
included the identification of the core practice strategies used within the IMR model, as
well as the primary focus of each of the 10 modules within the model.

A review of the OT literature specific to each of the core strategies and foci of
each of the 10 IMR modules was then conducted. Literature was sorted according to
source, journal articles in OT journals, in non-OT journals, and OT-authored textbooks.
Literature was additionally sorted according to the strength of the literature to separate
research-based pieces, expert opinion pieces, and reviews as part of OT textbooks.
Further the strength of the literature was evaluated in order to determine which modules
had the strongest support for the role of OT.

Results of the literature review were analyzed to determine the availability and
strength of OT support for participation in IMR program teams. Based on the results, the
authors determined a need for guidelines to guide OT practitioners in IMR program
teams. In addition, it was determined non-OT managers could also benefit from greater
understanding of the potential contributions of OTs to IMR programming.

The guidelines serve to enhance support for the role of OT in IMR model program
implementation and provide guidance during the intervention process within the 10 IMR
modules. The guidelines are intended to be used in mental health practice to support the
role of OT as part of the IRM programming team. The guideline documents are presented
in Chapter IV. Conclusions, recommendations for implementation, and limitations of the
scholarly project were developed and are provided in Chapter V.
Chapter IV
PRODUCT

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) published the Illness Management and Recovery (IMR) as an evidence-based model that supports the health and wellness of persons with severe mental illness (Mueser & MacKain, 2006). The IMR model includes four core concepts which support the 10 practice modules. The researchers of this scholarly project reviewed occupational therapy (OT) literature and textbooks that related to the concepts presented by SAMHSA. The strength of the OT literature within each IMR module was also reviewed to assist in determination of the role OT has in implementation of the IMR program modules.

Currently, there has not been published literature with researched evidence supporting the role of OT in IMR application, however the OT literature and textbooks support OT’s role in relation to the concepts addressed within the modules. Each module was evaluated individually and OT literature was applied accordingly to support the role of OT. Even though OT evidence was applied to each module, there was stronger OT support for the role of OT within some of the modules than others. Examples of modules with lower levels of evidence included module five, ‘Using Medication Effectively,’ module seven ‘Reducing Relapse,’ and module 10, ‘Getting Your Needs Met in the Mental Health System.’ Occupational therapy support was more evident in the other
modules as a variety of sources were available including professional national and international OT literature, OT textbooks, and other publications authored by OTs.

The materials presented in Chapter IV are intended to be used by managers and OT practitioners. The *Managers Guide* is designed to be used as an educational tool to support OT’s role as part of the IMR professional team. Managers that are not OTs will benefit from this product as it provides evidence in supporting OT’s role in using the IMR model in practice and best utilize the skills of the OT as part of the IMR team.

The *Practitioners Guide* is designed to be used as a professional guide to understanding the role of OT within each module. The research and evidence provided aids in defining OT’s role within IMR. The OT practitioners will be able to provide evidence-based care to clients specific to the profession of OT as it relates to the evidence-based model of IMR. In addition, direction is provided regarding IMR-based practice within occupation-based models of practice.

The project was designed to provide guidance for practicing OTs who are members of the IMR team. The guideline documents will direct interventions for OT practitioners implementing the IMR model and justify the need for OT services within IMR implementation to managers who may or may not be OTs themselves.
Chapter V
SUMMARY

The scholarly project was completed to research the role of occupational therapy (OT) within the Illness Management and Recovery (IMR) model. Literature was reviewed to explore intervention strategies OTs are using within mental health; the strategies were correlated to the core concepts outlined within the IMR model.

The systematic literature review revealed that evidence suggests that OTs may have a role within the IMR model. The strength of the literature within each module was evaluated to determine the role of OT within each of the 10 IMR modules. There was evidence supporting the role of OT within the modules of IMR including, ‘Recovery Strategies, Practical Facts about Mental Illness, The Stress-Vulnerability Model, Building Social Support, Drug and Alcohol Use, Coping with Stress, and Coping with Problems and Persistent Symptoms.’ The evidence was weaker in supporting the role of OT within ‘Using Medications Effectively, Reducing Relapse, and Getting your Needs Met in the Mental Health System.’ Two guideline documents were developed reflecting the strength of the literature to educate non-OT managers and OT practitioners of the role of OT within the IMR model programs, as well as the role of OT as part of the IMR program team.

The scholarly project is limited to implementation in mental health practice settings supported by IMR model research. It is expected that use of the supporting
guideline documents be limited to similar settings also seeking to maintain fidelity within IMR model design. A second limitation to the project includes the minimal practical experience of the student authors in IMR programming. It is recommended that the authors of the project collaborate with a practicing OT working in mental health implementing the IMR model program to further the scope of the research. The final limitation of the project includes the novice research experience and skills of the student authors. It is recommended that continued research could strengthen the evidence that supports the role of OT within IMR model implementation.

The product developed through the project process includes a non-OT *Managers Guide* and an *OT Practitioner Guide*. The guidelines serve as an educational tool supporting the role of OT in mental health and correlates OT intervention strategies to the core concepts of the IMR model. The *Managers Guide* is intended for the use of non-OT managers to gain an understanding of the role of OT as part of the IMR team. The *OT Practitioners Guide* includes the application of four occupation-based models compatible with IMR and the OT profession. Both of the guides include a list of references where the information can be obtained for further research.

Overall, the project presents a systematic review of literature to determine support for and compatibility of OT practice in IMR model programming. Guideline documents are provided for use as evidence supporting the role of OT within the IMR model by non-OT managers and OT practitioners.
REFERENCES


**Purpose**

The purpose of the ‘Managers Guide’ is to inform managers of varying educational backgrounds regarding the role of occupational therapy (OT) in mental health, specifically in the implementation of Illness Management and Recovery (IMR) model programs. The guide is designed as an educational tool supporting the role of OT within the IMR model. The guide provides the manager with evidence supporting the role of OT within each module of the IMR model and the role of OT in mental health, including the relationship of the OT domain and process of the *OT Practice Framework: Domain & Process* (AOTA, 2008) relates to IMR. Non-OT managers will gain increased understanding of the profession of OT through this guide, as well as understand how OT can be part of the IMR team.
The Role of OT within the IMR Modules

<table>
<thead>
<tr>
<th>Module</th>
<th>Module Focus</th>
<th>Role of OT</th>
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</thead>
<tbody>
<tr>
<td>Recovery Strategies</td>
<td>• Client’s personal definition of recovery.</td>
<td>• Provide education, evidence-based programs, and empowering clients to find meaning within life (Kelly, Lamont, &amp; Brunero, 2010).</td>
</tr>
<tr>
<td></td>
<td>• What helps people in the process of recovery?</td>
<td>• Empower clients to make self-directed decisions and goals to guide individualized recovery (Rebeiro Gruhl, 2005).</td>
</tr>
<tr>
<td></td>
<td>• Identifying personal goals to work towards.</td>
<td>• Promote wellness strategies including physical, spiritual, emotional, social, occupation/leisure, intellectual, and environmental (Swarbrick, 2009).</td>
</tr>
<tr>
<td></td>
<td>• Strategies to achieve goals.</td>
<td></td>
</tr>
<tr>
<td>Practical Facts about Mental Illness</td>
<td>• Understanding diagnosis, origin, and course of mental illness.</td>
<td>• Provide components of psychoeducation are present in OT programs, which are provided to clients and families (Eaton, 2002).</td>
</tr>
<tr>
<td></td>
<td>• Practical facts about schizophrenia and mood disorders.</td>
<td>• Include mental illness education, opportunity to work, and education to access of resources and supports (Eaton, 2002).</td>
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<td></td>
<td>• Public attitudes and behaviors towards people with mental illnesses.</td>
<td>• Utilize activity analysis to separate the demands of an activity into cognitive and psychosocial skills (Gutman, Kerner, Zombek, Dulek, &amp; Ramsey, 2009).</td>
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<tr>
<td>Module</td>
<td>Module Focus</td>
<td>Role of OT</td>
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<tr>
<td><strong>The Stress-Vulnerability Model</strong></td>
<td>• Causes of psychiatric symptoms.</td>
<td>• Utilize skills training to enhance work performance and goal achievement, which can result in management and reduction of symptoms (Lloyd &amp; Waghorn, 2007).</td>
</tr>
<tr>
<td></td>
<td>• Coping with biological vulnerability.</td>
<td>• Teach clients new skills or build upon current skills that can be applied to everyday experiences in the hospital or after discharge (Auerbach &amp; Jeong, 2005).</td>
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<tr>
<td></td>
<td>• Understanding treatment options.</td>
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<tr>
<td><strong>Building Social Support</strong></td>
<td>• Importance of social supports.</td>
<td>• Address social engagement and occupational participation to promote increased self-esteem, establish routines, and increase social networking (Cook &amp; Chambers, 2009).</td>
</tr>
<tr>
<td></td>
<td>• Meeting new people.</td>
<td>• Engage clients in meaningful occupations such as education, community outings, work, volunteer, and leisure (Cook &amp; Chambers, 2009).</td>
</tr>
<tr>
<td></td>
<td>• Starting a conversation with someone new.</td>
<td>• Promote interventions that support leisure interests leading to improved self-esteem and overall health (Mynard, Howie, &amp; Collister, 2008).</td>
</tr>
<tr>
<td></td>
<td>• Developing closer relationships.</td>
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<tr>
<td>Module</td>
<td>Module Focus</td>
<td>Role of OT</td>
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</tbody>
</table>
| **Using Medication Effectively** | • Role of medication and managing symptoms.  
• Identifying and responding to side effects.  
• Making informed decisions about medication.  
• Getting the best results from medication. | • Medication management is identified under health management and maintenance (AOTA, 2008).  
• Address occupational performance in therapy (Cole, 2011).  
• Address adaptive approaches to remembering to take medications (Cole, 2011). |
| **Drug and Alcohol Use**      | • Understanding drug and alcohol use.  
• Substance use and the stress-vulnerability model.  
• Pros and cons of sobriety.  
• Developing a sober lifestyle.  
• Developing a personal sobriety plan.  
• Revising your personal sobriety plan and putting it into action. | • Motivate clients to identify leisure activities to participate in that do not involve a using environment (Haertlein Sells, Stoffel, & Plach, 2011).  
• Include substance abuse interventions such as harm reduction, importance of social supports, community resourcing, and coping skills (Thompson, 2007).  
• Guide identification of environments, interpersonal, and emotional factors that are associated with using (Stoffel & Moyers, 2005).  
• Engage in motivational interviewing to understand the client’s addiction. OT’s acknowledge that change is difficult and that strength and personal values will help during recovery (Stoffel & Moyers, 2005). |
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<thead>
<tr>
<th>Module</th>
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</thead>
<tbody>
<tr>
<td><strong>Reducing Relapse</strong></td>
<td>• Identifying triggers of relapse.</td>
<td>• Motivational interviewing encourages the client to become of the agent of change in obtaining sobriety (Stoffel &amp; Moyers, 2004).</td>
</tr>
<tr>
<td></td>
<td>• Early warning signs of relapse.</td>
<td>• Cognitive-behavioral therapy guides the individual to using coping skills to change the way of thinking and behaving in high-risk situations (Stoffel &amp; Moyers, 2004).</td>
</tr>
<tr>
<td></td>
<td>• Responding to signs and symptoms of relapse.</td>
<td>• Anticipation and prevention of relapse occurs through learning assertiveness when in stressful situations, how to problem solve in everyday life, and the ability to recognize risky situations (Tayar, 2004).</td>
</tr>
<tr>
<td></td>
<td>• Developing a relapse prevention plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Coping with Stress</strong></td>
<td>• Origins of stress.</td>
<td>• Promote effective coping utilizing the following techniques: yoga, writing, art, exercise, nutrition, and breathing exercises (Haerl &amp; Christiansen, 2011; Stoller, Greuel, Cimini, Fowler, &amp; Koomar, 2012).</td>
</tr>
<tr>
<td></td>
<td>• Recognizing signs of stress.</td>
<td>• Promote stress alleviation and a sense of fulfillment through relaxation, nutritional education, and exercise (Crouch, 2008).</td>
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<tr>
<td></td>
<td>• Preventing stress.</td>
<td>• Address monitored breathing, meditation, social engagement, goal setting, mental imagery, and listening to music decrease stress (Rigby &amp; Wilson, 2006).</td>
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<tr>
<td></td>
<td>• Coping with stress using relaxation techniques.</td>
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<tr>
<td></td>
<td>• Additional strategies.</td>
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<tr>
<td>Module</td>
<td>Module Focus</td>
<td>Role of OT</td>
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<tr>
<td>Coping with Problems and Persistent Symptoms</td>
<td>• Method for problem solving and goal achievement.</td>
<td>• Reflective writing used to record coping strategies used during an event helps with identifying triggers, symptoms, and situations of distress (Rigby &amp; Wilson, 2006).</td>
</tr>
<tr>
<td></td>
<td>• Identifying common problems and persistent symptoms.</td>
<td>• Establish an occupational balance to promote participation in meaningful occupations when experiencing barriers, such as symptoms (Edgelow &amp; Krupa, 2011).</td>
</tr>
<tr>
<td></td>
<td>• Developing a plan to cope with common persistent and personal symptoms.</td>
<td>• Engage the client in interventions on social skills, structured activities, exploration, time management, and self-directed decision making promotes positive coping with symptoms and self-expression (MacRae, 2005).</td>
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<tr>
<td>Getting Your Needs Met in the Mental Health System</td>
<td>• Community mental health services.</td>
<td>• Assist with attaining knowledge and resources on legal rights and community services (AOTA, 2008).</td>
</tr>
<tr>
<td></td>
<td>• Financial and health insurance benefits.</td>
<td>• Guide the process of learning skills to find empowerment (Cottrell &amp; Langzettel, 2005).</td>
</tr>
<tr>
<td></td>
<td>• Advocating for yourself in the mental health system.</td>
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</tbody>
</table>
Role of OT in Mental Health

- OTs possess knowledge in neurology, psychosocial impacts, contextual influences, and activity analysis (Champagne & Gray, 2011).

- OTs support and educate clients on skills (Champagne & Gray, 2011).
  - Coping strategies
  - Development of habits and routines
  - Identify personal goals
  - Increase group participation and support, social engagement
  - Employment, volunteer, community events

- OTs use systematic and comprehensive assessments to develop collaborative goals with the client (Rigby & Wilson, 2006).

- OT’s develop therapeutic relationships with clients to encourage personal goal setting (Rigby & Wilson, 2006).

- OT’s provide interventions that engage the client in meaningful occupations, giving the client a sense of meaning in life (Legault & Rebeiro, 2001).

- OTs use psychosocial interventions that facilitate the client’s strengths to facilitate independence in living skills and management of the mental health diagnosis (Rigby & Wilson, 2006).

- OT’s provide clients with opportunities to engage in a range of meaningful occupations (Cronin-Davis, 2006).

- OTs use theoretical approaches to identify environmental conditions, strengths, resources, negotiate and evaluate outcomes, collaboratively develop action plans, and implement the plan through engagement in occupations (Cronin-Davis, 2006).
### OT Practice Framework Support Related to IMR

The *Framework* is composed of two major sections that are linked: the domain and process.

<table>
<thead>
<tr>
<th>OT Domain</th>
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<tbody>
<tr>
<td>Supporting health and participation in life through engagement in occupation</td>
</tr>
<tr>
<td>- Areas of occupation</td>
</tr>
<tr>
<td>- Activity demands</td>
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<tr>
<td>- Client factors</td>
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</tbody>
</table>
Collaboration between the practitioner and the client is central to the interactive nature of service delivery.

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Intervention</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Occupational Profile</td>
<td>Analysis of Occupational Performance</td>
<td>Supporting Health and Participation in Life through Engagement in Occupations</td>
</tr>
<tr>
<td>Identify:</td>
<td>Synthesize information</td>
<td>• Occupational performance</td>
</tr>
<tr>
<td>• Who is the client?</td>
<td>Observe client’s performance</td>
<td>• Adaptation</td>
</tr>
<tr>
<td>• Why is the client seeking services?</td>
<td>Select assessments</td>
<td>• Health and wellness</td>
</tr>
<tr>
<td>• What occupations and activities are successful or are causing problems?</td>
<td>Interpret assessment data</td>
<td>• Participation</td>
</tr>
<tr>
<td>• What contexts and environments support or inhibit desired outcomes?</td>
<td>Develop and refine hypotheses</td>
<td>• Prevention</td>
</tr>
<tr>
<td>• What is the client’s occupational history?</td>
<td>Collaborate with client to create goals</td>
<td>• Quality of life</td>
</tr>
<tr>
<td>• What are the client’s priorities and targeted outcomes?</td>
<td>Delineate areas for intervention based on best practice and evidence</td>
<td>• Role competence</td>
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<td></td>
<td></td>
<td>• Self-advocacy</td>
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<td></td>
<td></td>
<td>• Occupational justice</td>
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</tbody>
</table>

**OT Intervention Approaches**

- Create, promote (health promotion)
- Establish, restore (establish new skills or restore skill that has been impaired)
- Maintain (supports preservation of skills that have been regained)
- Modify (compensation or adaptation of the context or activity)
- Prevent (disability prevention)
REFERENCES


Purpose

The purpose of the ‘OT Practitioners Guide’ is to inform practicing occupational therapists (OT) regarding the relationship of OT to the Illness Management and Recovery (IMR) model. The guide includes a theoretical chart that outlines occupation-based interventions within OT practice. The IMR program has been compared to the following occupation-based models of practice: Canadian Model of Occupational Performance and Engagement (CMOP-E), Ecological Model of Human Performance (EHP), Model of Human Occupation (MOHO), and Occupational Adaptation (OA). Suggestions for implementation and OT practice specific to the concepts of each model are provided.

The guide supports occupation-based interventions within the IMR model, as well as defines the role of OT within each of the IMR modules. The reference table presents the OT literature, organized by the strength of evidence found supporting the role of OT within each of the IMR modules.

Occupational therapy practitioners can use the support and evidence within this guide to advocate for the role of OT in mental health, as well as the role of OT within the IMR model. The evidence supports the role of OT and shows that OT literature and textbooks support the profession in implementing the concepts within each of the IMR modules.
Conclusion

There is limited research evidence showing direct implementation of OT within IMR model application; however, there is evidence that suggests that OTs have a role within each IMR module. The strongest evidence supporting the role of OT is within ‘Recovery Strategies, Practical Facts about Mental Illness, The Stress-Vulnerability Model, Building Social Supports, Drug and Alcohol Use, Coping with Stress, and Coping with Problems and Persistent Symptoms.’ The evidence supporting the role of OT is limited within the modules ‘Using Medication Effectively, Reducing Relapse, and Getting Your Needs Met in the Mental Health System.’
<table>
<thead>
<tr>
<th>Model</th>
<th>Key Concepts of Model</th>
<th>IMR-Model Compatibility</th>
<th>Guidelines for OT Implementation</th>
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</thead>
<tbody>
<tr>
<td><strong>Canadian Model of Occupational Performance and Engagement (CMOP-E)</strong></td>
<td>• <strong>Person</strong>: affective, cognitive, physical, and spiritual.</td>
<td>• <strong>Collaborative relationship</strong> between client and team (SAMHSA, 2009a).</td>
<td>• <strong>Apply compensatory strategies or make accommodations to promote occupational performance</strong> (Gutman, Kerner, Zombek, Dulek, &amp; Ramsey, 2009).</td>
</tr>
<tr>
<td></td>
<td>• <strong>Occupation</strong>: self-care, leisure, and productivity.</td>
<td>• <strong>Creativity, leisure, social supports, and spirituality</strong> are believed to facilitate the recovery process (SAMHSA, 2009c).</td>
<td>• <strong>Promote recovery by using recovering strategies including physical, emotional, spiritual, social, occupation/leisure, intellectual, and environmental</strong> (Swarbrick, 2009).</td>
</tr>
<tr>
<td></td>
<td>• <strong>Power sharing</strong>: client-centered collaboration.</td>
<td>• <strong>Holistic interventions</strong> that incorporate the clients’ <em>mind, body, and spirit</em> (Whitley et al., 2009).</td>
<td>• Provide interventions focused on social interactions with the component of work. (Lloyd &amp; Waghorn, 2007).</td>
</tr>
<tr>
<td></td>
<td>• Therapist must be genuinely interested, acknowledge the client interests, empathetic, altruistic, and creative.</td>
<td>• <strong>Empowerment</strong> is knowledge and providing education about mental illness to consumers leaves them better equipped to take on an active role in the recovery process (SAMHSA, 2009d).</td>
<td>• <strong>Engage clients in meaningful occupations such as educational opportunities, work, volunteer opportunities, and engagement in leisure</strong> (Cook &amp; Chambers, 2009).</td>
</tr>
<tr>
<td></td>
<td>• <strong>Enablement skills</strong>: adapt, advocate, coach, collaborate, consult, coordinate, design/build, educate, engage, and specialize.</td>
<td>• Consumers are encouraged to <strong>develop their own definitions of recovery</strong> and their own strategies to move towards recovery (SAMHSA, 2009d).</td>
<td>• Provide empathy, self-efficacy, and acknowledgement that change is difficult, motivational interviewing uses the client’s strengths and values to guide therapy (Stoffel &amp; Moyers, 2005).</td>
</tr>
<tr>
<td></td>
<td>• <strong>Process/8 action points</strong>: enter/initiate, set stage, access/evaluate, agree on objectives plan, implement plan, monitor/modify, evaluate outcome, and conclude/exit.</td>
<td>• <strong>Assessment</strong>: Canadian Occupational Performance Measure (COPM) can be used to evaluate occupational issues and client goals (Craik, Davis, &amp; Polatajko, 2007).</td>
<td>• <strong>Assessment</strong>:</td>
</tr>
<tr>
<td>Model</td>
<td>Key Concepts of Model</td>
<td>IMR-Model Compatibility</td>
<td>Guidelines for OT Implementation</td>
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<tr>
<td>Ecological Model of Human Performance (EHP)</td>
<td>• Social, cultural, and temporal environments influence behavior.</td>
<td>• IMR supports the importance of establishing relationships by outlining places to meet new people within one of the modules (SAMHSA, 2009c).</td>
<td>• Identify skills and barriers to occupational performance. Re-establishing roles (Dunn, Brown, &amp; McGuigan, 1994).</td>
</tr>
<tr>
<td></td>
<td>• The person includes sensorimotor, cognitive, and psychosocial skills and abilities (Dunn, Brown, &amp; McGuigan, 1994).</td>
<td>• Establishing coping strategies help reduce and manage stress related to mental illness (SAMHSA, 2009c).</td>
<td>• Identify leisure activities, encouraging participation (Haertlein Sells, Stoffel, &amp; Plach, 2010).</td>
</tr>
<tr>
<td></td>
<td>• Interaction between person, context, and task performance (Rempfer, Hildenbrand, Parker, &amp; Brown, 2003)</td>
<td>• Restore existing relationships and establish new relationships (SAMHSA, 2009c).</td>
<td>• OT Practice Framework addresses create, promote, establish, restore, modify, prevent as intervention approaches (AOTA, 2008).</td>
</tr>
<tr>
<td></td>
<td>• Intervention strategies: (Rempfer, Hildenbrand, Parker, &amp; Brown, 2003). -Establish/Restore, Adapt/Modify, Alter, Create, and Prevent</td>
<td>• Client identifies triggers and early warning signs noted in previous relapses in order to prevent future relapse (SAMHSA, 2009c).</td>
<td>• Utilize client-centered outcomes in therapy, correlated to positive outcomes such as improved self-management skills (Gibson, D’Amico, Jaffe, &amp; Arbesman, 2011).</td>
</tr>
<tr>
<td></td>
<td>• The person brings own skills, abilities, and experience to therapy (Rempfer, Hildenbrand, Parker, &amp; Brown, 2003).</td>
<td>• Awareness of the environment and how it affects you is part of the recovery process (SAMHSA, 2009c).</td>
<td>• Identify personal strengths and goals, using coping strategies, learning or re-learning occupational roles, and community integrations (Rebeiro Gruhl, 2005).</td>
</tr>
<tr>
<td></td>
<td>• Task: self-care, work/productive activity, and play/leisure (Rempfer, Hildenbrand, Parker, &amp; Brown, 2003).</td>
<td>• Develop a prevention plan to identify strategies to engage in events, situations, and places that have led to relapse in the past (SAMHSA, 2009c).</td>
<td>• Introduce coping skills training to prepare individuals for unexpected situations that may occur (Lloyd &amp; Waghorn, 2007).</td>
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<td></td>
<td></td>
<td></td>
<td>• Enroll in educational programs to find new roles of interest or resume meaningful roles (Gutman et al., 2009).</td>
</tr>
<tr>
<td>Model of Human Occupation (MOHO)</td>
<td>Key Concepts of Model</td>
<td>IMR-Model Compatibility</td>
<td>Guidelines for OT Implementation</td>
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<tr>
<td><strong>Volition</strong></td>
<td>motivation for occupation. -Values and interests.</td>
<td>IMR encompasses treatment that is focused on the client’s <em>individualized goals</em> (Mueser et al., 2004).</td>
<td>Apply psychoeducation programs that are goal directed (Eaton, 2002).</td>
</tr>
<tr>
<td><strong>Habituation</strong></td>
<td>organize actions into roles and routines. -Habits and roles.</td>
<td>IMR emphasizes the client’s role in treatment by emphasizing establishing goals through <em>self-directed decision-making</em> (SAMHSA, 2009a).</td>
<td>Provide client-centered interventions which are correlated with positive therapy outcomes (Gibson et al., 2011).</td>
</tr>
<tr>
<td><strong>Performance capacity</strong></td>
<td>mental and physical abilities.</td>
<td>Education on how a mental illness can affect <em>performance in desired occupations</em> (SAMHSA, 2009a).</td>
<td>Empower clients to find meaning within life (Kelly, Lamont, &amp; Brunero, 2010) and to make self-direction goals (Rebeiro Gruhl, 2005).</td>
</tr>
<tr>
<td><strong>Occupational participation</strong></td>
<td>engagement in work, play, and activities of daily living (ADL).</td>
<td>The client designs a <em>personal plan</em> for prevention (SAMHSA, 2009a).</td>
<td>Facilitate client participation, creating motivation and encourage clients to establish routines (Swarbrick, 2009).</td>
</tr>
<tr>
<td><strong>Occupational identity</strong></td>
<td>who the client is and who they wish to become.</td>
<td>Developing and utilizing <em>coping skills</em> to prevent relapse and manage symptoms (SAMHSA, 2009a).</td>
<td>Provide the opportunity for social interaction and development of self-esteem through work (Lloyd &amp; Waghorn, 2007).</td>
</tr>
<tr>
<td><strong>Occupational narrative</strong></td>
<td>personal story.</td>
<td>Recovery includes <em>developing a sense of identity</em> that allows for personal growth beyond their mental illness (Mueser et al., 2004).</td>
<td>Engage clients in meaningful occupations such as education, community outings, work, volunteer, and leisure (Cook &amp; Chambers, 2009).</td>
</tr>
<tr>
<td><strong>Therapeutic strategies</strong></td>
<td>-Validating, identifying, giving feedback, advising, negotiating, structuring, coaching, encouraging, and physical support.</td>
<td></td>
<td>Utilize open-ended questions to understand the client (Cottrell &amp; Langzettel, 2005).</td>
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<tr>
<td>(Kielhofner, 2009)</td>
<td></td>
<td></td>
<td><strong>Assessment:</strong> There are 19 MOHO assessments, 14 assessments are used with adults and are appropriate to use to better understand the client (Kielhofner, 2009).</td>
</tr>
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<tr>
<td>Occupational Adaptation (OA)</td>
<td>• Client is the agent of change; OT is the agent of the environment.</td>
<td>• Clients are in charge of the treatment process and become the primary agent of change</td>
<td>• Occupational adaptation guide to practice (Schultz &amp; Schkade, 1992).</td>
</tr>
<tr>
<td></td>
<td>• Engagement in occupations defines roles.</td>
<td>• Education on how a mental illness can affect performance in desired occupations (SAMHSA, 2009a).</td>
<td>• Utilize assessments and interviews to help the client identify occupational roles. Engage client in desired roles including leisure/play, work, social networks, and finances (Lloyd, Waghorn, Williams, Harris, &amp; Capra, 2008).</td>
</tr>
<tr>
<td></td>
<td>• Occupational adaptation: client is faced with an occupational challenge. Role capacity.</td>
<td>• Outcome studies have indicated individuals show program retention and application after discharge from the hospital (Mueser et al., 2006).</td>
<td>• Use skills training during therapy with the client. By learning each skill in a process, clients are able to take the skills and apply them to everyday experiences (Auerbach &amp; Jeong, 2005).</td>
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<td></td>
<td>• Person, environment, and interaction between them.</td>
<td>• Formulating personal recovery goals helps gain mastery over symptoms and relapses (Mueser et al., 2004).</td>
<td>• Address engagement in roles promoting self-esteem, establishment of daily routines, and social networking within clients (Cook &amp; Chambers, 2009).</td>
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<td></td>
<td>• Adaptive capacity: ability to recognize need for change.</td>
<td>• Weighing the pros and cons of sobriety allows individuals to connect the need for change to abstinence or reduced substance abuse (SAMHSA, 2009c).</td>
<td>• Address the individual’s readiness to change through motivational therapies (Haertlein Sells et al., 2011).</td>
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<td></td>
<td>• Relative mastery: self-assessment of occupational response.</td>
<td>• Develop a plan of strategies on how to handle high-risk situations (SAMHSA, 2009c).</td>
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<td></td>
<td>• -Desire, demand, and press for mastery.</td>
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<td>• Performance in work, play/leisure, and self-care.</td>
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<td>• Internal adaptation: respond to challenges and change.</td>
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<td>• Adaptation gestalt: balance between sensorimotor, psychosocial, and cognition.</td>
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<td>(Schultz &amp; Schkade, 1992)</td>
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<td><strong>Recovery Strategies</strong></td>
<td>• Gibson, D’Amico, Jaffe, &amp; Arbesman (2011)</td>
<td>• Swarbrick (2009)</td>
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<td>• Kelly, Lamont, &amp; Brunero (2010)</td>
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<td>• Gutman, Kerner, Zombek, Dulek, &amp; Ramsey (2009)</td>
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<td><strong>The Stress-Vulnerability Model</strong></td>
<td>• Arbesman &amp; Logsdon (2011)</td>
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<td>• Auerbach &amp; Jeong (2005)</td>
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<td>• Inman, McGurk, &amp; Chadwick (2007)</td>
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<td>• Lloyd &amp; Waghorn (2007)</td>
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<td>• AOTA (2008)</td>
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<td>• Mynard, Howie, &amp; Collister (2008)</td>
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<td>Drug and Alcohol Use</td>
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<td>● Haertlein Sells, Stoffel, &amp; Plach (2011)</td>
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<td>● Stoffel &amp; Moyers (2005)</td>
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<td>● Chan, Krupa, Lawson, &amp; Eastabrook (2005)</td>
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