Reducing Inpatient Mental Health Readmissions: Connecting Recovery to Meaningful Life

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Reducing Inpatient Mental Health Readmissions:

Connecting Recovery to Meaningful Life

Emily Petersen

A doctoral project submitted in partial fulfillment of the requirements for

The Doctor of Occupational Therapy,

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Abstract

The rates of mental illness remain high with one in five experiencing a mental health diagnosis with estimates expected to rise significantly due to the COVID-19 pandemic (National Alliance for Mental Illness, n.d.; USA Facts, 2021). At the same time, mental health treatment has undergone significant changes over the last few decades. Treatment models have shifted to focus on preventative and community-based care, shorter lengths of acute inpatient hospital stay, and a strong push by multiple stakeholders to measure the quality outcomes of care. In healthcare settings, there is a strong drive amongst hospital leadership to improve health outcomes with measurable outcomes, enhanced patient experience, and reduced healthcare costs (Institute for Improved Healthcare, 2021).

The American Occupational Therapy Association (AOTA) has published guidelines and evidence-based practice standards for mental health; however, the acute inpatient mental health setting has not yet been adequately reflected in the research. While we believe that we play a vital role in helping our clients with a critical mental health hospitalization recover and resume their quality of life, what evidence is there to guide our treatment interventions and advocate for the value of our care? Despite our professional roots in mental health, this practice area has struggled to develop and maintain research standards to further inform good practice.

The aim of this project was to raise awareness of the current practice dilemma for mental health, provide education on the current literature of interventions that reduce readmissions, and the implications or recommendations for occupational therapists. The knowledge translation projects were disseminated in three approaches. The first method was education provided to occupational therapy practitioners, educators, and students through a continuing education webinar with the Minnesota Occupational Therapy Association (MOTA). The second project
included a poster session and presentation that was presented to practitioners, educators, and students hosted by MOTA. Lastly, the third way the knowledge was translated was through an article written to be submitted for publication in *OT Practice* magazine.

The three knowledge translation projects targeted increasing awareness of the effective interventions that reduce the likelihood of readmission to an inpatient psychiatric hospital. Through a review of the evidence, strong research studies have proven that using a recovery-oriented model to provide psychoeducation and discharge planning for individuals in an inpatient setting is effective at decreasing readmission rates. Occupational therapy is in direct alignment with the recovery model, but more research is needed on the role of OT within inpatient mental health settings, and more globally on the effectiveness of our interventions for mental health conditions, and the role we provide as vital members of the treatment team.
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Chapter 1. Introduction and Background

Background

When I began my career in occupational therapy (OT) in 2007, I was hired to practice inpatient OT at one of a few remaining freestanding psychiatric hospitals in the United States. The hospital housed multiple inpatient units and outpatient programs, that were separated by the age level, diagnosis, or the acuity needs of the population. Within each unit, there was a large dayroom, a dining room, additional group or individual meeting spaces, and a handful of the of the units had deck space attached for patients that were not allowed to leave. The other units had off unit features that included a deck with a playground structure, a garden deck on the rooftop, and a flat top deck for sports use to offer various outdoor experiences for clients.

In service to the inpatient units, the rehab department had fantastic facilities, including a large task room filled with wall-to-wall craft options for patients specific to the OT amenities. The space and supplies included a woodshop for woodworking, a kiln, and a variety of ceramic molds, a kitchen and attached dining room. As a new graduate, I heard stories from therapists who had worked at the hospital for decades. They shared experiences of the history of mental health, to a time when they had a pool on the deck and a hair salon in the clinic because patients would spend months at the hospital for their care. The space and supplies were akin to fostering an environment that promoted skill development in meaningful activity and occupations for individuals hospitalized with mental illness.

As I gained knowledge and experience within this practice area, I also observed significant change within the hospital services and the larger mental health structure of care and services. For example, even within my almost 15 years of working, our services and space have significantly changed. First, we moved into a different hospital building that is primarily a
medical hospital built for individuals with physical health needs and not tailored for the unique needs of mental healthcare. The dayrooms significantly shrunk to become a shared dining space that is difficult to maneuver and is not big enough to accommodate groups on the unit. The OT clinic became a small room with crafts made to fit into small cabinets and gone are the days of the woodshop and kiln. We used to have space and supplies to offer meaningful opportunities to engage in occupations, but the shift in new hospital design and operations has caused a needed shift in how we deliver care.

It is not just the space and supplies that have caused significant change, but healthcare, and particularly mental health quality standards, has undergone rapid changes. The average length of stay is now 6-12 days, compared to the longer lengths of stay that were common in previous decades. In addition, discharge planning now begins on day 1 of the admission, and the focus of hospitalization is on rapid reduction of symptoms, aftercare services, and preparing for the transition after hospitalization. We used to have a length of stay that afforded relational care, through assessments, and time spent in interventions that built occupational engagement and skills, but the model of mental health hospitalization has changed, and inpatient OT needs to adapt to serve the everyday occupational needs of the population, and mental health services at large.

As I was working and observing these changes, I grew increasingly concerned for the insufficient evidence for inpatient mental health interventions and advocating for our role and value of OT in inpatient mental health. I realized that despite knowing the value we provide to our patients through engagement in task and skills groups, qualitative feedback from patients, and quantitative measures such as high patient satisfaction scores, but lacking robust research in
mental health, there were limited outcome measures that we could use to advocate for our services.

As we continue to face barriers to deliver care in mental health settings, particularly in inpatient mental health due to federal and state regulations that do not define OT as a necessary service, the volume of our profession has decreased, but not our value to this population. Furthermore, the need for mental health services and psychosocial interventions is expanding beyond the classic mental health settings to all dimensions of OT services, including school-based services and physical medicine. Although mental health awareness and needs were increasing prior to the pandemic, the present need for mental health interventions is acutely observed due to COVID’s mental health effects on the population. The mind and the body are connected, and so too, the services should be collaborative. Yet, there is minimal research on the efficacy of our interventions to support the treatments we are providing, impeding the actualization and expansion of our value in delivery of care. Despite our rich history in mental health and traditional psychiatric settings, these factors have shrunken our impact, both acutely and generally.

It is important to consider the historical context of our profession when exploring the current practice dilemma of OT in mental health, particularly as it relates to the arts and crafts as a treatment modality. As OT curriculum was formulated and advancements in OT research catapulted, the profession aligned and was supported by a more medical model of care, and as such, the requirement of arts and crafts were dropped from the essentials of OT curriculum (Andersen & Reed, 2017). While crafts are no longer a required part of OT education or researched as an effective intervention, they are still a popular treatment intervention, especially amongst OTs working in mental health. The OT department continues to use craft skills as a
treatment modality despite a lack of formal training for incoming students and therapists. The level of therapeutic intervention that comes within a task craft group requires clinical reasoning and assessment skills, keen awareness of the safety constraints, and mastery of activity analysis. In its present delivery, a highly specialized skill has been diluted by over-generalization without any substantive efforts to ensure quality. The curricular changes further the gap between clinical practice and evidence-based research in mental health.

As a result of the evidence dilemma and my strong passion for maintaining the quality of OT in inpatient mental health, I returned to school to further my education in occupational therapy to identify evidence-based research for inpatient mental health. Throughout my studies, I have focused on trying to identify evidence-based practice research related to the specific population of inpatient mental health. I began my self-study with a general review of the evidence-based research in mental health. In taking a broad view of my topic area, I realized that I had many gaps in my knowledge and big dreams in my visions. I identified continuing education opportunities in mental health and searched the American Occupational Therapy Association (AOTA) resources and the critically appraised papers (CAPS) on mental health topics.

Additionally, connecting with mentors in my study area was a game-changer for my project. I began by attempting to offer evidence on functional skills, such as employment interventions; however, it became clear that finding established research for inpatient mental health was going to be a barrier in my knowledge translation project. This was particularly evident when I met with Dr. Elizabeth Griffin Lannigan, PhD, OTR/L, FAOTA, the former AOTA Mental Health Special Interest Section (SIS) chairperson. As part of her mentorship in selecting the topic of my project, she guided me toward the realization that teaching skills in
inpatient is challenging and an ineffectual intervention tool due to the length of stay. She recommended that I go back to the textbooks and formative mental health education to review the recommendations specific to acute mental health settings. Despite my desire to study employment, the research surrounding the topic was for outpatient settings, a challenge I would continue to encounter as I combed through the evidence. Through discussions with my mentors, colleagues, and professors, I began to realize that due to the lack of evidence for inpatient mental health in OT, it was essential to take a step back and identify what the effective interventions for inpatient mental health are and draw parallels to how OT is and can be involved in these evidence-based interventions.

**Review of Evidence**

**Anxiety and Mood Disorders**

Anxiety and depression are the most prevalent type of mental health condition in the United States (Anxiety and Depression Association of America [ADAA], 2021). According to the National Alliance of Mental Illness ([NAMI], n.d.), one in five Americans experience a mental illness, with anxiety disorders and mood disorders accounting for 35% of mental health conditions. The estimate of mental health has drastically increased since the pandemic, as evidenced by recent estimates that increased to 1 in 3 adults in California diagnosed with a mental illness (Kaiser Family Foundation [KFF], 2022). In addition, according to John Hopkins Medicine (2021), the top causes of disability in the United States (U.S.) and worldwide, include both depression and bipolar disorder. The rate of hospitalization for mental health disorders was also significant. In 2016, hospital stays with either a primary or secondary mental health condition accounted for 27.8% of the hospitalizations; however, when broken down by age group, the percentage of individuals ages 18-64 years hospitalized with a mental health condition
increased to 83.8%, or one out of every five hospital stays in the U.S. (Agency for Healthcare Research and Quality [AHRQ], 2019). While the need for mental health hospitalization is high and projected to grow, particularly post the COVID pandemic, an estimated 37% of the population does not have access to mental health care due to shortages amongst mental health professionals (Panchal et al., 2021; USA Facts, 2021). This shortage of mental health support means that over one-third of Americans are living in areas that are unable to provide adequate mental health care (USA Facts, 2021).

While it is normal to experience feelings of anxiety or fear in life, individuals suffering from an anxiety disorder experience frequent, and at times debilitating feelings of fear and panic (Mayo Clinic, 2021). Under the umbrella of anxiety disorders is generalized anxiety disorder (GAD), panic disorders, phobias, obsessive compulsive disorder (OCD), selective mutism, social anxiety, separation anxiety, and anxiety due to a medical condition (Mayo Clinic, 2021). Individuals suffering from anxiety disorders may experience intense nervous feelings or a sense of impending danger. There are many physical symptoms associated with anxiety disorder and these include increased heart rate, difficulty breathing, sweating, difficulty concentrating or focusing, poor sleep, gastrointestinal illness, headaches, muscle tremors or trembling, body weakness, feeling faint, and nausea (MacRae, 2019; Mayo Clinic, 2021).

Anxiety disorders can occur at any age, with a high prevalence occurring in adolescents (Mayo Clinic, 2021). It may be associated with life transitions, environmental changes, or other stressors (MacRae, 2019). Individuals struggling with symptoms of anxiety may have difficulty completing everyday routines or preferred activities, or they may struggle with preoccupation (MacRae, 2019). In addition, anxiety disorders can adversely impact an individual’s quality of
Major depression disorder (MDD), the most common mood disorder, impacts 19 million Americans a year (Mayo Clinic, 2021). The mood disorder category also includes bipolar disorder, seasonal affective disorder (SAD), and other less common mood disorders (NAMI, 2021; Mayo Clinic, 2021). According to the American Psychiatric Association (APA; 2021), depression impacts the way individuals feel, their thoughts, and behaviors. Depression results in the individual experiencing intense sadness, low energy, feelings of worthlessness, guilt, or shame, and a loss of interest or pleasure in activities (APA, 2021). Additional symptoms may include changes in appetite, pacing or an inability to sit still, slowed movements, difficulty focusing or concentrating, and suicidal thoughts (APA, 2021). It is caused by combinations of biochemistry, genetics, personality, and environmental factors, and is typically one of the most treatable mental disorders (APA, 2021).

Treatment for anxiety and mood disorders can occur in a variety of settings. While inpatient hospitalization addresses the immediate safety and symptom management of individuals, additional settings such as partial hospitalization programs or day programs, outpatient treatment care settings, and community-based programs offer effective courses of treatment options for maintenance care of these mental health disorders. The primary goal in inpatient treatment is stabilization (MacRae, 2019). Treatment models and interventions most used during inpatient hospitalization may include medication management, psychotherapy, cognitive behavioral therapy (CBT), and group therapy (NAMI, 2021; McLean, 2021). Recently, due to changes in healthcare reform and a shortage of hospital beds for mental health, inpatient treatment models have focused on reducing the length of stay, hospital readmission...
rates, and the healthcare costs (Ray et al., 2019). This evolution in the healthcare system in conjunction with the emergent need for quality mental health services has resulted in a growing interest in evidence-based treatments.

**The Recovery Model**

The concept of recovery has established roots in the field of physical medicine and rehabilitation (Rodgers et al., 2007). Someone with a chronic medical condition, or a disability, can navigate managing their symptoms or illness to continue or regain quality of life (Rodgers et al., 2007). The recovery model shifts perspective away from treating the illness, or eliminating the symptoms, to a person-centered perspective of how to treat the individual’s needs (Jacob, 2015). The principles of the recovery model are rooted in an emphasis on helping the patient gain control and develop resilience (Jacob, 2015). As stated by the Substance Abuse and Mental Health Services Administration ([SAMSHA], 2012) the definition of recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” (p 3). The SAMHSA Recovery and Recovery Support Initiative (2020) described recovery in four dimensions that support the individual, they include health, home, purpose, and community. As highlighted by Read & Stoffel (2019), support of an individual in their recovery means to follow a strength-based approach that is directed by the goals and skills that exist within the person.

The notion that one can recover from mental illness has been reflected upon for over 20 years by individuals, families, and communities impacted by mental health (Read & Stoffel, 2019). Despite this, psychiatry has been slow to adapt the recovery model framework into mental health treatment. Around the 1980s, personal stories and experiences of recovery published in literature, in addition to research that supported that individuals with mental illness
were capable of recovery began to shift the treatment model away from symptom management (Rodgers et al., 2007). This model has grown during the last few decades with the public health system response to mental health in the United States, working towards adoption of the recovery model (Rodgers et al., 2007).

When comparing the utilization of the recovery model versus the more traditional medical model in mental health treatment, there are several strengths and barriers to both approaches. The recovery model is client-centered and focuses care on achieving meaningful life goals for the individual (Duckworth, 2015). This shared decision-making process puts the experiences of the individual as the focus, and this creates positive expectations and an engagement in the recovery process for the clients (Duckworth, 2015). Within the model, some of the challenges or barriers are part of a larger and more pervasive issue in mental health care in generally: attempting to quantify outcomes of treatments. Recovery is a subjective concept and one that is hard to measure. In their article, Rodgers et al. (2007) discusses the different definitions and perspectives that have been formulated in the last few decades while this model grew in popularity. The recovery model, as is the case with many mental health treatments, relies on qualitative experiences and outcomes, unlike the medical model that uses scientific and objective facts to guide treatments (Duckworth, 2015). Lastly, many individuals struggling with acute mental health conditions may lack insight, have a higher level of care needs, or have ambivalence regarding their care and recovery goals which inhibit effective participation in treatment (Duckworth, 2015). Although there is a growing amount of research and evidence promoting a recovery model, many clinicians and institutions may find implementation of the recovery model challenging to utilize and justify without clearer outcomes in clinical care (Duckworth, 2015).
Mental Health Inpatient Readmissions and Healthcare Initiatives

Healthcare reform, particularly in mental health care settings, has dramatically changed in the last 30-40 years (Institute for Healthcare Improvement [IHI], 2021). While hospitals look to reduce cost and improve the effectiveness of care, they are targeting reducing the rate of readmissions. According to Heslin & Weiss (2015), “in 2010, 29 percent of Medicare insured psychiatric inpatients from free-standing psychiatric units or general hospital-based psychiatric units had two or more hospitalizations during the same year, and 21 percent were readmitted within 60 days of discharge” (p 1). Several issues stand out as commonly identified impacts from readmission: psychological stress to individual and family, demoralization to individual, potential feeling of failure for the treatment team, high cost for healthcare systems, and a drain of resources (Heslin & Weiss, 2015; Ray et al., 2019). When looking at the data, schizophrenia and mood disorders were the two most common diagnoses associated with readmission (Heslin & Weiss, 2015).

OT and Inpatient Mental Health

There are ample publications and documents that support OTs alignment with mental health treatment and the recovery model. As stated in AOTA OT’s role with mental health recovery fact sheet (2016) “occupational therapy practitioners work to empower each individual to fully participate and be successful and satisfied in his or her self-selected occupations” (para. 3). The treatment goals of OT directly align with the mental health recovery outcomes and World Health Organization (WHO) promotion of mental health (AOTA, 2016; AOTA, 2017). The benefits of OT in acute psychiatric care include encouragement and engagement in activity, addressing self-care skills, beginning the foundation of rehabilitation skills, assistance with treatment goal development, and community referrals (MacRae, 2019). When considering the
SAMSHA (2020) four dimensions of recovery, OT supports the individual in their recovery by assisting them with identifying what home, health, purpose, and community mean to them (Read & Stoffel, 2019). As stated by MacRae (2019), “occupational therapy can play a significant role in providing the beginnings of rehabilitation with skill development, helping patients to develop and refine realistic goals, and helping with referrals to the community where goal attainment is possible” (p 27-28). While there were many documents within AOTA, the Occupational Therapy Association of California (OTAC), and the World Federation of Occupational Therapists (WFOT), when narrowing down resources to solely review the documents related to OTs role in inpatient care, the search results were limited.

**Significance and Innovation**

The significance of this project is specifically targeted toward the gap and practice dilemma identified through my clinical experiences and by researching the available literature. Since the COVID-19 pandemic, mental health rates are increasing rapidly, including estimates that 33% of the population experiences mental health symptoms, this is up from the previous rate of 20% (NAMI, n.d.; KFF, 2022). Mental illness may impact the individual in an acute episode or a long-term chronic disorder and affects psychological, behaviors, and emotional well-being of the individual (KFF, 2022). According to NAMI (n.d.), of the reported conditions, anxiety disorders are the most common condition (19.1%), and depression is the second leading diagnosis (7.8%). These estimates have significantly increased during the COVID-19 pandemic, with individuals reporting higher mental distress, including anxiety, depression, alcohol and substance abuse, and disruptions in sleep hygiene (Panchal et al., 2021).

Since the start of the pandemic, the rates of individuals reporting mental illness has harshly risen to include an additional 53.2 million and 76.2 million cases of anxiety and MDD
(respectively) since 2020 (Institute for Health Metrics and Evaluation [IHME], 2021). According to the KFF (2022), the estimate of individuals in California reporting mental illness is one in three. Another study found the average number of adults who reported experiencing anxiety and depression increased by 30% between January 2019 and January 2021 (Panchal et al., 2021).

While there is some research on interventions for individuals experiencing from chronic or severe mental health disorders, such as schizophrenia, there is limited robust research on effective OT interventions for other more common diseases, such as the mood disorders of depression and anxiety. As a result, this project aims to address the intersection between the practice setting of inpatient psychiatric hospitals or units within a general hospital with adults affected by a mood disorder and the value that OT brings to supporting the individual in living a meaningful and independent life.

Another critical consideration for knowledge translation in mental health research is to identify what interventions are effective for meeting the needs of individuals in an acute mental health crisis. According to McDermott (2017) in a study that compared hospital stays from 2005 to 2014, inpatient hospitalization for mental health/substance use conditions rose 12.2% in the U.S., while hospital stays for all other conditions dropped by 6.6%. The study found that mental health hospitalization was the only cause of increase in hospital stays (McDermott, 2017). Furthermore, in the U.S. the rates of suicide have increased in almost every state and is the leading cause of death in America (KFF, 2022). To assist individuals in acute mental health crisis, treatment needs to focus on strategies to support transition back to one’s everyday life activities and routines and accruing the evidence for interventions that reduce the likelihood they will return to the hospital.
In addition to the steady incline in need for the population served, further encouragement for evidence is the fact that mental health treatment has undergone significant changes over the last few decades. Treatment models have shifted to focus on preventative and community-based care, shorter lengths of acute inpatient hospital stay, and a strong push by multiple stakeholders to measure the quality outcomes of care (Ray et al., 2017). As a result, the recovery model has emerged as the primary gold standard in mental health care (Lyon, 2020). Unlike many of the traditional mental health treatment models that were more authoritarian in care and decision making, the recovery model uses patient-centered and shared decision-making processes to guide the treatment (Lyon, 2020). Emerging research measures the effectiveness of interventions that promote the recovery model and quality of life outcomes for individuals with mental health (Lyon, 2020). Yet, still, many clinicians are unaware of the evidence of their interventions.

OT practice in mental health originated with the moral treatment model leading to an evolution of the arts and crafts movement that provided treatment to those suffering mental illness following World War I (Andersen & Reed, 2017). Despite our professional roots in mental health, this practice area as a specialty has struggled to develop and maintain research standards to further inform good practice as compared to other areas of OT research. Several factors contribute to the need for more research of effective mental health interventions. One part is the profession-wide shift in OT to a more medical/rehabilitative model of care, which historically meant that the field of medicine and psychiatry are treated separately (Andersen & Reed, 2017). Regulatory constraints and barriers, particularly in inpatient mental health, where OT is not considered a necessary member of the treatment team, further complicate our role in traditional mental health settings (Centers for Medicare and Medicaid Services [CMS], 2017). While the number of OTs working in mental health steadily declined over the last 40 years, the
profession has simultaneously expanded in theory development, research, and evidenced-based standards (Andersen & Reed, 2017). As a result, the evidence of OT interventions in mental health is deficient, and thus so is the efficacy of the practice of OT in mental health.

It is essential to note that barriers impeding the practice area of mental health are beyond the reach of the discipline and are regulated by state and federal law. While mental health services were overhauled as part of the Affordable Care Act (ACA), there is still great opportunities for advocacy of the value of our role for inpatient settings. Under the ACA’s reform for healthcare to focus on prevention and recovery, the unique proficiencies of OT, in connection to this paradigm, highlight opportunities for expansion in the behavioral health marketplace, and the opportunity to assert the value of our role in acute psychiatric settings (Stoffel, 2013). Part of this call to action is to produce robust data on the effectiveness of our interventions. The field of psychiatry has evolved, albeit slower than medicine, to adapt to a focus of measuring the treatment quantitatively. Although it is often challenging to quantify the usefulness of mental health interventions, there is a healthy impetus to measure and define the expected outcomes of care (Wobrock et al., 2009; AHRQ, 2017). For example, analyzing the length of stay, the rates of readmission, and reduction of self-harm are all outcomes that are commonly tracked as a measure of successful interventions (IHI, 2021).

Another significant factor of the need for an expanding database is the volume of OTs working in what is considered a classical mental health setting. As of 2018, it was estimated that only 2% of OTRs were working in mental health (AOTA, 2020). Within that small percentage of OTs, a smaller number are working in acute inpatient mental health settings. This directly correlates with the lack of research in this practice area; however, the number of individuals with mental illness, or co-morbidities with medical conditions is increasing (NAMI, n.d.). In a 2017
National Board of Occupational Therapy (NBCOT) Practice Analysis Executive Report, only 1.8% of respondents identified as working in mental health practice settings, but only 16% of OTs surveyed reported that they do not provide services to individuals within psychiatric diagnostic criteria (NBCOT, 2018). This is part of a larger systemic issue between medicine and psychiatry, which regularly continues to practice in silos with limited engagement or collaboration, despite research advocating for inclusive care (Knickman & Elbel, 2019). Every OT practitioner has the potential to be considered a mental health clinician, and additionally our services have the ability to bridge the gaps between a medical and behavioral health model of care to support the needs of the whole individual.

Despite the reported division of care by setting, there is a critical need for OT to produce richer evidence on the effectiveness of our mental health interventions. As practitioners, we holistically treat the whole human, which includes the mind and body connection, and is one that needs evidence-based standards and research guidance for the OT profession. According to Gutman (2012), in a review of the 278 research studies published in the American Journal of Occupational Therapy (AJOT) for four years, only 6% were related to mental health. Also, the study found that nearly half of the 17 articles found were special issue articles, and only 9 of the 18 articles covered the effectiveness of interventions within general mental health (Gutman, 2012). As a result of the significant change in healthcare and the lack of research on the efficacy of interventions, clinicians use treatment models based on past experiences and data without new evidence to validate treatment.

AOTA has published guidelines and evidence-based practice standards for mental health; however, the acute inpatient mental health setting has not yet been adequately reflected in the research. While practitioners believe that OT plays a vital role in helping this population with a
critical mental health hospitalization recover and resume their quality of life, what evidence is there to guide OT practice and treatment interventions, and advocate for the value of our care? More specifically, within the recovery model, what evidence-based practice interventions reduce readmissions for clients previously living independently but admitted to an acute hospital for a mood disorder? OT practitioners need to demonstrate the value they bring to the inpatient setting by targeting evidence-based interventions as meaningful to the individual and reduce the likelihood of readmissions (Ikigu et al., 2017).

**Aims**

The aim of the first knowledge translation project was to inform occupational therapy practitioners of the evidence-based interventions that reduce the likelihood of inpatient mental health hospitalization, provide the best practice recommendations, and discuss implications for OT as part of our role within inpatient mental health through a 30-minute virtual continuing education session via the Minnesota Occupational Therapy Association (MOTA).

The aim of the second knowledge translation project is to present the research and evidence to occupational therapy practitioners and students to increase awareness about recovery care and the relationship to occupational engagement as an evidence-based intervention for acute mental health settings through a poster presentation for the 2022 MOTA Poster Presentation.

The aim of the third knowledge translation project was to increase knowledge and awareness of recovery-oriented care and phases of occupational engagement for adults hospitalized with mental health disorders among occupational therapy practitioners and occupational therapy students through an article submitted for publication in the AOTA OT Practice publication.
Chapter 2. Evidence of Effective Interventions for Reducing Inpatient Readmission Rates: A Knowledge Translation Project via a Virtual Continuing Education Session

Aim

The knowledge translation project aim was to present evidence-based practice and research outcomes of the effective interventions for reducing the readmission rate in inpatient mental health, and the implications for occupational therapy practice through a 30-minute virtual continuing education session with OT practitioners hosted through the Minnesota Occupational Therapy Association (MOTA).

Description

To complete this knowledge translation project, a 30-minute virtual continuing education session was created and presented to members of the association via Zoom as part of a partnership between St. Catherine University and MOTA. My presentation was combined with one classmate from the program, who also presented her individual knowledge translation project. The title of the event was "Homeless Not Hopeless, Effective Strategies to Working with Homeless Women and Interventions to Decrease Readmission Rates in Inpatient Psychiatric Hospitals." The webinar was held on Tuesday, February 8, 2022, from 6:00-7:00 PM, CST. My presentation was 25 minutes long, with five minutes allotted at the end of my session for questions and discussions. There was a moderator from MOTA that assisted with the introductions and question-and-answer portion of the presentation.

My presentation focused on my evidence-based literature review of effective interventions for reducing the readmission rate in inpatient mental health. During the presentation, the steps used to complete my evidence-based practice literature review were presented, which included the background information and the clinical question, process of
conducting database searches, critical appraisals of four research studies, the literature matrix, discussion of the four themes extrapolated in the from the evidence, and implications for OT practice and further research.

**Approach**

The approach for this knowledge translation was a virtual continuing education session via Zoom. I created a 28-slide PowerPoint presentation with a parallel script for MOTA members. My narrated PowerPoint slides can be viewed in Appendix A.1. To present my PowerPoint slides, I used the advanced sharing option in Zoom. This feature allowed me to share only a small portion of my screen with the audience, while using the presenter view to read from my script. Participants were made aware that the event was recorded and consented to participation. However, due to technical difficulties with Zoom during my presentation, the presentation was interrupted on two occasions. Flexibility and adaptation on the spot were required, and with the assistance of moderators, the content was presented in full. Participants were provided with my St. Catherine University email address in the final slide of the presentation, and a Google Forms survey was created and shared in the chat box for any further questions or feedback. In addition, due to the technical glitches, my PowerPoint slides and Google Forms survey were sent out via MOTA to members that attended the presentation.

**Audience and Venue**

The audience for the continuing education session were occupational therapy practitioners, students, and educators. The event was hosted by St. Catherine University and MOTA via Zoom and was available to MOTA members and non-members. The fee for MOTA members was $5 and $25 for non-members. There were fifteen participants and three panelists
that attended the live zoom presentations. Participants registered for the event through MOTA and were able to earn one continuing education unit for involvement.

**Learning Objectives**

At the conclusion of this session, participants will:

- Describe the themes within research that are effective at reducing inpatient mental health readmission risk.
- Be able to identify interventions that are supported by evidence, and the level of confidence for the research of effective interventions for decreasing the likelihood of readmission to the hospital.
- Examine recommendations for OT practice related to effective interventions to reduce readmission and our role within the interdisciplinary mental health team.

**Evidence of Approach Used**

To propose our presentations to MOTA, my classmate and I prepared a one-paragraph description of our presentations, three learning objectives for each session, and a short biography of both presenters. Dr. Kathleen Matuska, PhD, MPH, OTR/L, FAOTA used this information to create a presentation timeline and proposal for our combined continuing education event. After reviewing the draft, Dr. Matuska sent this proposal to MOTA, and coordinated a date and time for these to be held. The PowerPoint presentation was created during the fall of 2021 under the guidance of Dr. Kathleen Matuska. A copy of the MOTA proposal is in Appendix A.2.

**Evaluation Method**

To evaluate the effectiveness of my first knowledge translation presentation for MOTA, a 6-question survey was created via Google Forms. On the survey, the first five questions utilized a five-point Likert scale with a rating of “Not at all” for one to “Very well” for five. The first
three questions asked the participants to rate how well the presentation met the three learning objectives. The next two questions used the Likert scale to ask participants to rate how well the presentation's content was organized and how well the presenter was able to communicate the information. The final question was an optional long text answer question that asked participants to provide any additional comments or suggestions. A link to this Google Forms survey was emailed to participants by MOTA along with my PowerPoint presentation. The survey was optional for participants. Nine participants completed the survey. The survey can be found in Appendix A.3 and results in Appendix A.4.
Chapter 3. Evidence-Based Practice for Recovery Model and Mental Health: A Knowledge Translation Project via Virtual Poster Presentation

Aim

The knowledge translation project aim was to provide evidence on the recovery model in mental health, the correlation between occupational engagement and the stages of recovery, and the implications for occupational therapy practitioners working in acute mental health settings, and best practice recommendations through a poster presentation hosted through the Minnesota Occupational Therapy Association (MOTA).

Description

To meet the objectives of this knowledge translation project, a poster presentation was created for a 2022 MOTA virtual session for their members. The poster topic included the evidence-based practice summary, and current literature on the recovery model and stages of occupational engagement, which included implications for OT practitioners working in inpatient mental health settings. The title of the poster is "Recovery Focused Care in Inpatient Mental Health: Connecting Recovery to the Value of Meaningful Living." The poster session was held on Wednesday, April 20, 2022, from 6:00-7:00 PM, CST. The poster was created into a ten-slide presentation that was presented to members of MOTA for 10 minutes, followed by a moderated discussion following the poster session for 5 minutes. The poster provided evidence on the effectiveness of the recovery model and the current research that highlights the correlation between phases of recovery and the link to occupational engagement and meaningful occupations. In addition, the poster provided implications for OT and recommendations on how to treat in a recovery-care oriented way. The poster can be found in Appendix B.1, and the moderated poster slides are in Appendix B.2.
Approach

The project approach will be an online poster presentation and facilitated discussion for MOTA. A multi-slide poster template was provided by St. Catherine University to create the presentation. The sections on the poster include background information, current evidence supporting the recovery model and the connection to OT, research on the phases of recovery and the connection to occupational engagement, implications and best practice suggestions, and recommendations for how to utilize the research findings in clinical practice. The moderator shared the screen and advanced my slides as I presented using a shared screen to read from my script to the audience. Participants were made aware that the event was recorded and consented to participation. References were included via scan code on the poster and included in the presentation slides for audience members. Participants were provided with my St. Catherine University email address in the final slide of the presentation, and a Google Forms survey was created and shared in the chat box for any further questions or feedback.

Audience and Venue

The poster presentation was presented to OT clinicians, students, and occupational educators. The fee for MOTA members was $5 and $25 for non-members. There were thirty-four participants and five panelists that attended the online presentations and discussion. Participants registered for the event through MOTA and were able to earn one continuing education unit for involvement.

Learning Objectives

As a result of attending my poster presentation, participants will:

1. Discuss the recovery model and how it connects with the values of the OT profession.
2. Describe the implications for OT related to the recovery model in inpatient mental health.
3. Identify evidence-based practice recommendations for inpatient mental health settings.

**Evidence of Approach Used**

To propose the poster, Dr. Darla Coss, OTD, OTR/L, CHT created a template for myself and my fellow student presenters to complete as a proposal to MOTA. The proposal included the poster title and description, references, and learning objectives. The proposal can be found in Appendix B.3. The poster was created with guidance from my faculty advisor, Dr. Teresa Wickboldt, OTD, OTR/L during the spring semester of 2022. Dr. Coss organized the details of the poster session hosted by MOTA in partnership with St. Catherine University and created a slide template for the poster session slides to be combined on a Google Drive. An invitation announcement regarding the presentations was sent to MOTA members and shared with the faculty and students of the OT Department at the University of St. Catherine. The invitation announcement can be found in Appendix B.4.

**Evaluation Method**

The evaluation method for this knowledge translation project an online Google Forms survey was created, as well as the qualitative discussion and feedback provided from the moderated discussion. A brief survey of six questions about the project poster was created that asked the participants three Likert scale questions about the poster presentation content, and two Likert scale questions about the presentation style. In addition, there was one Likert scale about the overall rating of the poster presentation and one open ended discussion question for general feedback or recommendations. The five Likert Scale questions were mandatory and the open ended write in question was optional for users. Nineteen participants completed the survey. A copy of this survey can be found in Appendix B.4, and the results are in Appendix B.5.
Chapter 4. Evidence-Based Practice for Recovery Model and Mental Health: A Knowledge Translation Project Proposed for the OT Practice Journal Publication

Aim

The aim of this knowledge translation project was to provide education on the recovery model in mental health, highlight the research related to utilization of the model, and the implications for occupational therapy practitioners working in acute mental health settings through an article submitted for publication in the AOTA’s OT Practice, an edited professional magazine that is not peer-reviewed, and “focuses on news and practical information that occupational therapy practitioners need to succeed professionally” (AOTA, 2022, para. 1).

Description

The article was written with guidance provided by the AOTA website on publications to OT Practice. The publication was selected based on the description of their purpose on the AOTA OT Practice Editorial focus webpage, which highlighted to importance of occupation-based articles. To create the outline for the article, I met with my mentor, Dr. Virginia Stoffel, PhD, OT, BCMH, FAOTA to reflect and discuss possible topics to address within the paper. The article was framed around providing education on the recovery model in mental health, and the correlation between phases of recovery and emergence of occupational engagement. The purpose of the article was to provide OTs with background on the research of the recovery model and the connection between recovery and occupation. More specifically, the role and value that OTs provide the individual in their recovery by supporting and facilitating the individual’s ability to identify meaningful everyday life. The article included background information on mental health and the significance of addressing the needs of this population, the current research on the
recovery model were highlighted, and the implication for OT practitioners practicing in acute mental healthcare settings. The initial draft of this manuscript can be found in Appendix C.1.

**Approach**

The approach for this knowledge translation project was following the AOTA *OT Practice* author guidelines to submit an article for publication on evidence-based practice on the recovery model and OT within mental health.

**Audience and Venue**

The audience for this article will be the members and readers of the AOTA *OT Practice* publication. The intended audience is OT practitioners, students, and educators who are members of AOTA, with an interest in the mental health. This publication allows for broad knowledge dissemination as the AOTA *OT Practice* is a national journal and part of AOTA.

**Learning Objectives**

As a result of reading this article, readers will:

1. Discuss the recovery model and its alignment with occupational therapy.
2. Describe the correlation between the phases of recovery and occupational engagement.
3. Identify strategies for OT practitioners working in inpatient mental health to utilize to within the recovery model framework.

**Evidence of Approach Used**

To begin the process of preparing an article for the AOTA *OT Practice*, I reviewed the author guidelines to understand the intended purpose of the publication and process for submitting articles. To follow the outlined steps, I located the contact information for submitting unsolicited articles to *OT Practice* on their webpage *OT Practice* magazine author guidelines (AOTA, 2022). The guidelines specify that all drafts can be sent to the publication email, and to
include your name, address, and phone number. The publication will notify the submitter after 
the draft has been reviewed for publication. The basic information provided by the website, in 
addition to the collaboration with Dr. Stoffel and Dr. Wickboldt were used to create a draft 
outline and article to be submitted to *OT Practice*.

**Evaluation Method**

To evaluate the aim of this Knowledge Translation project the article requires an editorial review process of the publication. At this time, the draft of the manuscript has been written for review, with the goal to submit to the *OT Practice* Editor by June 2022. According to the author guidelines, once the draft is received, the publication will notify the writer. Accepted articles are edited by the staff to make sure they meet the publication requirements and remain with the scope of the *Occupational Therapy Practice Framework: Domain and Process* (4th ed.).
Chapter 5. Evaluation Outcomes and Analysis

The Knowledge Translation Planning Template© (Barwick, 2008, 2013, 2019) was used as an evaluation tool for the knowledge translation (KT) projects in this proposal. The three projects were connected through themes of the importance of providing psychoeducation, using interventions that are linked to the recovery model, the connection between OT and the recovery model, and the implications for further research that is needed regarding best practice interventions for OT practitioners in mental health, with an emphasis on the inpatient hospital setting. The language and structure of the template were used as a guide for the evaluation outcomes and analysis of the projects.

Evaluation Outcomes

Knowledge Translation Project 1: Continuing Education Session

Knowledge Users. The knowledge users were the participants that attended the Zoom continuing education session that was hosted in collaboration between MOTA and St. Catherine University on February 8, 2022. The knowledge users consisted of OT practitioners, students, and educators.

Main Messages. The overarching main message that stemmed from the evidence of the project was that there are strong levels of research that prove using a recovery-oriented model to provide psychoeducation and discharge planning for individuals in an inpatient setting is effective at decreasing readmission rates. The three main messages shared with the audience were:

1. Using the recovery model as an intervention includes supporting the individual in their recovery by instilling hope, self-empowerment, and allowing for decision making by the individual in managing the everyday aspects of their diagnosis.
2. Providing education and interventions that allow the individual to plan and prepare for the challenges they will face when discharged from the hospital within the safety of the inpatient setting, allows the patient to envision their barriers and facilitate coping skills to address the perceived barriers before they occur.

3. Therapists and providers should consider the roles and relationships of the individual and consider recommendations that can support the individual in the community.

**Knowledge Translation Goals.** The intended goals of the project were:

1. Generate awareness and share knowledge by describing the themes within research that are effective at reducing inpatient mental health readmission risk.

2. Inform research and decision making by being able to identify interventions that are supported by evidence, and the level of confidence for the research of effective interventions for decreasing the likelihood of readmission to the hospital.

3. Facilitate practice or behavior change by examining the recommendations for OT practice related to effective interventions to reduce readmission and our role within the interdisciplinary mental health team.

**Knowledge Translation Strategy.** This project was an integrated process that generated awareness, interest, shared knowledge, and informed decision-making of the current evidence through a 25-minute narrated PowerPoint continuing education presentation. Audience members were provided with educational information that included a professional development presentation of the background information, practice dilemma, research question and methods, current data and statistics, and qualitative information regarding effective interventions that reduce the risk of readmission to psychiatric inpatient hospitalization. Following the presentation, an opportunity for questions and discussions was provided to the group to foster a
collaborative research and evidence experience within the project. The information was used to inform the knowledge users of the current research and facilitate through meeting dialogue and synthesis of the evidence.

**Knowledge Translation Evaluation.** To evaluate the goals of the project, an electronic post-presentation survey was utilized. Questions asked the participants to rate how well the presentation objectives were met using a Likert scale to rate the response. The final question was an optional long text answer question that asked participants to provide any additional comments or suggestions. Additionally, throughout the project, informal evaluation was provided by my peers in the program when the project was shared during class opportunities. Lastly, Dr. Matuska provided direction and recommendations throughout the project.

**Knowledge Translation Project 2: Poster Session and Facilitated Discussion**

**Knowledge Users.** The knowledge users were the participants that attended the virtual poster presentation session hosted by MOTA and St. Catherine University on April 20, 2022. The audience comprised of OT clinicians, students, and educators.

**Main Messages.** The overarching main message that stemmed from the evidence of the project was that as OT practitioners our skills support the individual with the ability to establish meaningful roles and occupations that guide them through their recovery process, and OT provides an integral role within the recovery model. The three main messages shared with the audience were:

1. OT has a unique and valuable role to offer our clients evidence-based recovery-oriented care that is in synch with our framework and the recovery model because of our focus on everyday occupations.
2. As clinicians we provide holistic, client-centered care that supports the whole needs of the individual by shifting between a medical, rehabilitative, and recovery perspective.

3. Using recovery-oriented care, OT assists the individual in the phases of recovery by believing in the individual’s ability and capacity to create change, instilling hope in recovery, and supporting them to identify what is meaningful in their everyday lives.

Knowledge Translation Goals. The intended goals of the project were:

1. Share knowledge through a discussion of the recovery model and how it connects with the values of OT.

2. Share knowledge and inform decision-making by describing the implications for OT related to the recovery model.

3. Facilitate practice or behavior change by identifying evidence-based practice recommendations for inpatient mental health settings

Knowledge Translation Strategy. The second project was an integrated process that provided the audience with an opportunity to participate in a facilitated discussion following a brief virtual poster presentation. The process was geared towards engaging participants’ interest and buy-in with the information, shared knowledge and experiences through collaborative discussion, and informed decision-making of the implications for OT and how to practice the project recommendations. The information was provided with a 10-minute narrated PowerPoint of the poster sections. This information was used to inform the knowledge users of the current research and facilitate through meeting dialogue and synthesis of the evidence.

Knowledge Translation Evaluation. To evaluate the goals of my second KT project, I created a Google Forms survey of 6 questions for participants to evaluate the poster presentation. On the survey, the first five questions were marked as required for answering on the form and
utilized a five-point Likert scale with a rating of “Not at all” for one to “Very well” for five. The survey asked the participants three Likert scale questions about the poster presentation content, and two Likert scale questions about the presentation style. In addition, there was one Likert scale about the overall rating of the poster presentation and one open ended discussion question for general feedback or recommendations. A copy of this survey can be found in Appendix B.4, and the results are in Appendix B.5. Additionally, to evaluate my project, Dr. Wickboldt and Dr. Stoffel provided direction and recommendations on the poster and presentation slides.

**Knowledge Translation Project 3: OT Practice Article**

Knowledge Users. The audience for this article will be readers of the AOTA *OT Practice* publication, including OT practitioners, students, and/or educators. This publication allows for broad knowledge dissemination as the AOTA *OT Practice* is a national magazine and part of AOTA.

**Main Messages.** The overarching main message of the project articles was highlighting the interconnected relationship between recovery and occupation, and the research supporting engagement in everyday occupations contributing to higher quality of life. The three main messages shared with the audience were:

1. The stages of recovery align with the phases of occupational engagement and OT can support an individual in recovery by identifying and engaging in meaningful occupations.
2. Our role in their treatment allows us to believe in the individuals’ ability and capacity to recover, and support them in identifying personal strengths, goals, and meaning in recovery.
3. Further research is needed to identify evidence-based mental health interventions and to advocate for our role as an integral part of the behavioral health treatment team.
**Knowledge Translation Goals.** The intended goals of the project were:

1. Share knowledge through a discussion of the recovery model and generate awareness of its alignment with occupational therapy.

2. Inform decision-making and facilitate practice or behavior change by describing the correlation between the phases of recovery and occupational engagement.

3. Inform decision-making and facilitate behavior change by identifying strategies for OT practitioners working in inpatient mental health to utilize to within the recovery model framework.

**Knowledge Translation Strategy.** This writing piece was an integrated KT process that provided the audience with an article of the research findings and implications for OT. The process was geared towards engaging participants’ interest and buy-in with the information, shared knowledge, and experiences through reflection of the current literature and clinical implications for the profession of OT and our role with offering mental health interventions to individuals. The information was provided through an article submitted for publication through AOTA OT Practice.

**Knowledge Translation Evaluation.** To evaluate the goals of my final project I followed the editorial review process for the AOTA OT Practice publication. A draft of the manuscript was written with the goal to submit the article to the OT Practice Editor by June 2022. According to the author guidelines, once the draft is received, the publication will notify the writer. Accepted articles are edited by the staff to make sure they meet the publication requirements and remain with the Occupational Therapy Practice Framework: Domain and Process. The magazine website does not specify the expected timeline for the editorial process.

**Evaluation Analysis**
Comprehensiveness

Reflecting on the entirety of my doctoral project, there were evident strengths and weaknesses regarding the project comprehensiveness. The strengths include that the project was guided through the process by a project partner with expertise on the knowledge translation process. Due to this strength, my project is based on a foundation of current evidence and a strong methodology to identify research related to the practice dilemma and clinical question. Additionally, an organized process was followed to identify themes of the research to apply to each KT project. A central strength to my doctoral project was the use of three different methods to disseminate the projects to knowledge users by using a professional presentation, poster session, and an article. Another strength was that each project embedded evidence-based clinical implications for OT into the over-arching main message and goals for the project. Opportunities for feedback were built into the KT process each project, and a KT plan evaluation was created for each project. Continuous evaluation included survey, feedback from my advisor, mentorship, and peer-feedback. The evaluation methods produced favorable results to meeting the goals and expectations of each project.

Weaknesses concerning the comprehensiveness of my project include a limited diversity of multidisciplinary service provider knowledge users. All projects were geared towards OT practitioners and the project would benefit from including interdisciplinary service provider engagement in the KT strategies to promote a discussion of results. This is particularly evident for KT project one that included multidisciplinary research findings that were specific to effective interventions for inpatient mental health and included collaborative implications for multiple disciplines. In addition to the lack of other specialty representation from service providers, my project is missing the opportunity to include knowledge users of
patients/consumers that receive mental health services in the findings, and discussion about how the research connects with the lived experiences for individuals with mental illness. Discovering a method of dissemination that could connect the research findings with a discussion about practical and everyday application for service users is needed to advance the clinical findings further.

Another identified weakness included targeting one location of knowledge consumers and partners. Other than one project aimed at a national level, the other two projects were limited to one location with knowledge users from the Minnesota state association and did not reach a vast network of service providers. Furthermore, the national OT publication that the project will be submitted to is a non-peer reviewed publication. While appropriate for this project as it is focused on connecting research to clinical applicability, to further advance the research of efficacy of OT interventions in mental health, more clinical research and peer-review processes are needed.

Reflecting on the KT tool (Barwick, 2018), an area for improvement that I ranked as weak was input from project partners and degree of engagement from mentors that had specialized experience in mental health settings. Collaborating with clinicians that had an intimate understanding of the unique setting of inpatient mental health and the practice dilemmas as part of formulation of the clinical question would have been valuable for my projects. Mentors in mental health were engaged in the process, but reflecting upon opportunities for growth in my projects, there was potential benefit of engaging specialized project partners in a structured role at the beginning of the project.

The last weakness evaluated was highlighted in the KT evaluation of project two and highlighted that the knowledge users felt the project was limited in implications for OT
practitioners. After reviewing the results of the survey for KT project two (see Appendix B.5), although mostly ranked as positive (Likert scale 4 or 5), the scores related to the content being practical and applicable for work was rated lower than other questions. In response to these scores, the article drafts for KT project 3 was edited to include more examples of clinical and practical applications of the content. Part of the obstacle with including implication for OT in the project is due to the lack of strong evidence on OT interventions in mental health. This was a barrier related to the practice area and overall clinical question of the project. It is a challenge to provide practical strategies until the evidence in this area grows; however, this project highlighted not only the value that OT has within mental health but the integral part that we play in the success of an individual’s recovery in mental health through connecting meaning to everyday life.

Alignment

Using the evaluation findings to reflect on the alignment with project goals, projects one and two appear to be good to excellent in alignment. The KT projects appeared to be aligned with delivering the findings of current literature and targeted meeting the identified objectives and project aims, although project three has not been completed in its entirety; therefore, it cannot fully be evaluated until it is submitted for publication in June 2022. Although project three is unable to be fully evaluated for alignment with objectives, feedback was provided by Dr. Wickboldt and Dr. Stoffel with creating the initial outline and providing initial editing of drafted manuscript.

The feedback for project one was tabulated using Google Forms (see Appendix A.4). The questions were ranked using a Likert Scale with number one being “Not at all” and number five stated at “very well” and one open-ended question at the end of the survey for general feedback.
The questions asked participants to rate how each learning objective, or KT goal, was met, as well as a question regarding organization of materials and overall impression of the presenter’s ability to communicate those materials. The average ranking of all questions was 5, except for question three. Question three stated “Please indicate how well the presentation met the stated learning objective: Examine recommendations for OT practice and our role within the interdisciplinary mental health team” and the average rating was 4.9. Additionally, the open-ended comments were also enthusiastic and included statements such as “Your topic is incredibly interesting and addresses a need long unmet” and “Emily your presentation was well organized and timely for the current trends in the profession. I felt that I learned a lot about the current practice in mental health”.

Reflecting on project two, the feedback showed the most opportunity for improvement, particularly with evaluating the information sharing as it related to implications for practice. The results were again tabulated using Google Forms (see Appendix B.5). The questions were ranked using a Likert Scale with number one being “Poor” and five ranked as “Excellent” and one free-text question at the end for general feedback or comments. There were 6 questions that asked the audience to rank 1) the clarity of the information, 2) how informative the presentation was, 3) practical examples and useful techniques, 4) presenter knowledge about the topic, 5) if the presenter maintained interest during the presentation, and 6) overall rating of presentation and discussion. The average ranking for all questions was 4.7 with the exception of question 3 (clinical implications) which had an average ranking of 4.6 on the tool. Similarly, the open-ended comments were also positive and included statements such as “I loved this presentation and thought it was put together very well. You did a nice job keeping the audience's attention
and shared your information in a fun way!” and “Great job answering questions! You were very knowledgeable and passionate about this topic.”

Projects one and two were well received in evaluation, however, the feedback in the projects highlighted the opportunity for improvement with alignment related to tangible applications for clinical practice. Although both projects allowed for discussions, project one was hindered by technical issues that stunted the question-and-answer section and ability to produce a live evaluation of content alignment post presentation. The poster session had several questions following the presentation that surpassed the five-minute duration allocated for discussion. The opportunity to have a discussion via the chat function of zoom allowed for audience participation and engagement with the content. Through this process, opportunities for questions or clarifications assisted with measuring alignment with the project learning objectives.

The alignment for project three is not known at this time, as the article has yet to be submitted to OT Practice for publication. Despite this, there are strong indications that the alignment is good – excellent as the article has been created and written with guidance and active engagement from my project partners, Dr. Wickboldt and Dr. Stoffel. Similarly, the article meets the vision of the magazine by including “practical information to help occupational therapists and occupational therapy assistants to succeed professionally” (AOTA, 2022, para. 1).

One alignment barrier that was identified related to the expansive clinical experiences and backgrounds of the knowledge users that participated in both project presentations. While my project highlighted the opportunities for all OT practitioners to be aware of mental health interventions, there was also a specialized focus on the inpatient mental health setting folded into the content. Identifying a project venue that catered to mental health specialists in the audience
which would have provided for a richer discussion if one of the project findings. The challenge of identifying such a venue is reflective of the continued advocacy that is needed to preserve OTs working in traditional mental health settings. To align with the KT goals of the projects, identifying an opportunity to engage in a collaborative discussion and partnership of the KT messages and information with knowledge users that had understanding and experience of the inpatient mental health setting and the implications for OT practitioners would have been beneficial.

**Feasibility**

The feasibility of all three KT projects was excellent. The team composition included academic instructors and mentors that demonstrated excellent expertise in competency and skills to meet the project needs. The first project included team collaboration with guidance from faculty and peers to develop and execute the project and disseminate that information. Similarly, project two was supported by faculty mentorship and advisement of project materials. Lastly, project three included information that was available on the *OT Practice* AOTA website for editor guidelines and support from my advisor and mentor to execute the creation of a draft article.

Similarly, there was availability of resources that were afforded to the projects due to the academic affiliation and support provided by St. Catherine University was excellent. Additionally, the KT strategies were completed within the timeline and constraints that were outlined by St. Catherine University with support and guidance from the faculty. Completing this project while in school allowed me to learn the steps of KT in three projects, and as a result, allowed KT to become more tangible and realistic to complete in my clinical practice and to share with my colleagues.
Although these projects were rated highly with feasibility, the overall need of KT projects and research related to mental health interventions continues to have barriers that are necessary to overcome to produce more robust research within this practice area, and to develop adequate services to meet the needs of this population. Overcoming the burden for cost of care, lack of services, and efficacy of interventions despite the growing need is a larger system issue that significantly impacts the larger feasibility issues for research in mental health. Despite these constraints, the value for OT in this area continues to exist and therefore, further research is needed to reflect the benefits we provide for individuals suffering from mental health disorders.
Chapter 6. Reflection and Recommendations

The St. Catherine graduate OT curriculum has taught me so much, especially in this culminating doctoral project. I returned to school with a passion to identify effective and evidence based mental health interventions as part of a larger belief that, as OT practitioners, we have the potential to provide our clients with meaningful engagement with occupations that improve their overall quality of life, and that we are a valuable member of the treatment team. As I have progressed through the program and with this project, I have refined my skills and delved deeper into understanding how to identify a practice dilemma, formulate a clinical question, create effective search terms, analyze current research, and develop themes based on the findings. After completing these steps and the implications for OT, I believe more than ever in the critical role we play in mental health, and the critical need to advocate for our services.

Reflection

This project has led me to understanding the deeper need for mental health interventions beyond the traditional practice area of mental health. Even prior to, but critically impacted by COVID-19, the rates of individuals affected by mental health are skyrocketing. The impacts of mental disorders have touched everyone. Our practice is founded on humane treatment for individuals suffering, and that includes the psychosocial context. We need to equip all practitioners with evidence for how to support and facilitate meaningful engagement for anyone suffering from symptoms of physical or mental illness, in all practice settings. When I began this project, I wasn’t sure what research I would find, but after completing my project, I am hopeful with the evidence I found, and how tangible our framework is connected to the strong research of the effectiveness of the recovery model.
AOTA’s 2025 Vision

According to AOTA (2022), the 2025 vision states that “as an inclusive profession, occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living” (para 1). To carry out the vision, AOTA identified five pillars outlined for occupational therapy practitioners, and they include:

- **Effective.** Occupational therapy is evidence based, client centered, and cost-effective.
- **Leaders.** Occupational therapy is influential in changing policies, environments, and complex systems.
- **Collaborative.** Occupational therapy excels in working with clients and within systems to produce effective outcomes.
- **Accessible.** Occupational therapy provides culturally responsive and customized services.
- **Equity, diversity, and inclusion.** We are intentionally inclusive and equitable and embrace diversity in all its forms. (AOTA, 2022).

The alignment of my doctoral project was designed to meet the vision statement. My KT projects were executed with the goal of identifying evidence-based interventions to support everyday engagement in meaningful occupations to improve the health, well-being, and quality of life for individuals impacted by mental health. Looking at the pillars within the vision, the first column of effectiveness was accomplished in my doctoral project by identifying current research that outlined robust evidence on effective interventions. These interventions specifically aimed to reduce the psychological burden to the individual, and the healthcare costs associated with readmissions to psychiatric inpatient hospitals. As the interventions were examined within
the scope of OT, the interventions proposed remained client-centered and rooted in supporting the individual with reaching recovery with their illness, through the identification and use of everyday engagement in meaningful occupations.

The second pillar is leaders, and through my project, I believe that OT has the potential to be industry leaders in using recovery-oriented care within mental health treatment. As this evidence-based model aligns with our framework, we can advocate for our clients and support them with voicing their goals, values, and beliefs to be included in the decisions about their care and in their capacity to recover. Furthermore, as a profession, we can harness our unique skills as an opportunity to create more research that highlights the influential role we provide for mental health interventions, and advocate for broader policy change within mental health treatment.

The third and fourth pillars are collaborative and accessible. The strengths of my project fits within the pillars with an emphasis on collaborative client-centered care that meets the needs of the individual. With that said, further greater system efforts are needed to increase collaboration and accessibility of mental health services. Additionally, the larger system issues related to quality and access to behavioral health services. This includes social determinants of health (SDoH) that are specifically impacting behavioral health by factors such as service location opportunities, cost of services, and the overall quality of care. Additionally, there continues to be significant barriers for occupational therapy practitioners to provide our services without regulatory support to be included in the standards of care. While my project continues to promote growth in these areas, further research and substantial change is needed.

The fifth pillar is equity, inclusion, and diversity. My project is admittedly lacking in directly addressing the data surrounding this column. SDoH significantly impact the services and
quality of mental health care. To address what recovery means to the individual and greater
mental health systems, attention needs to be paid to health equity and the disparities across
various cultural and socio-economic levels. Furthermore, careful attention and consideration is
worthy of examination to define what recovery means across the spectrum of cultures and
backgrounds.

**St. Catherine University Henrietta Schmoll School of Health**

The Henrietta Schmoll School of Health mission is as follows: The Henrietta Schmoll
School of Health educates diverse learners and engages clinical and community partners
to influence health, health systems and health policy. The School is distinguished by an
emphasis on relationship-centered care, socially responsible leadership and
interdisciplinary initiatives (Bass & Matuska, 2020, p. 4).

My doctoral project fits within the mission of the school by emphasizing the current
interdisciplinary research and the global implications for mental health services, and how OT can
support individuals within healthcare systems. Furthermore, my project focused on using
relationship-based care models, such as the recovery model to promote the health and well-being
of individuals and to advocate for change in mental health treatment interventions.

**St. Catherine University Department of Occupational Therapy**

The focus of the Department of Occupational Therapy at St. Catherine includes providing
excellent education, which states “scholarly inquiry on human occupation, and services the
broader community by prompting occupational health and well-being” (Bass & Matuska, 2020,
p. 4). My project aligns with the focus of the OT Department by identifying evidence on
effective mental health interventions and relating the evidence to occupation-based strategies for
practitioners, and the overarching belief in occupational therapy, that humans are occupational beings (Clark, 1997).

Furthermore, in KT projects two and three, the evidence on use of the recovery model was directly correlated to phases of occupational engagement. Within these stages, recommendations, and implications for OT interventions that promoted occupational engagement were incorporated into the projects. Also remaining true to the values of the OT Department at St. Catherine University, my projects highlight the value of respecting and promoting occupational well-being for individuals with mental health and advocating for their personal voice through identification of personal goals, skills and strengths, and person-centered care of advocating for meaningful occupations and roles.

**Knowledge Translation as a Focus for Advanced Practice**

Before returning to school, and even for a large portion of during my first year, I didn’t know or understand very much about knowledge translation. When discussed, I could make sense of it, but the practical application of it became rather clunky and messy for me to execute. We learned throughout our programming that the time it takes for research to be implemented is an average of 17 years (Morris et al., 2011). And yet, I wanted to find research related to mental health interventions which felt like an even bigger lag in data.

To identify my practice dilemma, I went down countless rabbit holes of potential projects that may benefit inpatient mental health settings but were not true KT projects. Upon meeting with Dr. Griffin-Lannigan and Dr. Matuska, both scholars set me on a course to investigate what works beyond OT research and then retrace the steps back to how OT can be applied to the research. This process of casting a wider net and then analyzing how it applied to OT was infused within all three KT projects and influenced how I looked at the evidence and the
implications for advancement in OT. Through the guidance of my peers, faculty advisors, and mentors, I learned how to follow all the necessary steps of KT and refined my skills at taking evidence, applying it to clinical practice and disseminating the knowledge. This process has given me skills and confidence to continue this process beyond my school experiences and expectations, as I continue to grow in my professional development and future.

I believe each project has contributed to maintaining our value within mental health and the advancement of evidence-based interventions for occupational therapist treating mental health conditions. Despite our deep roots in mental health, we have struggled to maintain the high regard to practice standards and evidence. By completing my KT projects, I have identified evidence for reducing the burden of readmissions to psychiatric hospitalization, but even further, the projects highlight the alignment that occupational therapy shares with the evidence-based interventions. Our profession is in synch with the research highlighting the recovery model and yet we are not reflected in the wealth of studies regarding its effectiveness. For mental health interventions, further research is needed to strengthen the efficacy of the interventions that we use, and to highlight this inherent connection that OT possesses to propel forward the evidenced-based recovery model. I am excited to have learned to steps to continue to forge this path forward with newfound intelligence on the process and a continued whole-hearted passion for the population.

Culminating in my completed doctoral project and graduation, the entirety of the project was presented in person to an audience of invitees by the Department of Occupational Therapy at St. Catherine University. The final doctoral project presentations included the graduates of the 2022 Occupational Therapy Doctorate Post Professional Program (OTD-PP). The advertisement
for the presentation can be found in Appendix D.1. The PowerPoint slides can be found in Appendix D.2.

**Professional Development**

My foundation in leadership skills and human centered care began during my formative years at St. Catherine University. By obtaining my master’s degree from their program, the knowledge and values of the institution have been ingrained in my professional being. My training in the program provided me with opportunities to work at a higher institution that prides itself on research, quality services, and person-centered care. By deciding to return to St. Catherine University, I knew that the program would continue to support and mold my professional skills. Through completing my doctoral project in school, I was able to learn each step of the KT process with guidance and in an incredibly supportive environment. Not only did the readings and assignments provide clarity on the process, but I found the program recommendations for scholarly networking with researchers and academicians to be incredibly beneficial.

Even more surprising was how attainable the professional connections were, far more than I would have believed had I not been encouraged to complete. The kindness, support, and willingness to connect and mentor me throughout each step was something I will forever be awestruck and grateful. Each step and opportunity provided me with a new skill, insight, or idea that influenced my project, but hopefully the greater advancement of OT collectively.

As mentioned previously, my passion for mental health contributed to my returning to school and with my topic selection. As I have grown in the program, so to have my clinical skills and contribution to innovative patient care at my work. One active project that has developed as part of my doctoral projects is the implementation and design of technology opportunities to
educate and engage individuals in aspects of their care while in the hospital. Through a tablet program that connects to the medical record, I am part of a workgroup that is looking at content creation and opportunities to use the technology to engage patients in decisions and planning for their care. Furthermore, I have met with colleagues to review research related to work and employment training in community mental health settings in the pursuit of developing a work-based intervention group for inpatient mental health. Both projects would not have been possible without the mentorship and knowledge that the post professional doctorate program has provided towards my professional growth.

**Recommendations**

**Summary of Needs for Future Knowledge Translation**

Through the evaluation of my project, a few opportunities for improvement were found within the areas ranked as weaknesses. One was the lack of input from the lived experiences of individuals with mental illness, and additionally, the lack of evidence that supports our role in providing effective interventions within the inpatient hospital setting. To understand the importance of meaningful occupation for our clients, as well as understand the barriers and impacts that they are facing with meaningful occupations, we need to use strength-based assessments to understand their needs, as well as provide education on the value of occupations to the consumers in a way that makes the information tangible and relevant.

Additionally, another facet of the project outcomes highlighted the importance of evidence-based interventions that had clinical applications for practitioners. While research for interventions remains an area of further development, recent literature on the use of strength-based assessments and their connection to the recovery-model is worth exploring. By researching the use of strength-based assessments, it would provide the practitioner with a
clinical application that can be utilized within the constraints of an inpatient environment, and through the assessment findings, can support the individual in identifying skills and strengths, and begin education on how meaningful occupations can improve their everyday quality of life, health, and overall well-being.

**Proposed Future Knowledge Translation Project: Effective Interventions for Recovery in Inpatient Mental Health: Strength-based Assessments**

**Knowledge Users.** The primary audience of this project will be occupational therapy practitioners that would administer the strength-based assessments in inpatient settings. The secondary user would include the consumers, and possibly their family or friends that would participate in the assessment and through the findings, education, and support on the identification of occupational meaning and engagement would be targeted.

**Main Messages.** According to Rapp & Goscha (2011), a strength-based assessment is:

“The strengths assessment is a tool that helps the worker stay purposeful in helping people recover, reclaim, or transform their lives. It is a tool that, when used well, offers a holistic view of the individual. It does not reduce the complexity of the person to a diagnosis or set of problems, but rather it is used to search for understanding and meaning from the person’s viewpoint. The creative practitioner does not see the strength assessment as paperwork, but rather a canvas on which to create a portrait of the unique person that is before them” (pp. 95-96).

The main message of this KT project will be to research the evidence and implications for using a strength-based approach in inpatient mental health setting, as well as to generate a list of evidence-based strength-based assessments. Additional information to be considered is qualitative evidence from consumers on their perceptions of using strength-based assessments in
their mental health treatment, and clinical experiences from practitioners with using various assessment tools in practice.

**Knowledge Translation Goals.** The goals of this project would be to identify the current literature and best practice standards on the utilization of strength-based assessments in inpatient mental health. Additionally, a goal would be to provide practical application of the literature by generating a list of strength-based assessments that meet criteria, and tools for how to use them in their clinical setting. Lastly, the goal would be to include basic clinical education guides on how to use the results of the assessments to educate the individuals on the importance of meaningful roles and occupations in their everyday life.

**Knowledge Translation Strategies.** Given that this project is aimed at educating practitioners on the importance of strength-based assessment tools for inpatient mental health, the recommended strategies would be the same methods used in KT projects one, two, and three. A presentation or poster would be a helpful method of disseminating the information to participants, and an article has a broad diversity of shared information with practitioners. Similar to project three, the creation of a table or visual would be an effective strategy for highlighting the results of the project.

**Knowledge Translation Evidence.** The knowledge translation tools identified in projects one, two, and three would be applied to this KT project to evaluate for effectiveness (Barwick, 2008, 2013, 2019). The goal of the project includes identification of strength-based assessments and evaluation would be determined by the number of assessments identified and the quality of the analysis of their usage. To gain insight during the project, I could ask my colleagues to administer the assessments for feedback into the tool, as well as ask the clients...
their perspective of the assessment process. The feedback received would be used to create education materials for other practitioners and consumers.

**Conclusion**

As a primary focus of my project has been identifying evidence-based interventions in mental health which includes supporting the individual in identifying strengths and instilling hope, I couldn’t help by conclude by reflecting on what this process has taught me about my own strengths and vision for the future. Using the character categories created by Niemich & McGrath (2019), as outlined in the VIA Character Strengths Indicator, I found that my strengths include love, social intelligence, honesty, kindness and humor. I believe it is these strengths that supported my decision to return to school and further my clinical knowledge. My love, humanity, and kindness for others was what drew me to OT and has remained a steadfast in my clinical practice. Throughout this project, these character strengths have continued to grow and cultivate new ideas and meaning as I have refined my skills.

My middle strengths which I believe were stretched further through the hard work and perseverance needed to complete the project include a love of learning, humility, hope, and gratitude. My love of learning has been the wind in my sails throughout the last two years. The program has provided me with new knowledge that I have either applied or had a new perspective on in my clinical practice. I am incredibly grateful for the journey and all the wonderful people and scholars that have supported me along the path. In addition, I have stretched in my grace and flexibility in situations that challenge my thinking or comfort, and with each new awareness a curiosity of the grander significance and opportunity.

While I have grown in many areas, there is still potential, particularly in the bravery and courage needed for leadership skills and confidence with decisions, as well as creativity to be an
innovative thinker. This project has given me the knowledge and facts to advocate for mental health services, and the value that OT provides. Parallel to our practice and the interventions that we utilize to support our clients, it is not just enough to identify one’s skills but to expand beyond by doing. As I have reflected on my project and the accomplishments that I have achieved, I would be remiss not to include the importance for continuing the share the knowledge with others, exploring new opportunities for projects, and using the strengths of our profession to support others in recovery through finding meaning in their everyday life.
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MENTAL HEALTH READMISSIONS: IMPLICATIONS FOR PRACTICE

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Appendix A.1. MOTA Continuing Education Session Narrated Slide Presentation

Slide 1

Narration.

Hello. My name is Emily Petersen, and I am an occupational therapist working in inpatient psychiatry at a hospital in California. This presentation will focus on my evidence-based literature review of effective interventions for reducing the risk of readmission in inpatient mental health.

As I am presenting, please place questions in the chat box, and I will answer them during the question and discussion time. If we do not have time for all of the questions, please feel free to send me an email. There will also be a link for a google form that I ask you to please complete. We greatly appreciate your attendance at our presentations and your feedback.
The learning objectives for this presentation that I hope to share with you all will include describing the themes that were found in the research of readmission risk, identifying themes and interventions that are supported with evidence and the level of confidence, and exploring the recommendations and further implications for the role of OT in mental health.
MENTAL HEALTH READMISSIONS: IMPLICATIONS FOR PRACTICE

Slide 3

Narration.

Mental health treatment has undergone significant changes over the last few decades. There is a strong emphasis in healthcare on higher quality standards and evaluating outcome measures, and typically involve identifying measurable outcomes, enhancing the patient experience, and reducing healthcare costs. One measure of quality, especially for inpatient settings, is reducing readmission rates. Several issues stand out as commonly identified impacts from readmission: the psychological stress to individual and family, demoralization to individual, potential feeling of failure for the treatment team, high cost for healthcare systems, and a drain of resources.

As the research on quality healthcare changes, so too is the model of care in mental health. The recovery model shifts perspective away from treating the illness, or eliminating the symptoms, to a person-centered perspective of how to treat the individual’s needs. The focus becomes resilience and helping the individual gain control of their illness or symptoms.

While the benefits of OT and significance of our role in mental health is understood, along with our alignment with the recovery model, there is limited evidence or research on our value and role in OT in inpatient mental health. Furthermore, the volume of therapists practicing in mental health is decreasing despite our value to the population. Without evidence, we have struggled to develop and maintain research standards to further inform good practice.
Narration.

The evidence-based question for this project was: what practice interventions are proven to reduce readmissions for independently living clients in an acute hospital for mental health disorders. And more specifically for OT, while we believe that we play a vital role in helping our clients with a critical mental health hospitalization recover and resume their quality of life, what evidence is there to guide our treatment interventions and advocate for the value of our care?
To begin my project, I searched and reviewed the documents that we have within our own discipline. Summarizing the things that I learned after reviewing the AOTA resources highlights the inherent value that OTs have within the area of mental health treatment.

First, there is significant consideration of the history of OT in mental health, our value within this population, and known usefulness as an important part of the treatment team.

Second, the foundational goals of the profession of OT align with the principles of the recovery model and this shared value in recovery further supports the benefit of OT to support many of the healthcare initiatives discussed on the previous slide.

The third lesson learned is that OT is uniquely rooted in a diversity of clinical skills and roles to assist the client with many aspects of reintegration that are needed for optimal recovery, development of personal goals, and transition back to independent living after hospitalization.

After reviewing the resources and comparing them to the summary of the interdisciplinary documents it was apparent that while OT has a distinct and valuable role in mental health treatment; however, how we collect evidence and research about our role was lacking. There is limited data and research on the role of OT within the acute inpatient setting.
I used the following databases and the alternative search measures of using google scholar and reference lists, to collect articles.

Based on my PICO question, the following keywords were used within the advanced searches. MeSH phrases and Boolean searches were used. The search was limited to adults’ ages 18-64 years, and articles that were published within the past 10 years. This project focused on non-pharmacological interventions.
These were the main databases used. While doing a database search, the abstracts would be selected, and then the studies were selected if they were relevant to the PICO. Search keywords and advanced search topics were refined to yield a smaller number of studies and to capture the appropriate studies.
Slide 8

Narration.

For my project, I found secondary level I systematic reviews and one meta-analysis systematic review article. For primary research, there were a few randomized controlled trials and several level III and IV studies. I also had a few qualitative studies that were used for the project.
The first of 4 studies that I will talk about is a systematic review that highlighted the transition interventions and the research that supports their efficacy. Of the interventions selected, the ones that were found to have the highest amount of evidence included psychoeducation, CBT, and peer support. This article found that there is evidence to suggest that psychoeducational interventions assist with mental health outcomes and readmission rates. The most effective interventions targeted a single or specific problem. In addition, the therapeutic relationship was found to be beneficial in the recovery and outcome measures of the studies. Although these were found to be effective, many of the research was lacking robust data or findings, leaving more implications for further research. Even when interventions focused on a single solution, researchers measured select outcomes using different measurement tools making it difficult to assess the effectiveness of any single element with regards to outcome measures. This study also highlighted the disparities of care in mental health. The article recommends that to improve readmission involves reducing the professional and physical boundaries between hospital and community by supporting therapeutic relationships, education, and empowerment of service users.
The second study was a randomized controlled trial that divided three groups of inpatients into the control group that received treatment as usual group plus a few individual supportive therapy sessions. The intervention groups were divided into two groups. One group received an inpatient manualized group therapy program for illness education and teaching CBT strategies, and the other group received the same group therapy education/CBT intervention program and additional individualized sessions following discharge from the hospital for 6 months. What was interesting in the study was the finding that after a two-year period, the group that received the only the inpatient education and CBT strategies had the lowest rate of readmissions compared to the other two groups, including lower than the group that had the 6 months of post discharge sessions. In addition, the study found that the knowledge of illness and satisfaction with the program were comparable for the 2 intervention groups. This indicates that providing a brief educational and CBT focused intervention in the inpatient setting can have long-term benefits on patient care outcomes for depression.
Narration.

Study #3 was a randomized controlled trial that used hospital records to randomly assign individuals to two groups – the intervention group and the treatment as usual group. In the intervention group, the individuals received a client-centered assessment prior to discharge from the hospital that reviewed their risk factors and considerations for adjustment as they return to community living. Included in this education was the creation of an individualized crisis plan that outlined their needs as they prepared for discharge. Furthermore, the intervention group received a monthly call to review the plan and discuss their status, which included problem solving any issues that were identified in the call. The control group was given a referral for aftercare recommendations and the initial appointment was set-up for the individual. The study found that the involuntary readmission rates in the intervention group were significantly lower than compared to the control group. The rate for voluntary readmission was not significantly different between the two groups. Furthermore, the study indicated that those with previous involuntary hospitalizations were at higher risk for readmissions, as was the diagnosis of a personality disorder, or a psychotic disorder.
This study separated participants into two groups, the treatment as usual cohort and the intervention group. The intervention group received a brief individual interview that focused on discharge planning and preparing for barriers to community re-integration. The study found that the participants that received the brief intervention were significantly less likely to be readmitted within 30 days following discharge. Additionally, the study identified risk factors associated with readmissions which included being 26 and younger, and individuals that were involved in crisis aftercare services such as assertive community training and outpatient mental health services. This study highlighted the importance of recovery-focused interventions that begin in inpatient settings to prepare individuals for the challenges and barriers they will confront in the transition from the hospital.
There were 19 articles used on the literature matrix for this project. The matrix organized the articles by research design and level and assisted with beginning to identify themes and strength of evidence.
The 4 themes that were identified from the research and literature matrix were: recovery-oriented care interventions with strong evidence, psychoeducation with strong evidence to support it as an intervention model, transition services which had mixed results and moderate evidence, and risk and protective factors associated with readmission with mixed to weak research.
As part of the first theme, I wanted to briefly explain recovery-oriented care. The recovery model uses patient-centered and shared decision-making processes to guide the treatment. The recovery model is centered on the relationship and building collaborative care between provider and client. Part of this in practice is transparency between provider and client, shared decision making and focus on shared goals. The treatment measures move away from curing the illness or symptoms, to establishing recovery through self-resilience to live a meaningful life with mental illness.

While this model sounds intuitive and beneficial, it is important to acknowledge that it is a significant paradigm shift in the practice of mental health, particularly in inpatient psychiatry where many of the patients are admitted against their will, and it comes with many barriers and challenges that make the research findings and clinical application differ in practice.

Lastly, it reemphasizes identifying interventions that acknowledges and attempts to reduce further trauma and giving control back to the individual. Part of this is using trauma informed care, and shifting treatments, documentation practices, and increasing provider awareness of labels that can continue to stigmatize mental disorders.
Through the data analysis, strong evidence was found linking recovery-oriented interventions to lower readmission rates. The most convincing evidence was found in two Level I systematic review articles, and one randomized controlled trial. There were also three lower efficacy level 3 and 4 research studies and two qualitative studies. Involvement in the decision making and care process, communication and relationship amongst providers and the individual, and self-empowerment were themes throughout the studies. The research highlighted that individual’s participation in their discharge and recovery plan was an effective intervention because it allowed the individual to change their personal outlooks, how they viewed themselves, and empowered them in their role and sense of agency over their recovery.
The common aspects of recovery-oriented interventions that were highlighted across the level 3 and 4 study designs included recovery training and practical facts; reason for admission; barriers and motivation for treatment; medication considerations; self-improvement, stress vulnerability and coping strategies for symptoms/problems.

The intervention strategies also included transitional aspects of discharge planning such as building social support; community engagement; relapse reduction/crisis plan / safety planning; referrals and aftercare planning; inpatient needs to assist with transition; and personal goals. Although these studies were both a two-group comparative design that lack the rigor of a RCT, they were still able to provide moderately strong evidence that recovery-oriented interventions are helpful in reducing rehospitalization.

The length, duration, or style (i.e., individual or group) of the intervention was not found to be a significant factor in the outcomes.
Similar to the first theme, the research on patient education reducing the risk of readmission is strong. There were four systematic reviews that linked psychoeducation to reduced readmission rates, one randomized controlled trial, and two qualitative studies.

Likewise, with recovery-oriented care, patient-centered education is intertwined with personal empowerment as it provides the individual with information about their condition. Through this exchange of information, they are also being supported with self-awareness of their condition, and self-management or coping tools to overcome their symptoms.

Using psychoeducation as an intervention strategy is different than other treatment modalities in that the focus becomes the knowledge of one’s illness, and the focus is on shifting the behavior outcomes associated with their disorder. The systematic reviews and RCT demonstrated the importance of providing this education while the individual is still in the hospital, prior to the transition back into the community. By providing this education in the inpatient setting, patients began adapting self-care skills and managing their illness more actively which supports in their preparation for the transition after discharge.
Educational topics covered in the research included: Illness management; self-care and coping skills; behavior management; self-management; and education can assist with medication adherence.

The qualitative studies highlighted that service users appreciated the education provided on coping skills for crisis planning after discharge, and specific skills training as a useful tool for planning and developing coping strategies.
While there is compelling research about the acute nature of the transition back to the community following discharge, there is mixed evidence for what is the best intervention to support individuals in this time frame.

Part of the issue with the mixed level of studies was complexity within the research with broad variability of different models and interventions that weakened the efficacy of the evidence.

Having an outpatient appointment set-up following discharge decreased the likelihood of individuals being readmitted to the hospital as compared to those without an appointment. Furthermore, there is some level I, 3 and qualitative data that suggest benefits of interventions that bridge the gap between the two settings of inpatient and the community through relational care and communication amongst providers lowers the likelihood of readmissions.

Some of the research found it important to include aspects of the discharge environment. Factors that support recovery include enabling a sense of belonging in the community, including creating a structured or daily routine, and assisting the individual with finding stability within a social network. This was further emphasized in the qualitative studies with service users reporting safety and a sense of belonging in the hospital that they don’t have after they discharge. Although more research is needed to strengthen this area of evidence, there is emerging important considerations for clinicians with reintegration into the community and planning for social support.
The last common theme in the research, although weak in conclusive findings, was assessment for individuals at the highest risk for readmission and considering the protective factors to reduce that risk. There is convincing evidence in multiple studies, including strong research models, which support the highest risk factor for readmission being one or more previous hospitalizations.

Similar risk factors that were identified, but were weak in research, included age, and diagnosis. The age of the individual was found to be a risk factor with individuals aged 26 and younger. Literature also indicated that different diagnosis or lifestyle choices carried a higher risk, such as individuals with a personality disorder or individuals with a dual diagnosis or substance misuse.

The protective factors illustrated by the research was limited but included social supports and satisfaction within relationships, and employment.
Through a review of the evidence, strong research studies have proven that using a recovery-oriented model to provide psychoeducation and discharge planning for individuals in an inpatient setting is effective at decreasing readmission rates. This intervention includes aspects that instill hope, self-empowerment and decision making for the individual in managing the everyday aspects of their diagnosis. Similarly, providing education and interventions that allow the individual to plan and prepare for the challenges they will face when discharged from the hospital within the safety of the inpatient setting, allows the patient to envision their barriers and facilitate coping skills to address the perceived barriers before they occur. Therapists and providers should consider the roles and relationships of the individual and consider recommendations that can support the individual in the community.

Risk factors should be considered when assessing and discharge planning for individuals identified as having higher risk for readmission. Although important to assist the individual with community based after care services, the interventions to bridge this transition were moderate in proving their efficacy in the research and more studies are needed to identify the direct variables that are imperative to reducing readmission.
Slide 23

Narration.

Occupational therapy (OT) is in direct alignment with the recovery model, but we are not reflected in the research or evidence. There was no research that demonstrated the benefits of OT for inpatient hospitalization related to reduction in readmission rates. While OT was mentioned as a service in some studies, there was no evidence of the efficacy of the inpatient treatment for reducing readmission to the hospital. As the mental healthcare models and payment sources have shifted away from longer lengths of stay and decreased inpatient hospitalizations, there is a gap in the research and role of OT within inpatient mental health. Despite this clinical gap, there is a call to action for research in mental health, as outlined in the research priorities from the American Occupational Therapy Foundation.

Occupational therapy has a unique role to offer in mental health and recovery-oriented care. The four dimensions established by SAMHSA for their recovery framework include health, home, purpose, and community, and are concurrent with the AOTA Practice Framework. As therapists we support the whole client, with an ability to shift between a medical, rehabilitative and recovery perspective for the individual. In addition, our ability to work with individuals to establish meaningful roles and occupations supports them through the recovery process, including preparing and planning for reintegration into the community. In the qualitative study the theme of meaningful activity after discharge was mentioned in every focus group they conducted. This is an important aspect for clinicians to consider as they support an individual with discharge planning and recommendations for community referrals. More research is needed on the role of OT within inpatient mental health settings and the role we provide as vital members of the treatment team.
Thank you!
Appendix A.2. MOTA Continuing Education Session Proposal

MOTA Course Application

Event Name/Course Title: Homeless Not Hopeless, Effective Strategies to Working with Homeless Women.

Event Name/Course Title: Interventions to Decrease Readmission Rates in Inpatient Psychiatric Hospitals

Date of Event: Tuesday, Feb 8, 2022
Start Time: 6:00pm   End Time: 7:05 pm
Category: Presentation – Webinar (virtual but presenters are live)

Timed Agenda:

6:00-6:25 Presentation - Elizabeth Campbell
6:25-6:30 questions
6:30-6:55 Presentation - Emily Petersen
6:55-7:00 Questions and evaluation
7:00 – course evaluation

Event Description:

● Presenters will share the evidence found for the topics above, including the search strategy, level 1 and level 2 evidence, summary of themes and recommendations.

● It will be a 25-minute PowerPoint presentation

● Please include 2-3 references that support evidence-based practice.

  ○ Emily Petersen


Speaker Credentials and Biographies:

Emily Petersen, MA, OTR/L, is an occupational therapist (OT) that works in an inpatient psychiatric hospital. After completing her Master’s in OT at St. Catherine University in 2007, Emily worked in an early intervention outpatient program for children diagnosed with ASD for ten
years before transitioning to inpatient mental health. She has completed several quality initiatives at her worksite, including collaboration with an inpatient Shared-Decision Making project and utilizing technology to enhance patient education. Emily is currently in her second year in the Post Professional OTD program at St. Catherine’s University, focusing on evidence-based mental health interventions.

Learning Objectives: Emily Petersen
Participants will:
- Describe the themes within research that are effective at reducing inpatient mental health readmission risk
- Be able to identify interventions that are supported by evidence, and the level of confidence for the research of effective interventions for decreasing the likelihood of readmission to the hospital.
- Examine recommendations for OT practice related to effective interventions to reduce readmission and our role within the interdisciplinary mental health team.

Target Audience: All
Level of Content: Advanced
AOTA Practice Area: Health & Wellness, Mental Health
CEUs presentation – 1 hr.
MOTA Members only? No
Primary Speaker #2 Contact information
- Name: Emily Petersen
- Phone: 310-622-5605
- Email: empetersen743@stkate.edu

Would you like to use any additional technology tools on the day you present? These can be set up to use the beginning of the presentation, during the presentation, or at the end.

Will you be using a PowerPoint or other presentation tool?

X Yes, I will be using PowerPoint. Please email your presentation to motafunctionfirst@gmail.com at least 24 hours prior to your presentation.
Appendix A.3. MOTA Continuing Education Session Survey
Appendix A.4. MOTA Continuing Education Session Survey Results

1. Please indicate how well the presentation met the stated learning objective:
   Describe the themes within research that are eff...t reducing inpatient mental health readmission risk
   9 responses

   ![Survey Results Chart]

   Please indicate how well the presentation met the stated learning objective:
   Identify interventions that are supported by eviden...sing the likelihood of readmission to the hospital.
   9 responses

   ![Survey Results Chart]
Please indicate how well the presentation met the stated learning objective:
Examine recommendations for OT practice and our r... within the interdisciplinary mental health team.
9 responses

4. Please indicate how well the content of the presentation was organized
9 responses
Please indicate your overall impression of the presenter’s ability to communicate this material. 9 responses:

- 5: 9 (100%)
Appendix B.1. MOTA Continuing Education Poster Session Poster
Appendix B.2. MOTA Continuing Education Poster Session Presentation

Slide 1

Slide 2
Appendix B.3. MOTA Continuing Education Poster Session Proposal

MOTA Poster Session Proposal
Emily Petersen, MA, OTR/L, OTD-S

Presenter Bio:
Emily Petersen, MA, OTR/L, is an occupational therapist (OT) that works in an inpatient psychiatric hospital. After completing her Master’s in OT at St. Catherine University in 2007, Emily worked in an early intervention outpatient program for children diagnosed with ASD for ten years before transitioning to inpatient mental health. She has completed several quality initiatives at her worksite, including collaboration with an inpatient Shared-Decision Making project and utilizing technology to enhance patient education. Emily is currently in her second year in the Post Professional OTD program at St. Catherine’s University, focusing on evidence-based mental health interventions.

Presentation Title: Recovery Focused Care in Inpatient Mental Health: Connecting Recovery Services and the Value of Meaningful Living

Poster Description:
- Poster will share evidence-based interventions for inpatient mental health, including the current research on the recovery model and its connection to OT, implications for interventions and next steps to advocate for more OT research in acute mental health settings.
- It will be a poster session followed by a brief moderated discussion.
- Please include 2-3 references that support evidence-based practice.

Objectives:
As a result of attending my poster presentation, participants will:
1. Discuss the recovery model and how it connects with the values of OT.
2. Describe the implications for OT related to the recovery model.
3. Identify evidence-based practice recommendations for inpatient mental health settings.
Appendix B.4. MOTA Continuing Education Poster Session Invitation

St. Catherine University Occupational Therapy
And Minnesota Occupational Therapy Association

Post Professional Doctoral Poster
Presentations
Wednesday, April 20, 2022 6:00-7:00 pm CST

6:00 - 6:15 p.m.
Paola M. Stommel, MA, OTR/L, ATP
Evidence-Based Interventions and Screening Tools for
Promotion of Sleep in Children with Developmental
Disabilities

6:15 - 6:30 p.m.
Jennifer Brady-Johnson, MA, OTR/L
Teaching Regulation in Social Emotional Learning

6:30 - 6:45 p.m.
Emily Petersen, MA, OTR/L
Recovery Focused Care in Inpatient Mental Health:
Connecting Recovery to the Value of Meaningful Life

6:45 - 7:00
Elizabeth Campbell, MOT, OTR/L
Homeless Not Hopeless: How We Can Help

REGISTER HERE
or go to https://mota.memberclicks.net/
and register under Professional Development
Appendix B.5. MOTA Continuing Education Poster Session Evaluation
Appendix B.6. MOTA Continuing Education Poster Session Evaluation Results

The poster presentation delivered the material in a manner that was clear and structured.
19 responses

The poster presentation was concise and informative
19 responses
The presentation contained practical examples and useful techniques that applied to current work
19 responses

The presenter was knowledgeable and about the topic and answered questions effectively
19 responses
The presenter maintained my interest during the entire presentation
19 responses

Overall, I would rate this poster presentation and discussion as:
19 responses
Appendix C.1. OT Practice Article

Unlocking the key to recovery: How Occupational Therapy can harness the power of the recovery model through the connection of occupations and meaningful living.

Introduction

Mental health affects one in five people annually and impacts the psychological, behavioral, and emotional well-being of the individual (National Alliance of Mental Illness ([NAMI], n.d.; Kaiser Family Foundation [KFF], 2022). Since the pandemic, reports of mental health intensified to include an additional 129.4 million cases of anxiety and MDD (Institute for Health Metrics and Evaluation [IHME], 2021).

While the acute necessity for treatment of mental health conditions has grown, healthcare reform has changed. The recovery model has replaced the traditional medical model as the standard in mental health care, and there is strong evidence that use of this model reduces the risk of inpatient readmissions (Lyon, 2020). The definition of recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Substance Abuse and Mental Health Services Administration ([SAMSHA], 2012, p 3). Recovery is viewed in four dimensions of health, home, purpose, and community (SAMHSA, 2012). Despite the strong evidence of the recovery model as an effective treatment intervention and quantitative benefits to the everyday meaningful outcomes for consumers, many clinicians find implementation of the recovery model challenging to utilize (Tyler et al., 2019; Giacco et al., 2018; Duckworth, 2015).

Occupational Therapy and Mental Health

The shift in mental health care has dramatically impacted the role and value of OT within mental health settings, particularly inpatient hospitalization. With an average length of stay now
3-10 days, discharge planning is the primary focus of hospitalization (Ruffalo, 2019). Our profession no longer has the duration of care that affords interventions built upon skill development. There is a need to identify how to best deliver occupation-based care to fit within the constraints of the environment, and limited research on the efficacy of our interventions.

Furthermore, the need for mental health services and psychosocial interventions is expanding to all dimensions of OT services. In a 2017 National Board of Occupational Therapy (NBCOT) Practice Analysis Executive Report, 1.8% of respondents identified as mental health practitioners, but 85% reported that they provide services to individuals with a psychiatric diagnosis (NBCOT, 2018). This means that nearly every OT has the potential to be considered a mental health clinician, and yet, the critical need for OT to produce more robust evidence on the effectiveness of our mental health interventions remains.

**Connecting Recovery Model Evidence to Occupational Therapy Interventions**

There are ample publications that support OTs alignment with the recovery model. We support the individual in their recovery by identifying and setting personal goals, identifying interests and meaningful occupations, and helping to find referrals to the community to support them in meeting their goals (MacRae, 2019). OTs focus on the person-environment-occupation (PEO) embraces principles of the recovery model built into the foundations of the framework (Baum & Baptiste, 2002; Merryman & Riegel, 2007).

Taking a step back and looking at the strong research that use of recovery-oriented care and psychoeducation are effective interventions for inpatient psychiatric care, and that they align with our framework and values, why then, are we missing stronger evidence on effective interventions in mental health? Why are inpatient OTs not equipped with research that is rooted in occupation as an intervention, and instead are turning to treatment that supports symptom
reduction during crisis, such as mindfulness and coping strategies. Instead, our focus should be on supporting and educating individuals on the valuable role that occupation plays in their recovery and quality of life outcomes. Research has shown the importance of psychoeducation within inpatient settings to plan, and problem solve for the transition back to the community, and this should include education on engagement in meaningful occupations and routines as a critical dimension of discharge planning (Tyler et al. 2019; Park et al., 2018; Duhig et al., 2017). The alignment of our framework with the recovery model supports our role in becoming leaders in delivering recovery-oriented care in inpatient mental health treatment (Merryman & Riegel, 2007; Sutton et al., 2012).

Stages of Recovery and Occupational Engagement

Within the recovery process, the individual must reconstruct their sense of self and formulate a newfound meaning in their everyday life (Merryman & Riegel, 2007). Research identifies four stages of recovery, and within the process lies the opportunity for the individual to reach acceptance of their experiences and live beyond their disease (Merryman & Riegel, 2007). Each stage of recovery correlates to discovery of occupational meaning and engagement (Sutton et al., 2012). Recently, research has highlighted the importance of moving beyond the occupational profile for the individual (i.e., type, duration, engagement) to connecting meaning in occupation through the relationship and experiential facets that meaningful occupations provide to well-being (Hancock et al., 2015). According to Doroud et al. (2015) occupational engagement supports building identity, purpose and meaning, and provides the individual with control to create a future-oriented perspective of their life. As OTs, we can support the individual through the stages of recovery by supporting their occupational engagement level and providing
recovery occupation interventions. Within the phases of recovery, the individual moves from “Why me” to “What now”, and Occupational Therapy offers an individual “What matters?”

Table 1

<table>
<thead>
<tr>
<th>Stage of Recovery (Merryman &amp; Riegel, 2007)</th>
<th>Occupational Engagement Phase (Sutton et al., 2012)</th>
<th>Recovery Occupation Interventions (Sutton et al., 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overwhelmed</td>
<td>Disengaged</td>
<td>Implication for OT: Instill Hope</td>
</tr>
<tr>
<td>Getting through the day-to-day of living with their illness is taxing.</td>
<td>Numb, detached, no senses, heavy, psychotic, unattached to reality, it’s a non-doing mode.</td>
<td>“Hope was found in the possibility of caring for and committing to something” (Sutton et al., 2012, p 145).</td>
</tr>
</tbody>
</table>

- Assist the individual in establish personal goals and finding strengths / assets to support the individual in recovery:
  - Use Strength based assessments that include a strong emphasis on strengths and skills of the individual, and barriers to strengths that require OT intervention. Use “Aware-Explore-Apply” (Niemic & Pearce, 2021).
  - Used shared decision making to collaborate on goals.
  - Educate the individual on how to advocate for their goals with the treatment team.
  - If appropriate – introduce the Personal Recovery Outcome Measure (PROM; Barbic, 2015) tool to measure recovery outcomes.
- Respite in simple or rhythmic occupations that ground the individual:
  - Incorporate a simple reflection on occupation as part of the intervention.
  - Begin education on the meaning of occupations.
- Identify interests and explore meaningful occupations:
  - Interest checklist, Meaningful Activity Participation Assessment
**Struggling**

*Acknowledges the situation; begins to develop a narrative explanation and identify their strength and meaning.*

**Partial Engagement**

*Heavy or slow, effort to engage in occupation.*

*Engagement is a struggle, but participants are attempting.*

**Implication for OT: Explore**

*In this phase the process of occupation was more important than the outcome. Allow expression of self and open possibilities of “being” (Wilcock, 1999).*

- Explore reason for hospitalization and what occupations supported or hindered everyday life.
  - Education on diagnosis and support to identify how it impacts engagement in everyday occupations. Understanding of illness constructs internal locus of control (Synovec, 2015).
- Emphasis on occupations and how they support recovery:
  - Role identification and occupational history to assess role participation.
  - Education on meaning and occupation.
- Identification of occupations that support recovery:
  - Implement an occupational diary to assist with reflections on activity patterns and contribution to well-being (Bailliard et al., 2021). Example includes the Occupational Experience Profile (OEP).
- Coping skills that link to fulfillment of occupational engagement.
- Explore environment and community resources:
  - Use PEO model to explore and educate the individual on their environment.
  - Engage individual in discussion
about potential environmental triggers and barriers to engaging in occupations post-hospitalization.
- Support in problem solving and making plans to prepare for challenges within the safety of the inpatient environment.
- Explore social support and connectedness in the community.
- Support the discharge planning process by providing appropriate referrals for occupational engagement, community integration, and peer support networks.

<table>
<thead>
<tr>
<th>Living With</th>
<th>Everyday Engagement</th>
<th>Implication for OT: Reconnection &amp; Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Comes to terms with and begins to assume their meaningful roles/activities</em></td>
<td><em>Direction, commitment, expectations, social connections.</em></td>
<td><em>Connection to uniform and routine occupations. Stability and structure.</em></td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td><em>Collaboration between inpatient and community-based OTs to support discharge.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Support individual in setting up of daily routines.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Education and support to form social connections with others.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Identify networks and referrals for peer support.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Practice through doing and reflect on experience:</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Trial and error phase – support in ability to problem solve and reflect on occupational engagement process.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Increase belonging and social identity through occupations.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Beyond</th>
<th>Full Engagement</th>
<th>Implication for OT: Support and Fulfillment</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Well-connected to self, others, and environments of choice.</em></td>
<td><em>Integrated and energized through doing and occupations.</em></td>
<td><em>Support individual in fulfillment of everyday occupations as needed.</em></td>
</tr>
<tr>
<td></td>
<td><em>Focused attention,</em></td>
<td><em>Peer support and social network connections.</em></td>
</tr>
</tbody>
</table>
great enjoyment, integration of one with their environment.

Able to balance enjoyment and mundane stressors of life and find enjoyment in everyday life.

- Encourage recognition of the non-linear process of recovery and meaningful occupations.
- Education to access to supports when needed.

Conclusion

In inpatient mental health hospitalization, individuals are in the overwhelmed or struggling phase of recovery (Merryman & Reigel, 2007). Providing education and supporting the individual on making meaning from the disengagement phase highlights the value we bring to the recovery continuum. Within OT, we shift the individual’s sense of self and value on how they can define meaningful living for themselves as a person beyond their diagnosis or clinical presentation (Merryman & Riegel, 2007; Sutton et al., 2012). It involves identifying strengths and skills, choice and decision making, exploration, and coping skills of challenges related to condition to develop meaningful life roles (Merryman & Riegel, 2007; Kelly et al., 2010; Sutton et al., 2012). Occupational engagement contributed to the individual’s recovery by supporting acceptance and improved self-concept (Kelly et al., 2010). The ability to foster meaning in everyday living through occupation is so uniquely and distinctly something that OT can contribute to the inpatient mental health setting.

While there are many barriers to the recovery model and collaborative care within inpatient mental health settings, as OT practitioners we have a valuable role to offer in the delivery of recovery-oriented care. The recovery model is rooted in strong evidence and in direct alignment with our framework (Read & Stoffel, 2019; Tyler et al., 2019). As clinicians we
support the whole client, with an ability to shift between a medical, rehabilitative, and recovery perspective. Our ability to work with individuals to establish meaningful roles and occupations supports them through the recovery process, including preparing and planning for reintegration into the community. To advocate for the value of our role within mental health, further research is needed to strengthen the evidence of our interventions, particularly within inpatient mental health, and to provide evidence-based standards for our clinicians.
References


Appendix D.1. St. Catherine University Student Presentation Invitation
Hello, my name is Emily Petersen, and I am an occupational therapist working in an acute inpatient mental health hospital in California. This presentation will discuss the evidence and best practices related to inpatient mental health, and the implications for OT clinicians.

After reviewing and analyzing the evidence on effective interventions that reduce the likelihood of readmissions to the hospital for mental health, I disseminated this information with other practitioners through a process called knowledge translation. This presentation will serve as a summary of the three projects that I completed in pursuit of my post-professional clinical doctorate in Occupational Therapy.
I work at a free-standing psychiatric hospital in California, which has a rich history in mental health treatment, but at the same time, has seen many of the changes that have impacted all healthcare settings, but particularly mental health in the last decade or so. When I first started in 2007, the hospital had many amenities for treatment, which included an amazing OT clinic with a woodshop, a kiln for ceramics, a kitchen, 4 deck/outdoor spaces, a playground, a kitchen and separate dining room, and ample space. The environment was akin to fostering skill development in meaningful activity and occupations for individuals hospitalized with mental illness.

But even just in the time since I started, and even more so for many of the therapists I work with, things have significantly changed. For starters the space, we don’t have hardly any of that anymore. We moved into a medical hospital that is built for medical needs, such as large pt. rooms and tiny dayrooms. The OT room is tiny and many of the supplies must fit onto a cart that can be taken to the unit instead of patient’s entering our clinical space like before.

And it is not just the space and supplies that have caused significant change, but healthcare, and particularly mental health, has undergone rapid changes. Most of our patients come into the hospital in crisis, and the goal is to quickly stabilize and return to their community services. We used to have a length of stay that afforded relational care, through assessments, and time spent in interventions that built occupational engagement and skill building as treatment, but the model of mental health hospitalization has changed. Teaching skills in inpatient is challenging and, in most cases, an ineffectual model of intervention due to the length of stay and
time it takes to build skills and habits. Inpatient OT needs to adapt to serve the everyday occupational needs of the population, and mental health services at large.

I believe it was Dr. Bass that taught us that it takes research an average of 17 years to reach clinical practice, and I can only speak for myself, but I think it takes another 17 years for clinical settings to fully implement it and culture to change. Mental health is rapidly reforming the delivery model, and on top of that, has a growing need for services, but OT is behind the curve with limited evidence-based guides for clinicians. It is for these reasons that I choose this topic to explore for my project.
My project was focused on identifying evidence-based research for inpatient mental health, but as I combed through our interprofessional and intraprofessional documents and research, I had difficulty finding research that was specific to inpatient. Although mental health data is not robust, most of the evidence I did find was for community mental health. Through discussions with my mentors, colleagues, and professors, I began to realize that due to the lack of evidence for inpatient mental health in OT, it was essential to take a step back and identify what the effective interventions for inpatient mental health are and draw parallels to how OT can be involved in these evidence-based interventions.
Anxiety and depression are the most prevalent type of mental illness in the United States. The rate of mental illness was estimated at 1 in 5 individuals experiencing a mental illness, but those rates have significantly risen since the COVID-19 pandemic. The estimate in my state of California is now 1 in 3 adults, and nationwide there are approximations that it has increased by 30% of individuals reporting depression and anxiety since the pandemic. Additionally, mental illness accounts for many of the hospitalizations in America and is one of the few causes for hospitalizations that is steadily increasing. For example, in a report looking at hospitalizations in 2016, hospital stays with either a primary or secondary mental health condition accounted for 27.8% of the hospitalizations; however, when broken down by age group, the percentage of individuals ages 18-64 years hospitalized with a mental health condition increased to 83.8%, or more than one out of every five hospital stays in the U.S.

While it is normal to experience feelings of anxiety or fear in life, individuals suffering from an anxiety disorder experience frequent, and at times debilitating feelings of fear and panic. Individuals suffering from anxiety disorders may experience intense nervous feelings or a sense of impending danger. There are many physical symptoms associated with anxiety disorder and these include increased heart rate, difficulty breathing, sweating, difficulty concentrating or focusing, poor sleep, gastrointestinal illness, headaches, muscle tremors or trembling, body weakness, feeling faint, and nausea.

Major depression disorder (MDD), the most common mood disorder, and it impacts the way individuals feel, their thoughts, and behaviors. Depression results in the individual
experiencing intense sadness, low energy, feelings of worthlessness, guilt, or shame, and a loss of interest or pleasure in activities. Additional symptoms may include changes in appetite, pacing or an inability to sit still, slowed movements, difficulty focusing or concentrating, and suicidal thoughts. Depression is the leading cause of disability worldwide.
Healthcare, and particularly mental health quality standards, has undergone rapid changes. While hospitals look to reduce cost and improve the effectiveness of care, they are targeting reducing the rate of readmissions. Furthermore, the model of mental health care has shifted to a focus on preventative care and community services with crisis care focusing predominantly on re-integration into community.

The LOS has significantly decreased with estimates of the average length of stay anywhere from 3-12 days, compared to the longer lengths of stay that were common in previous decades. In addition, discharge planning now begins on day 1 of the admission, and the focus of hospitalization is on rapid reduction of symptoms, aftercare services, and preparing for the transition after hospitalization.

When you consider the experience of readmissions, several issues stand out as commonly identified impacts, and they include the psychological stress to individual and family, demoralization to individual, potential feeling of failure for the treatment team, high cost for healthcare systems, and a drain of resources. When looking at the data, schizophrenia, and mood disorders, which includes depression, were the two most common diagnoses associated with readmission.
The concept of recovery has established roots in the field of physical medicine and rehabilitation. Someone with a chronic medical condition, or a disability, can navigate managing their symptoms or illness to continue or regain quality of life, but psychiatry has been slow to adapt to this model, and historically has focused on treating to remove the symptoms of mental disorders. The recovery model shifts perspective away from curing the illness, or eliminating the symptoms, to a person-centered perspective of how to treat the individual’s needs, a focus on quality of life beyond your mental illness. The SAMSHA definition of recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” It is a strength-based approach that is directed by the goals and skills that exist within the individual.

This model began to grow in popularity over the last few decades, initially encouraged by individuals living with mental illness and their families and sharing their lived experiences of meaningful life with mental illness. Admittedly, there are many barriers to the recovery model versus the traditional medical model in inpatient psychiatry. For example, at my hospital, greater than 50% of patients are admitted against their will and lack autonomy over their care. Additionally, individuals in an acute mental episode may lack insight, have a high level of acute needs, or have ambivalence regarding their care and recovery goals.

Using the recovery model in inpatient requires clinicians to be motivated and supportive of the model and adaptive to overcoming the challenges and pitfalls of using a more traditional or authoritarian model of care. Part of the recovery model includes finding ways to create an
opportunity for shared decision making within the hospital and this allows the experiences and goals of the patient as part of the treatment process. It creates positive expectations and an engagement in the recovery process between provider and patient. Although there is a growing amount of research and evidence promoting a recovery model, many clinicians and institutions may find implementation of the recovery model challenging to utilize and justify without clearer outcomes in clinical care.

With that said, the recovery model aligns with the OT framework and there are ample publications and documents that support OTs alignment with mental health treatment and the recovery model.
While I am not going to give you a history lesson on OT in mental health (although I am confident I could after Dr. Fleming’s class), it is important to note the historical context and how that contributed to where we are today. As we aimed to develop into an advanced practice area with research, we moved away from the origin of arts and crafts. Despite our professional roots in mental health, this practice area as a traditional setting has struggled to develop and maintain research standards to further inform good practice as compared to other areas of OT research. To highlight this, there was a 2012 study that looked at 4 years of AJOT articles and found that only 6% were related to mental health, and within that, only 9 articles covered the effectiveness of interventions.

The benefits of OT in acute psychiatric care include encouragement and engagement in activity, addressing self-care skills, beginning the foundation of rehabilitation skills, assistance with treatment goal development, and community referrals. When working with individuals, we can support them in their recovery by advocating for their capacity to set personal goals, identify their strengths and skills, development of meaningful activities and purpose in life, and education for how to cope with specific problems or symptoms of their mental illness. Additionally, we can provide them with education to begin to plan for the transition back to the community, this includes problem solving challenges within the supportive environment of the hospital and identifying the social and community supports needed for when they leave.

While we know we play a beneficial role to support individuals with a critical mental health hospitalization recover and resume their quality of life, what evidence is there to guide OT practice and treatment interventions, and advocate for the value of our care?
The issue of lack of evidence is not just a traditional mental health setting barrier, either. As I highlighted in the prevalence data, mental health illness or awareness and acceptance of it, is increasing. And the mind and the body, despite our healthcare system separating them into two fields, they are still connected. OTs working in traditional mental health settings, which has been heavily determined beyond the control of our profession by payer sources and regulatory constraints, has decreased to about 2% of OTs working in this area. But in a recent NBCOT practice analysis report, they practitioners that they surveyed, 84% of them reported that they worked with individuals with a mental health diagnosis. This pairs with the hospitalization data that I shared a few slides back. This means that nearly every OT has the potential to be considered a mental health clinician.
For the first of my knowledge translation projects, the purpose or aim was to inform OT practitioners, educators and students of the research that I found on effective interventions that reduce readmission, share the process I followed and the themes within the research that I identified, and what the implications were for OT clinicians.
The second project aim was to take the evidence found in project one and present the connection the evidence has, particularly the recovery model, to occupational therapy and development of occupational engagement within the phases of recovery through a poster session and brief presentation.
Lastly, the aim of the third project was to take that information and raise awareness and knowledge through an article written for OT Practice.
The first knowledge translation was a 30-minute continuing education webinar via Zoom that was sponsored in partnership with St. Kate’s and the Minnesota Occupational Therapy Association, MOTA in Feb 2022. There were fifteen participants that attended the event.

The presentation was focused on sharing the findings from my evidence-based literature review on the effective interventions that reduce hospital readmissions in mental health. In addition to highlighting the process of the review, I also shared with the group 4 themes that were identified within the literature, and the strength of evidence. While OT was not directly part of the evidence found, there were many implications for OT practitioners, and this was also shared within the meeting and was used to shape the direction of the next KT projects.
My second KT project was a poster session and 10-minute presentation with 5 minutes allotted for question and answers. The event was sponsored by St. Kates and MOTA and was presented in April 2022 via Zoom. There were 34 participants at this event.

The poster provided evidence on the effectiveness of the recovery model and the current research that highlights the correlation between phases of recovery and the link to occupational engagement and meaningful occupations. In addition, the poster provided implications for OT and recommendations on how to treat in a recovery-care oriented way.
For my third project, an article was written for OT Practice Magazine on the recovery model, mental health, and occupational therapy. The goal is to submit the draft of the article in June 2022. The image on this slide is for good luck and is aspirational as this was the issue that Dr. Haertl’s mental health article is featured.

To create the outline for the article, I met with my mentor, Dr. Stoffel to reflect and discuss possible topics to address within the paper. The article was framed around providing education on the recovery model in mental health, and the correlation between phases of recovery and emergence of occupational engagement through a table that outlined the four stages of recovery and matching phase of occupational engagement. The purpose of the article was to provide OTs with background on the research of the recovery model and the connection between recovery and occupation. More specifically, the role and value that OTs provide the individual in their recovery by supporting and facilitating the individual’s ability to identify meaningful everyday life. The article included background information on mental health and the significance of addressing the needs of this population, the current research on the recovery model were highlighted, and the implication for OT practitioners practicing in acute mental healthcare settings.
To evaluate my projects, a Google Forms survey was created for participants to complete for KT project 1 and 2. The survey’s had Likert scale questions for rating the content and my performance presenting the materials, with 5 being very well or excellent, and 1 being poor. As you can see, the results for KT project #1 were all positive, and with the majority of the 9 respondents rating my performance with a 5.

KT project #2 was a bit more mixed, but overall remained positive. There was a comment about an error with completing the form, so it is possible that the lower scores of 1 or 2 were in error but there is no way to know as the survey was anonymous. When I reflected on the scores, the rating on implications for OT as it related to their practice settings were ranked lower than other questions. With this information, I tried to incorporate more clinical information or recommendations within the article knowing that this was something I could improve upon. It was challenging as the project is looking at a model and conceptualizing what it means for clinical practice; however, I think OT has many opportunities within the recovery model which I tried to highlight within the article.

The evaluation for the article will come through the submission process, which is not peer-reviewed, but involves a professional editorial review by the magazine.
Also, within the surveys, one open ended question to share feedback or recommendations was provided but not required. Here is a sample of some of the comments that were provided by participants.
Slide 17

Narration.

The overarching main message that stemmed from my knowledge translation projects were that there are strong levels of research that prove using a recovery-oriented model to provide psychoeducation and discharge planning for individuals in an inpatient setting is effective at decreasing readmission rates. And not only that, but that OT has a distinct and valuable role that can align with the research. The recovery model is rooted in strong evidence and in direct alignment with our framework. Because of this, OT should become the leaders in delivering recovery-oriented care in inpatient mental health treatment.

Within OT, we shift the individual’s sense of self and value on how they can define meaningful living for themselves as a person beyond their diagnosis or clinical presentation. It involves identifying strengths and skills, choice and decision making, exploration, and coping skills of challenges related to condition to develop meaningful life roles. Furthermore, by providing education and supporting the individual on making meaning highlights the value we bring to the recovery continuum. The ability to foster meaning in everyday living through occupation is so uniquely and distinctly something that OT can contribute to the inpatient mental health setting.

To advocate for the value of our role within mental health, further research is needed to strengthen the evidence of our interventions, particularly within inpatient mental health, and to provide evidence-based standards for our clinicians.
It’s hard to even put this part into words, and to be honest, I think I am still processing what a ride these last two years have been. Returning to St. Kate’s has been such a gift and I have learned and grown so much. Over the last 2 years, I have seen a refinement in my skills and a path that each class has shaped and taught a deep connection of my understand within my clinical practice. As my project focused on teaching our clients to identify their skills and character strengths, I have seen an evolution in my knowledge, passion, and heart for service in mental health.

I have also seen ways that I can challenge myself and areas that I have needed to step out of my comfort zone to grow.

One important thing that has centered my practice and way of thinking throughout school is the larger context of what this all means, and that it is not just enough to learn but that I need to expand by doing. This can mean sharing my knowledge, innovative thinking of how to apply it, and advocating for change in my practice and work setting.

Lastly, and one that I think has the most meaning for my personal growth is that I need to share the same kindness that has been given to me throughout this process with others. I have been amazed by the kindness and heart of service that scholars and mentors have shown me throughout the process, many of them just agreeing to meet with me as a stranger, and listen and guide me in my growth. Incorporating the lived experience and voices of individuals with mental health is important, and something that I want to include in future projects. And lastly, students. I became an OT because an OT took the time to guide and show me. She went above
and beyond because she saw a passionate teenager with an interest, and I want to do the same to help grow and build future OTs.