2020

Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation

Sara Anderson

Ashley Malina

Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation

By

Sara Anderson, MOTS

Ashley Malina, MOTS

Advisor: Dr. Fox

A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Occupational Therapy

Grand Forks, North Dakota

May 2020

APPROVAL

This Scholarly Project Paper, submitted by Sara Anderson & Ashley Malina in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Dr LaVine Fox Signature of Faculty Advisor

April 15, 2020
Date

PERMISSION

Title: Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation

Department: Occupational Therapy

Degree: Master of Occupational Therapy

In presenting this Scholarly Project in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, we agree that the Department of Occupational Therapy shall make it freely available for inspection. We further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised our work or, in her absence, by the Chairperson of the Department. It is understood that any copying or publication or other use of this Scholarly Project or part thereof for financial gain shall not be allowed without our written permission. It is also understood that due recognition shall be given to us and the University of North Dakota in any scholarly use which may be made of any material in our Scholarly Project.

Signature Sara Anderson

Date 4/15/2020

Signature Ashley M. Mahn

Date 4/15/2020

TABLE OF CONTENTS

Acknowledgment

The authors would like to formally express our appreciation to our advisor, Dr. Fox, Ph.D., OTR/L, for her expert guidance and scholarly advice. We are grateful for her willingness to donate innumerable hours throughout the completion of this scholarly project. Her time and effort have not gone unnoticed, and we are grateful to have this opportunity to work under her guidance. Thank you to all of the University of North Dakota Occupational Therapy Department faculty. They have taken the time to support us throughout the past three years, allowing us to become capable occupational therapy practitioners. Additionally, we would like to thank our families and friends for providing continuous support and encouragement throughout our time in this program.

-Ashley Malina, MOTS & Sara Anderson, MOTS

Abstract

Title: Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation

Citation: Sara Anderson, MOTS, Ashley Malina, MOTS, & LaVonne Fox, Ph.D., OTR/L. Department of Occupational Therapy, University of North Dakota School of Medicine and Health Sciences, 1301 N Columbia Rd, Grand Forks, ND 58203—2898

Problem: Current practice is that the occupational therapists' identity has become rooted in the practice setting they are working in versus the core values and beliefs of the profession. Despite the core values and beliefs of the profession, occupational therapists have pigeon-holed themselves as physical or mental health practitioners (Terry & Westcott, 2012). This results in restricted assessments and interventions that are not holistic and often not occupation based (Terry & Westcott, 2012). "Occupational therapy practitioners need to have an understanding of the physical, emotional, and psychosocial aspects of recovery from physical disability to address potential obstacles to their patient's holistic well-being" (Tully, 2019).

Methods: A literature review was conducted on: 1) the historical changes of occupational therapy to current day, 2) current occupational therapy trends, 3) returning to the holistic roots and 4) reimbursement. Concepts from Malcolm Knowles Andragogy and information from the literature review were used to guide the development of the product.

Conclusion: This scholarly project focuses on the role of occupational therapists working with individuals who have physical disabilities. This is the area, in particular, where

occupational therapists may be struggling to meet the psychosocial needs of their clients. Within the physical dysfunction setting, having a holistic viewpoint of the patient is important to be able to address all aspects of the person to provide the most client-centered care. The final project is a guide developed for occupational therapists that are practicing in physical disability settings. We believe that the application of this guide can contribute to the professional development needed to address mental health practices within physical disability settings. This could result in an improved therapy outcome and increase therapeutic relationships with clients.

CHAPTER I

Introduction

The Occupational Therapy profession has had holistic care woven into its ideology since its inception. As time progressed, occupational therapists shifted their focus from the holistic approach to focusing on the body structure, largely due to the medical models' strong presence (Kearney, 2004).

"Despite our roots, occupational therapists have become pigeon-holed as 'physical' or 'mental health' practitioners, resulting in restricted assessments and interventions that are not completely holistic, and perhaps not even occupational" (Terry & Westcott, 2012). This may lead to occupational therapists not addressing the person holistically. Currently, in Occupational Therapy (OT) practice, occupational therapists define themselves by the setting they are working in, such as acute care, nursing home, mental health, etc.

The goal of this scholarly project is to present a resource for occupational therapists and occupational therapy assistants, who work in physical disability practice, to successfully address both the physical and mental health needs of their clients. This guide is evidence-based using current data and strategies to integrate mental health components in evaluation and interventions.

The model of Andragogy was selected because it provides strategies that have been effective for adult learners. Areas that are strongly emphasized in this model are self-directed learning, past life experiences, readiness to learn, practical reasons to learn,

and internal motivation. These concepts are interwoven throughout the guide through reflection questions located at the end of the activities.

Within this scholarly project are terms and concepts that may be unfamiliar or have multiple meanings to the reader. The following definitions of various terms are used so the reader is clear on what the terms or concepts mean pertaining to the scholarly project.

Key Terms and Concepts:

1. Andragogy: “The art and science of helping adults learn” (Knowles, 1980).
2. Chronic Conditions: “conditions that las one year or more, require ongoing medical attention, and/or limit activities of daily living” (CDC, 2020).
3. Empathy: “Striving to understand the client’s thoughts, feelings, and behaviors while suspending any judgment while ensuring that the client verifies and experiences the therapist’s understanding as truthful and validating” (Taylor, 2008, p. 53).
4. Holistic Care: “A behavior that recognizes a person as a whole and acknowledges the interdependence among one’s biological, social, psychological, and spiritual aspects” (Zamanzadeh et al., 2015).
5. Physical Agents: “A type of treatment used to reduce or modulate pain, reduce inflammation, increase tissue extensibility and range of motion, promote circulation, decrease edema, facilitate health, and stimulate muscle activity” (AOTA, 2018b).
6. Physical Dysfunction Setting: An area where therapists work including but “not limited to acute care, home health agencies, inpatient rehabilitation, transitional care units, long-term care facilities, outpatient rehabilitation, or skilled nursing facilities” (Brown & Carroll, 2016).

7. Mental Health: “Encompasses emotional, psychological, and social well-being” (CDC, 2018).

Chapter II reviews the current literature of therapists addressing mental health and wellness within a physical disability setting. Chapter III describes the methodology used to create the guide materials. Chapter IV provides the scholarly product in its entirety. Chapter V summarizes the purpose, recommendations, limitations of the process and project.

CHAPTER II: REVIEW OF LITERATURE

Introduction

Clients experience occupational disruption, deprivation, and imbalance when incurring a physical disability. “Occupational therapists need to have an understanding of the physical, emotional, and psychosocial aspects of recovery from physical disability to address potential to their patient’s holistic well-being” (Tully, 2019). If occupational therapists do not, then they are adding to that disruption, deprivation, and imbalance because only one aspect is being address. Within the physical dysfunction setting, having a holistic viewpoint of the patient is important in order to address all aspects of the person to provide the most client-centered care.

This scholarly project focused on the role of occupational therapists who are working with individuals who have physical disabilities. This is the area, in particular, where occupational therapists seem to be significantly struggling to meet the psychosocial needs of their clients. A review of the literature was conducted on topics related to a historical look at occupational therapy, the influence of the medical model on the profession, and the current trends in practice settings. The literature review examined the topics of psychological implications of physical disability and the need to focus on returning to holistic treatment in physical dysfunction settings.

Current Day

The origins of occupational therapy are rooted in mental health/psychiatry (American Occupational Therapy Association [AOTA], 2017), as the creation of the

profession dovetailed with the early 20th century's mental hygiene movement (Stoffel, Reed & Brown, 2019). Occupational therapy has several services it provides for clients with mental health needs. Occupational therapists believe that participating in one's daily occupations is vital to mental health wellness. "Occupational therapy practitioners work collaboratively with people in a manner that helps to foster hope, motivation, and empowerment" (AOTA, 2016g, pg. 1). Occupational therapists who do not address the mental health wellness and occupational needs, in all aspects, are doing a disservice to the client and the profession.

In the early 20th century, the founders and early writers in occupational therapy created a body of literature that supported the therapeutic value of occupation (Dunton, 1918; Reed, 2006). Dunton believed Adolf Meyer's theory of psychobiology because it was holistic and practical (Christiansen & Haertl, 2014). Meyer's theory also highlighted that a person is organized through active participation and that it was essential to have a balance between work and rest for an overall balanced life (Christiansen & Haertl, 2014). Dunton and Meyer believed that occupational therapists had an essential role in assisting clients with adjusting their habits and regaining their optimism (Christiansen & Haertl, 2014). Meyer's theory was in line with the beliefs of occupational therapy in that it recognized that being forced to be inactive not only was morally wrong, but it was also debilitating to the client physically and mentally (Christiansen & Haertl, 2014). To have people engaging in occupations could help prevent depression and increase self-confidence that would help motivate a client further in their recovery (Christiansen & Haertl, 2014).

According to AOTA (2014), “Occupational therapy is founded on the understanding that active engagement in occupation promotes, facilitates, supports, and maintains health and participation.” The term occupation is defined as, *life activities that people “engage in throughout their daily lives to structure time and give life meaning”* (AOTA, 2014). One of the goals of occupational therapy is to promote physical and mental health and well-being in all people, with and without disability-related needs (AOTA, 2017). Additional focuses are to establish, restore, maintain, and improve function and quality of life for people at risk for or affected by physical or mental disorders (AOTA, 2017, pg. 1). Occupational therapy practitioners’, who support the mental health of clients, should transcend settings and diagnoses to promote an increased quality of life (AOTA, 2017).

In the 1920s and 1930s, leaders in the occupational therapy profession were working on making occupational therapy a legitimate medical profession and believed allying with medicine would assist in achieving this goal (Christiansen & Haertl, 2014). It was in the 1930s when occupational therapy began to adopt more physical agents in their daily practice (Christiansen & Haertl, 2014). Physical agents used included goniometry and tools to increase strength and range of motion (Christiansen & Haertl, 2014). As occupational therapy began using the medical model, it gave the occupational therapy profession a common language with which to communicate with other professions since more collaboration was beginning to happen with treatments.

The Army was influential in solidifying the shift of occupational therapy towards the hospital-based rehabilitation practice setting (Christiansen & Haertl, 2014). At the beginning of World War II (WWII), the occupational therapy profession moved away

from crafts to focus more on the physical aspect of the patients, influenced by occupational therapist leadership (Christiansen & Haertl, 2014). The 1940s brought soldiers home from the war with health challenges from war injuries and chemical wounds (Christiansen & Haertl, 2014). Other influences on practice included a movement by Thomas Kidner, who advocated for occupational therapists to work in tuberculosis hospitals (Christiansen & Haertl, 2014). All of these influences contributed to strengthening the position of occupational therapy in the physical rehabilitation setting (Christiansen & Haertl, 2014).

Occupational therapists, practicing in rehabilitations, were influenced by the rise of physical medicine and rehabilitation (Christiansen & Haertl, 2014). Frank H. Krusen, MD, who is considered the founder of physical medicine and rehabilitation, believed that occupational therapy was a specialty of physical therapy (Christiansen & Haertl, 2014). He also believed that occupational and physical therapy should merge into one discipline (Christiansen & Haertl, 2014). Physical medicine and rehabilitation were influenced by physicians who practiced physical therapy and used physical modalities, which was reflected in the occupational therapy literature (Christiansen & Haertl, 2014).

In 1936, the Essentials of an Acceptable School of Occupational Therapy were published in the Journal of American Medical Association (Kearney, 2004, para. 12). Prior to this, there were no standards of preparation for an occupational therapist. In the mid-1930s it was the AMA who became a "significant force influencing occupational therapy entry-level education" (Colman, 1990, pg. 1029, para. 5). These Essentials were revised in 1943 which created a balance between the medical model and the moral treatment model (Kearney, 2004, para. 13).

In 1949, a revision of the Essentials reflected the changes occurring in medicine, which included specializations (Kearney, 2004, para. 17). The following years found more occupational therapists working in more specialized settings (Kearney, 2004, para. 18). Among occupational therapists, some believed education should be generalized, and others believed in specializing which was reflected in other professions such as medicine, law, and engineering (Kearney, 2004, para. 18). The division amongst occupational therapists affected education programs, which resulted in students who were competent in a specific specialized area but were unable to provide services in other areas of practice (Kearney, 2004, para. 18).

In 1965, the American Journal of Occupational Therapy [AJOT] published an editorial where four key recommendations from the curriculum study were summarized as:

1. A belief that occupational therapy practice has an understanding and perspective of both the physical and psychosocial dysfunction;
2. It is recommended for the curriculum to increase the emphasis on behavioral science to balance with the biological sciences;
3. Increase the emphasis on clinical knowledge along with the coursework; and
4. Readjust the focus within the curriculum to focus on the approach to obtain the skills needed rather than on traditional arts and crafts (Kearney, 2004, para. 19).

These recommendations lead to revisions in the education Essentials that reflected many of the recommendations from the curriculum study (Kearney, 2004, para. 19). The revised Essentials of education moved towards a scientific and specialized practice that reflected closer to the medical model than the moral treatment model (Kearney, 2004,

para. 19). In the 1960s, leaders and educators in occupational therapy began to question the direction of specialization in occupational therapy practice (Kearney, 2004, para. 20).

In 1970, a call for a renewed focus arose in education and the role of occupation within the professional field (Kearney, 2004, para. 20). The value and meaning of occupation was the core concept of the development of the profession, but with the deviation away from these concepts, many felt there was role confusion and a loss of identity in occupational therapists (Kearney, 2004, para. 20). Throughout the 1970s, medicine and occupational therapy realized that reductionism would not be able to solve all medical problems (Kearney, 2004, para. 20). This was found to be true for those with chronic diseases and disabilities where the issues were based within the environmental and societal influence rather than based on the individual (Kearney, 2004, para. 20). Gillette & Kielhofner (1979) state that some people within the profession believed that the medical model had caused the profession to become too dependent on medicine and limited occupational therapy's focus (as cited in Kearney, 2004, para. 20). Using the medical model to continue developing concepts and research in support of occupational therapy would be counterproductive (Kearney, 2004, para. 20).

In 1992, AOTA took steps to break the alliance the organization had with the American Medical Association [AMA] for accreditation (Reed & Peters, 2006). While creating the Accreditation Council for Occupational Therapy Education (ACOTE), the issue of defining the profession came into focus (Reed & Peters, 2006). Occupational therapists wondered if the profession should be focused on managing disease or health and wellness promotion (Reed & Peters, 2006).

Current Trends

Modern society has adopted the language of medicine as a framework for organizing all health services (Townsend, 1998). The trajectory of occupational therapy within the medical model has continued into current practice. Over the years, occupational therapy practitioners have decreased in numbers for those working in mental health due to the change in perception within the public stigma surrounding mental health (Tully, 2019). In 2014, when AOTA collected membership information, there was a decline in school-based services, mental health, hospitals, home health, and community health services (Christenson & Haertl, 2019, p. 34).

Since occupational therapists have the tendency to either work in physical dysfunction or psychosocial settings, this led therapists to only focus on specific aspects of a client versus addressing the client holistically (Cole & Tufano, 2008, p.4). Practitioners that have this holistic focus impact the overall care that is provided to clients. Many occupational therapists have specialized and narrowed the focus of care they provide, which departs from holistic care (Schkade & Schultz, 1992; Terry & Westcott, 2012). This concept is referred to as the reductionist view (Kearney, 2004). This narrowing of focus may be due to limited experience and understanding of mental health issues (Terry & Westcott, 2012).

In settings where the focus is on physical dysfunction such as the acute hospital setting, addressing mental health is often absent in practice because it's not seen as reimbursable. The medical model has influenced how payers (health and automotive insurance) look at health. The medical model defines health as the absence of disease, which does not include a person's well-being, quality of life, or continued engagement in

meaningful activities (Cole & Tufano, 2008, p. 15). Kielhofner (2004) describes the medical model, which is used today as "reductionistic, mechanical, and scientific." The medical model breaks a person down into components that are measurable and does not consider the whole person. The breakdown of a person into components led the medical model to focus on symptoms versus examining the influence of the person's environment, context, social, and psychological aspects that could be impacting the dysfunction. The medical model also focuses on resolving the dysfunction and not addressing how this dysfunction affects a person's quality of life and well-being.

There is still not a clear answer amongst occupational therapists in regards to where the delineation should be on managing disease or treating the person as a whole. In a study by Björklund, Svensson, and Read (2006), they found that occupational therapists in Sweden showed strong holistic views for health, but some still support the reductionist view, also known as the medical model. In 2016, Rogers, Bai, Lavin, and Anderson conducted a study/survey and found that additional spending for occupational therapy services resulted in lowered readmission rates for 1,595 hospitals in the United States. This was the only service to provide this result. This study proves the validity and therapeutic impact that occupational therapy has for patients and hospitals.

While research and medicine advanced within the twentieth century, the medical model continued to alter practice. Therapists shifted their focus from environmental, social, and emotional to a human functioning focus at a cellular level (Kearney, 2004, p. 3). It is critically important that research is now validating what occupational therapy has always known—that the therapeutic use of valued occupations (frequently called task-specific training in the literature) results in functional improvements in patients (Muir,

2012). Based on the data, the OT's role in physical rehabilitation is considerable. The question is, could addressing the mental wellness component, in physical rehabilitation, dramatically increase our outcomes even more?

Getting Back to Holistic Roots

Zamanzadeh et al. (2015), defines holistic care as "a behavior that recognizes a person as a whole and acknowledges the interdependence among one's biological, social, psychological, and spiritual aspects." Occupational therapists have been trained to look at a person holistically, which is in occupational therapy's scope of practice ("Finding the correct," 2009). "Occupational therapy practitioners have a holistic perspective in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team" (AOTA, n.d.-a, para. 4). Addressing clients holistically is often characterized as a unique aspect of the occupational therapy profession (McColl, 1994), but it is not consistently happening across the profession. Finlay (2001) goes in-depth about holism, positing if it is a realistic concept that occupational therapists can obtain in practice. Finlay goes on to discuss the barriers that challenge the concept of delivering holistic care, such as time and financial constraints and the prominent biomedical model (2001). So let's take a closer look at two of these areas: 1) time and 2) reimbursement.

Time

The issue of time is a consistent concern that arises. Therapists seem to be under pressure to address the physical needs and well-being needs is "in addition" to meeting the physical needs of the client. This assumption negates the concept of holistic occupational therapy. When looking at our clients holistically, occupational therapists

need to not only look at a client's physical disability but also the mental health component related to the physical disability (Yuill, 2019).

When addressing physical and mental health, it is not that one leads to the other, but "The link between physical and mental health is circular rather than linear" (Allen & Kelly, 2014). Individuals who struggle with mental health issues have an increased chance of developing chronic physical conditions such as heart disease and stroke (Allen &Kelly, 2014). A new physical condition, such as a broken hip or a stroke, will often exacerbate anxiety and depression (Chris, 2017). Negative thought patterns can come from this new physical condition and impede the client from fully engaging and benefiting from a traditional rehab program (Chris, 2017).

It is also possible that those who have chronic conditions have an increased chance of developing a mental disorder such as depression or anxiety (Allen & Kelly, 2014). When a person acquires a physical disability, stressors can present as: being dependent on another, the feeling of vulnerability, and facing their mortality, etc. (Tully, 2019). These feelings can impact their relationships, roles, and their sense of identity (Yuill, 2019). If these are not addressed the issues could get worse, develop into a long-term physical issue, decrease interpersonal relationships, and decrease quality of life (American Addiction Centers, 2019). Individuals with a physical disability require time to come to terms with their limitations and to find ways to adapt activities to live a meaningful life (Tully, 2019).

Allen & Kelly (2014) suggest that with this correlation between mental and physical conditions, an individual will not achieve optimum health unless both are

addressed. Occupational therapists must "tune in and address the mental health needs of all clients in all practice settings" (AOTA, 2016a).

Reimbursement

Whether we fundamentally agree with it or not, healthcare is a business. This means that occupational therapists need to be cognizant of the costs and billing for their services. It is critical for occupational therapists to document and code correctly to be reimbursed by third-party payers. A review of the literature resulted in limited information on reimbursement for mental health in a physical disability setting. Primarily, reimbursement in physical disability settings is related to physical medicine and rehabilitation codes such as complexity levels and evaluation codes (therapeutic exercise, therapeutic activities, etc.) (AOTA, 2016f; Lloyd-Randolfi, 2018; Mariano, Metzler, & McGuire, 2018; Wisconsin Department of Health Services, n.d.).

Through research and contacting experts at AOTA on the subject found that there are no specific codes related to mental health services in physical disabilities settings. As a result, it is through documentation that occupational therapists demonstrate how they are addressing a person holistically. As holistic occupational therapists, it is essential to use the terminology and resources of the occupational therapy profession when documenting and billing for services. Utilizing the Occupational Therapy Practice Framework and the Occupational Profile can be the means of addressing the patient's holistically through resources produced and supported by AOTA. The trend for healthcare is that reimbursement is moving toward outcome-based payments and value-based purchasing. The outcomes will be higher when both aspects, physical and emotional, are addressed.

Summary and Product

The historical background of occupational therapy was presented, as well as how the medical model influenced practice, and the current trends of occupational therapy in practice settings. The psychological implications of physical disabilities and the need to return to the roots of the profession through holistic practice was reviewed. Finley indicated that even some occupational therapists believe that holistic care is unattainable (2001).

As occupational therapists, the question that is still being asked is, which should we treat first: mental health or physical disabilities? (Yuill, 2019). Why not treat both mental health and physical disabilities at the same time? (Yuill, 2019). The occupational therapy profession specifically provides interventions that encompass a person's physically, emotionally, and mental well-being as well as addressing their roles and environment to promote quality of life (St Catherine University Online OTA, 2017; Thedevotedyogi, 2019, AOTA, 2016a). Obviously, we believe that holistic occupational therapy is attainable. The only barrier is the occupational therapist's perspective. For this reason, we developed ***Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation***.

Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation, is created for occupational therapists who work in physical disabilities so that they can address the psychological needs of the client, in response to the physical disability. The guide provides a rationale that can be incorporated for increasing confidence in competence, evaluation, and documentation. The outcome of this project is

a guide for occupational therapists and occupational therapy assistants as tool to provide holistic evaluation and intervention regardless of the practice area.

Theoretical Approach

Redirected Mindset: A Guide to a More Holistic Practice **is based on andragogy.** Malcolm Knowles (1980) popularized the concept of andragogy ("the art and science of helping adults learn"), contrasting it with pedagogy ("the art and science of teaching children"). He presented a set of assumptions for adult learners.

1. Self-concept: to move from dependency to increasing self-directedness as he/she matures and can direct his/her own learning.
2. Experience: As an adult, you will draw on your accumulated life experiences to aid learning.
3. Readiness to learn: As we mature, our readiness to learn becomes oriented increasingly to learn what is needed in our new social or life roles.
4. Orientation to learning: As we become more experienced and mature, our learning becomes immediate and problem-centered.
5. Motivation to learn: Adults are motivated to learn internally, and we want to pursue positive self-development experiences and learning opportunities.

Table of Contents

A Guide to a More Holistic Practice in Physical Rehabilitation is presented in its entirety in Chapter IV. Chapter III provides an overview of the methodology used to create the product. Chapter V will conclude with recommendations.

CHAPTER III

Activities/Methodology

This scholarly project began with exploring topics that were of interest to both occupational therapy students. One student was interested in mental health, and the other was interested in chronic conditions. The students explored these options by completing a mini-review of information regarding the topics of interest. They also reviewed previous scholarly projects on the University of North Dakota (UND) Scholarly Commons about topics of interest. The students narrowed their focus after several level I fieldwork experiences in which the students discussed what they had experienced in their physical and mental health placements. The students reflected on how the occupational therapy program stresses the importance of viewing the client holistically, which addresses the client's context, psychosocial factors, and physical factors. The students noticed and discussed with fieldwork supervisors the lack of occupational therapy addressing mental health in the physical disabilities' settings. The students discussed this with their fieldwork supervisors, within the physical dysfunction setting, regarding why this was a struggle. The supervisors stated that they did not know where to start the process of incorporating these areas into their practice setting.

The students began discussing this issue with a faculty member. She provided additional resources pertaining to their topic of interest in addressing mental health in a physical dysfunction setting. The students, through the discussion with their advisor, decided to look more into the physical dysfunction setting to address mental health.

There were several reasons that this topic was chosen. There is a high percentage of occupational therapists practicing in physical disability settings and this is an opportunity to provide new material for therapists to use.

After determining the focus of the research and the goal of the scholarly project, the authors conducted a literature review on occupational therapy in physical disabilities settings, occupational therapy holistic practice, and the history of the profession. The authors used CINAHL, PubMed, American Occupational Therapy Association, American Journal of Occupational Therapy, OT Practice, textbooks that were required for the occupational therapy program, Google Scholar, and Google. Terms used in searching included "holistic", "holism", "occupational therapy", "mental health", psychosocial", "physical rehabilitation", "physical disability setting", "occupational therapy history". The students also reviewed occupational therapy journals, blogs, and other sources but did not find any resources that would assist occupational therapists on how to begin to incorporate these concepts into their practice. Throughout the literature review, the idea of broadening the topic search arose to obtain more literature. Broadening the search topic was put into action by the students and their advisor by integrating the history and current trends into their search to create this guide. The authors decided it was important to reflect on the roots of the profession to show how occupational therapy has evolved through time and shaped how occupational therapists practice today.

When choosing a theory for this scholarly project, the students began by reflecting on some of the models that they had learned throughout their years of schooling. The Andragogy model was chosen since the focus in on the adult occupational therapy practitioners learner. Malcolm Knowles (Corley, M, 2011, para.2; Smith, M.K.,

1999) identified crucial assumptions about the characteristics of the adult learner. This model focuses on the learner's personal experience, self-concept, readiness to learn, motivation to learn, and their orientation to learning. The premise is that the occupational therapist is a self-directed learner that strives to maximize the experience and outcomes of the client through their professional development and competency.

CHAPTER IV
Product

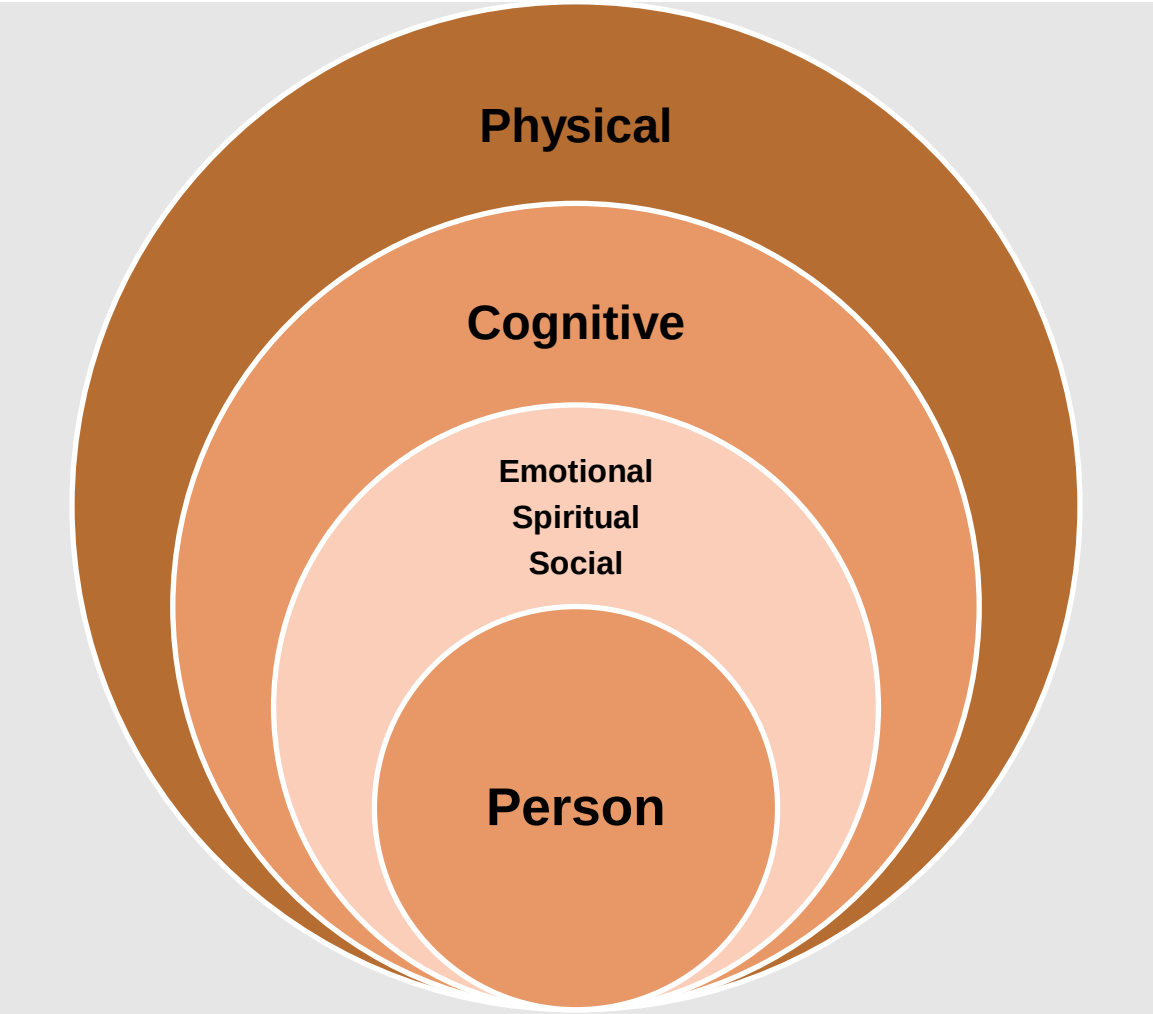
The purpose of this product is to assist occupational therapists and occupational therapy assistants, who work in physical disabilities, on providing a broader/holistic approach to their clients. It is designed to address the common concerns found in the literature, 1) how to address mental health and wellness and the referral simultaneously, and 2) the issue of reimbursement.

Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation is organized into three units.

1. The first unit, *Reflecting on Competence with Confidence*, is divided into six sections that review foundational knowledge. The six sections are competence, continued professional development, standards of practice, code of ethics and core values, empathy, and cultural competency.
2. The second unit, *Evaluation*, is divided into three sections to address the evaluation process that happens with the client. These sections are occupational profile, stress management, and assessments/screens.
3. The last unit, D*ocumentation*, is divided into two sections to address how to describe the client holistically in the documentation. The sections are billing and CPT codes.

In the appendix, there is an outcome measure of how effective the guide is along with other additional resources about the topics in the guide. In this section, you can view the guide in its entirety.

Redirected Mindset:
A Guide to a More Holistic Practice in Physical Rehabilitation



Sara Anderson, MOTS & Ashley Malina, MOTS

Dr. LaVonne Fox, Advisor

University of North Dakota

Department of Occupational Therapy

2019-2020

Table of Contents

Purpose of the Guide

The purpose of **Redirected Mindset: A Guide to a More Holistic Practice** is to provide you a resource to use in your physical disability practice to address both the physical and mental health needs of your clients. It is evidence-based using current data and strategies to integrate mental health components in your evaluation and interventions.

Rationale

When individuals acquire a physical disability, it can affect many aspects of their lives. These aspects can include roles, habits, and routines which can impact their performance in meaningful occupations. Tully (2019) states, “Initial reactions to an acquired physical disability typically are characterized by a range of conflicting emotions” (pg. 265). These emotions can include sadness, guilt, disbelief, denial, loneliness, and withdrawing from activities and support systems (Tully, 2019). Any of these emotions can appear at any time after the onset of the physical disability from weeks to years later. When a person acquires a physical disability, stressors can come about such as being dependent on another, the feeling of vulnerability, and facing their mortality (Tully, 2019). These feelings can impact their relationships, roles, and their sense of identity (Yuill, 2019). Individuals, with a physical disability, require time to come to terms with the limitations from the physical disability and to find ways to adapt to live a meaningful life (Tully, 2019).

Zamanzadeh, Jasemi, Valizadeh, Keogh, and Taleghani (2015) defines holistic care as “a behavior that recognizes a person as a whole and acknowledges the interdependence among one’s biological, social, psychological, and spiritual aspects” (pg. 214). Occupational therapists have been educated to look at a person holistically, as defined in occupational therapy’s scope of practice (“Finding the correct,” 2009). Addressing clients holistically is often characterized as a unique aspect of the occupational therapy profession (McColl, 1994) but it is not consistently happening.

Finlay (2001) goes in-depth about holism, posing the question if it is a realistic concept that occupational therapists can attain? Finlay discusses the barriers that challenge the concept of delivering holistic care such as time and financial constraints and the prominent biomedical model (2001). Some occupational therapists are unfamiliar with the whole spectrum of services that occupational therapy can address with mental health (Chandler, n.d.). Finlay indicated that even some occupational therapists believe that holistic care is unattainable (2001). Obviously, we believe that it is attainable. The only barrier is really your perspective of how you can creatively address the mental wellness needs alongside the physical needs.

When occupational therapists are working in any physical disability setting, they focus on addressing the medical condition for which the client was referred to OT (Chandler, n.d.). Any physical condition, new or chronic, will often exacerbate mental health challenges such as anxiety and depression (Chris, 2017). Any negative thought patterns can impede the client from fully engaging and benefitting from a traditional rehab program (Chris, 2017). To truly provide holistic OT services, occupational therapists need to consider the physical and mental health components (Yuill, 2019).

Design

Redirected Mindset: A Guide to a More Holistic Practice is based on andragogy. Malcolm Knowles (1980) popularized the concept of andragogy ("the art and science of helping adults learn"), contrasting it with pedagogy ("the art and science of teaching children"). He presented a set of assumptions for adult learners:

1. **Self-concept:** To move from dependency to increasing self-directedness as he/she matures and can direct his/her own learning. As OTs, you have been trained to be a self-directed learner. You have been trained to take the initiative.
2. **Experience:** As an OT you will draw on your accumulated life experiences to aid learning. With your practice, you have considerable experience to draw from to build new learning opportunities.
3. **Readiness** to learn: As we mature, our readiness to learn becomes oriented increasingly to learn what is needed in our new social or life roles. What does this mean to you? That you orient your own learning to the skills you need specifically for the job or the direction you want your job to go.
4. **Orientation** to learning: As we become more experienced and mature, our learning becomes immediate and problem-centered. As OTs, we encounter problems and challenges. We work to learn how to solve those problems and then we apply that knowledge to the problem(s). So it's clearly connected to experience.
5. **Motivation** to learn: Adults are motivated to learn internally, and we want to pursue positive self-development experiences and learning opportunities. As OTs we ask, what is the value of **why** we need to learn this information. As OTs we want to make our practice more effective and efficient and strengthen our outcomes for our clients.

Organization

This guide begins with a literature review. The literature review presents current information regarding providing holistic occupational therapy approaches in physical disability settings. The Guide then progresses into 3 units:

1) Reflecting on Competence with Confidence,
2) Evaluation,
3) Documentation

Within all 3 units, activities and resources are provided to strengthen my knowledge and skills allowing for a more holistic approach to my clients. Each activity is organized as follows:

Title of Activity

- **Objective(s) of Activity**: A brief introduction to the topic.
- **Introduction to Activity:** This will list the purpose of the activity.
- **Duration**: The duration of the activities can vary depending on the reflection process. There will be an estimation on how long this can take but will vary person to person.
- **Activity Steps:** Steps to complete the activity**.**
- **Reflection questions related to Knowles Andragogy**: The activities, in this guide, address the 5 assumptions of andragogy through a reflection process that is located at the end of each activity as seen below in Figure 1.

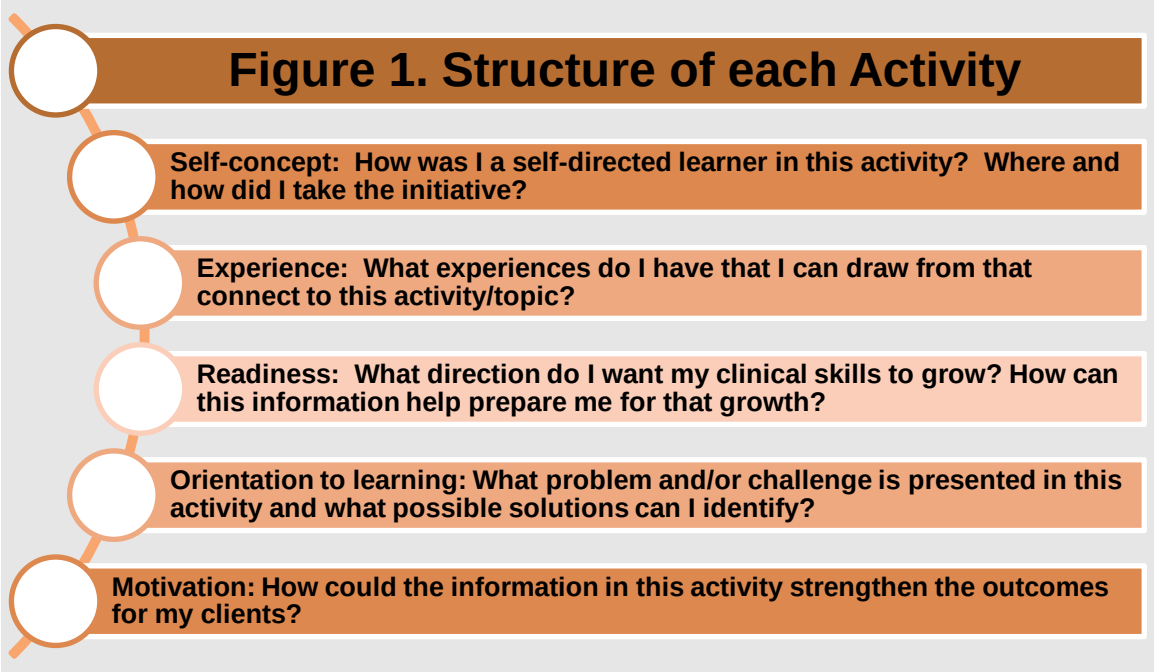


Figure 1. Structure of each Activity
Self-concept: How was I a self-directed learner in this activity? Where and how did I take the initiative?
Experience: What experiences do I have that I can draw from that connect to this activity/topic?
Readiness: What direction do I want my clinical skills to grow? How can this information help prepare me for that growth?
Orientation to learning: What problem and/or challenge is presented in this activity and what possible solutions can I identify?
Motivation: How could the information in this activity strengthen the outcomes for my clients?

Introduction – Literature Review

Currently, in Occupational Therapy (OT) practice, occupational therapists primarily define themselves by the setting they are working in, such as acute care, nursing home, mental health, etc. “Despite our roots, occupational therapists have become pigeon-holed as ‘physical’ or ’mental health’ practitioners, resulting in restricted assessments and interventions that are not completely holistic, and perhaps not even occupational” (Terry & Westcott, 2012, pg. 297).

“Occupational therapy practitioners need to have an understanding of the physical, emotional, and psychosocial aspects of recovery from physical disability to address potential obstacles to their patient’s holistic well-being” (Tully, 2019, pg. 264). It is important to be able to address all aspects of the person to provide the most client-centered care.

This scholarly project focused on the role of occupational therapists who are working with individuals who have physical disabilities. This is the area where OTs seem to struggle to meet the psychosocial needs of their clients. A review of the literature was conducted on topics related to a historical look of occupational therapy, the influence of the medical model on the profession, and the current trends in practice settings. The literature review also looked at the topics of psychological implications of physical disability and the need to focus on returning to holistic treatment in physical dysfunction settings. The results of the literature review are summarized in the following section.

Historical to Current Day

The origins of occupational therapy are rooted in mental health/psychiatry (American Occupational Therapy Association [AOTA], 2017), as the creation of the profession dovetailed with the early 20th century’s mental hygiene movement (Stoffel, Reed & Brown, 2019). Occupational therapy has several services it provides for clients with mental health. These include helping all individuals develop and maintain positive mental health, prevent mental ill health, and recover from mental health challenges in order to live full and productive lives (AOTA, 2016d).

In the early 20th century, the founders and early writers in occupational therapy created a body of literature that supported the therapeutic value of occupation (Dunton, 1918; Reed, 2006). Dunton believed Adolf Meyer's theory of psychobiology because it was holistic and practical (Christiansen & Haertl, 2014). Meyer's theory also highlighted that a person needed to be organized through doing and that it was essential to have a balance between work and rest for an overall balanced life (Christiansen & Haertl, 2014). Dunton and Meyer believed that occupational therapists had an essential role in assisting clients with adjusting their habits and regaining their optimism (Christiansen & Haertl, 2014). Meyer's theory was in line with the beliefs of occupational therapy in that it recognized that being forced to be inactive not only was morally wrong, but it was also debilitating to the client physically and mentally (Christiansen & Haertl, 2014). To have people engaging in occupations could help prevent depression and increase self-confidence that would help motivate a client further in their recovery (Christiansen & Haertl, 2014).

According to AOTA (2014), "Occupational therapy is founded on the understanding that active engagement in occupation promotes, facilitates, supports, and maintains health and participation" (pg.S1) The term occupation is defined as, "life activities that people engage in throughout their daily lives to structure time and give life meaning" (AOTA, 2014, pg. S6). One of the goals of occupational therapy is to promote physical and mental health and well-being in all people, with and without disability-related needs (AOTA, 2017). Additional focuses are to establish, restore, maintain, and improve function and quality of life for people at risk for or affected by physical or mental disorders (AOTA, 2017, pg. 1). Occupational therapy practitioners' support of the mental health of clients transcends settings and diagnoses to promote an increased quality of life (AOTA, 2017).

In the 1920s and 1930s, leaders in the occupational therapy profession were working on making occupational therapy a legitimate medical profession and believed allying with medicine would assist in achieving it (Christiansen & Haertl, 2014). It was in the 1930s that occupational therapy began to adopt more physical agents (Christiansen & Haertl, 2014). Physical agents used included goniometry and tools to increase

strength and range of motion (Christiansen & Haertl, 2014). Other influences on practice included the polio epidemic and the profession, led by Thomas Kidner, advocating for occupational therapists to work in tuberculosis hospitals (Christiansen & Haertl, 2014). The Army was influential in solidifying the shift of occupational therapy towards the hospital-based rehabilitation practice setting (Christiansen & Haertl, 2014). The 1940s brought soldiers home from the war with health challenges from war injuries and chemical wounds (Christiansen & Haertl, 2014). All these influences contributed to occupational therapy in the physical rehabilitation setting (Christiansen & Haertl, 2014).

As occupational therapy began to use the medical model, it gave the occupational therapy profession a common language with which to communicate with other professions since more collaboration was beginning to happen with treatments. At the beginning of World War II (WWII), the occupational therapy profession moved away from crafts to focus more on the physical aspect of the patients, which was influenced by OT leadership (Christiansen & Haertl, 2014). The rise of physical medicine and rehabilitation influenced occupational therapists to practice in rehabilitation settings (Christiansen & Haertl, 2014). Frank H. Krusen, MD, who is considered the founder of physical medicine and rehabilitation, believed that occupational therapy was a specialty of physical therapy (Christiansen & Haertl, 2014). Krusen also believed that occupational and physical therapy should merge into one discipline (Christiansen & Haertl, 2014). Physical medicine and rehabilitation were influenced by physicians who practiced physical therapy and used physical modalities, which was reflected in the occupational therapy literature (Christiansen & Haertl, 2014).

In 1936, essentials for occupational therapy schools were published in the Journal of American Medical Association (Kearney, 2004, para. 12). These essentials were revised in 1943, which created a balance between the medical model and the moral treatment model (Kearney, 2004, para. 13). In 1949, a revision of the essentials reflected the changes occurring in medicine, which included specializations (Kearney, 2004, para. 17). The following years found more occupational therapists working in more specialized settings (Kearney, 2004, para. 18). Among occupational therapists, some believed education should be generalized, and others believed in specializing

which was reflected in other professions such as medicine, law, and engineering (Kearney, 2004, para. 18). The division amongst occupational therapists affected education programs, which resulted in students who were competent in a specific specialized area but were unable to provide services in other areas of practice (Kearney, 2004, para. 18).

In 1965, the American Journal of Occupational Therapy [AJOT] published an editorial with four key recommendations from the curriculum study. The first belief is that occupational therapy practice has a general knowledge of both physical and psychosocial dysfunction (Kearney, 2004, para. 19). The second belief is that within the curriculum, there should be an increase in the emphasis on behavioral sciences therefore to balance with the biological sciences (Kearney, 2004, para. 19). The third key recommendation is to increase emphasis on clinical knowledge to balance with the coursework (Kearney, 2004, para. 19). The last key recommendation is to focus on the approach to obtain the skills needed rather than on traditional arts and crafts (Kearney, 2004, para. 19).

These recommendations lead to revisions in the education essentials that reflected many of the recommendations from the curriculum study (Kearney, 2004, para. 19). The revised essentials of education moved towards a scientific and specialized practice that reflected closer to the medical model than the moral treatment model (Kearney, 2004, para. 19). In the 1960s leaders and educators in occupational therapy began to question the direction of specialization in occupational therapy practice (Kearney, 2004, para. 20).

In 1970, a call for a renewed focus arose in education and the role of occupation within the professional field (Kearney, 2004, para. 20). The value and meaning of occupation was the core concept of the development of the profession, but with the deviation away from these concepts, many felt there was role confusion and a loss of identity in occupational therapists (Kearney, 2004, para. 20). Throughout the 1970s, medicine and occupational therapy realized that reductionism would not be able to solve all medical problems (Kearney, 2004, para. 20). This was found to be true for those with

chronic diseases and disabilities where the issues were based within the environment and society rather than based on the individual (Kearney, 2004, para. 20).

Gillette & Kielhofner (1979) stated that some people within the profession believed that the medical model had caused the profession to become too dependent on medicine and limited occupational therapy's focus (as cited in Kearney, 2004, para. 20). Using the medical model to continue developing concepts and research in support of occupational therapy would be counterproductive (Kearney, 2004, para. 20).

In 1992, AOTA took steps to break the alliance the organization had with the American Medical Association [AMA] for accreditation (Reed & Peters, 2006). While creating the Accreditation Council for Occupational Therapy Education (ACOTE), the issue of defining the profession came into focus (Reed & Peters, 2006). Occupational therapists wondered if the profession should be focused on managing disease or health and wellness promotion (Reed & Peters, 2006).

Current Trends

Modern society has adopted the language of medicine as a framework for organizing all health services (Townsend, 1998). The trajectory of occupational therapy within the medical model continues through to today. Over the years, occupational therapy practitioners have decreased in numbers for those working in mental health due to the change in perception and the public stigma surrounding mental health (Tully, 2019). In 2014, when AOTA collected membership information, there was a decline in school-based services, mental health, hospitals, home health and community health services (Christenson & Haertl, 2019, p. 34).

Since occupational therapists have the tendency to either work in physical dysfunction or psychosocial settings, this led therapists to only focus on specific aspects of a client versus addressing the client holistically (Cole & Tufano, 2008). Many occupational therapists have specialized and narrowed the focus of care they provide, which departs from holistic care (Schkade & Schultz, 1992; Terry & Westcott, 2012). This concept is referred to as the reductionist view (Kearney, 2004). This narrowing of focus may be due to limited experience and understanding of mental health issues (Terry & Westcott, 2012).

In settings where the focus is on physical dysfunction such as the acute hospital setting, addressing mental health is often absent because it's not seen as reimbursable. The medical model has influenced how payers (health and automotive insurance companies) look at health. The medical model defines health as the absence of disease, which does not include a person's well-being, quality of life, or continued engagement in meaningful activities (Cole & Tufano, 2008). Kielhofner described the medical model as "reductionistic, mechanical, and scientific" (2004). The medical model breaks a person down into components that are measurable and does not consider the whole person. The breakdown of a person into components led the medical model to focus on symptoms versus examining the influence of the person's environment, context, social, and psychological aspects that could be impacting the dysfunction. The medical model also focuses on resolving the dysfunction and not addressing how this dysfunction affects a person's quality of life and well-being

There is still not a clear answer amongst occupational therapists regarding where the delineation should be on managing disease or treating the person as a whole. In a study by Björklund et al. (2006), they found that occupational therapists in Sweden showed strong holistic views for health but some still support the reductionist view, also known as the medical model. Occupational therapy is making large impacts within the physical dysfunction setting. In 2017, Rogers, Bai, Lavin, and Anderson conducted a study/survey that found that additional spending for occupational therapy services resulted in lowered readmission rates for all 1,595 hospitals on the United States. This was the only service category to provide this result. This study proved the validity and therapeutic impact that occupational therapy has for both patients and hospitals. Research is now validating what occupational therapy has always known—that the therapeutic use of valued occupations (frequently called task-specific training in the literature) results in functional improvements in patients (Muir, 2012). Based on the data, the OTs role in physical rehabilitation is significant. The question is, could addressing the mental wellness component, in physical rehabilitation, dramatically increase our outcomes even more?

When addressing physical and mental health, it is not that one leads to the other but “The link between physical and mental health is circular rather than linear” (Allen & Kelly, 2014). Individuals who struggle with mental health issues have an increased chance of developing chronic physical conditions such as heart disease and stroke (Allen &Kelly, 2014). It has also been noted that those who have chronic conditions have an increased chance of developing a mental disorder such as depression or anxiety (Allen & Kelly, 2014). Allen & Kelly (2014) suggest that with this correlation between mental and physical conditions, an individual will not achieve optimum health unless both are addressed.

UNIT I

Reflecting on Competence with Confidence

The purpose of Unit I is to help me determine my level of confidence with integrating mental health and wellness strategies into my evaluation and documentation. If I feel confident, this unit could just be a refresher or possibly provide me with activity ideas to use with other clinicians or students so he or she can become more knowledgeable and confident. It has six sections with activities that address:

1. Competence,
2. Continued Professional Development,
3. Standards of Practice,
4. Code of Ethics and Core Values,
5. Empathy, and
6. Cultural Competency.

These six topic areas are chosen because it is of vital importance to keep the foundational knowledge of what our profession values when practicing. These items were not placed in order of importance as the authors feel they are all equal in value of importance. It is important to review official documents from both the national and state level to assist in developing a holistic, quality, competent, and professional practice. Also included are optional activities I can choose to do to expand my knowledge.

Competence with Confidence

Objectives of Activity:

1. Reflect on what drew me to the holistic aspects of OT.
2. Assess my competence and confidence in providing holistic services that include addressing the mental health and wellness components.

Introduction to Activity:

We believe that it is likely that the majority of OTs were drawn to the OT profession because of the holistic approach. It is our bet that many wrote or stated that a major thing they liked was that OT considered the physical and psychological aspects of a person. It is a major factor that defines and separates us from other healthcare professionals.

Duration: 30-60 minutes depending on the depth of the self-reflection.

Activity Steps:

1. Complete Table 1.1 with strengths I feel I possess and strengths that I think a holistic practitioner would possess. These can include skills and knowledge acquired schooling, continuing education, and practice.
2. Reflect between the two columns that I have filled out.
3. In the Personal Reflection area, write down what skills I would like to build/strengthen toward becoming a more holistic practitioner
4. At the end of this activity, there are a series of questions to reflect on.

<u>Holistic Definition</u>

Each of us were drawn to occupational therapy for different reasons. This activity helps us reflect on our competence and confidence to provide holistic OT services

regardless of the practice setting. This first activity reflects on what drew us to the holistic aspects of OT.

Zamanzadeh et al. (2015) defines holistic care as “a behavior that recognizes a person as a whole and acknowledges the interdependence among one’s biological, social, psychological, and spiritual aspects” (pg. 214). This is the definition that this guide is using throughout this product. Tully (2019) describes a holistic approach as having all person systems (person, environment, and occupation) are present with a balance within the occupational challenge. Additional resources available for holistic definitions include:

- McColl, M. A. (1994). Holistic occupational therapy: historical meaning and contemporary Implications. *Canadian Journal of Occupational Therapy,61*(2), 72-77. doi:10.1177/000841749406100202
- Finding the correct meaning of “holistic” [Web log post]. (2009, March 18). Retrieved from https://meaningfuloccupation.wordpress.com/2009/03/18/finding-the-correct-meaning-of-holistic/

Table 1.1 Personal Strengths & Holistic Practitioners Strengths

List MY strengths	List strengths of a HOLISTIC Practitioner

Personal Reflection: What skills I would like to build/strengthen toward becoming a more holistic practitioner?

1.
2.
3.
4.
5.

Thoughts:_____
_____
_____
_____
_____

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: What strengths do I possess that positively impact my clients?

Self-directed: What can I take from this activity to increase my own personal learning and improve the outcomes with my client?

Experience: What experiences do I have that I can draw from to strengthen my skills as a holistic practitioner?

How can I challenge myself to stay accountable to work on increasing my strengths?

What problem and or challenge is presented in this activity and what possible solutions can I identify?

What are some motivating reasons to learn/do this? How can it benefit the outcomes of my clients?

Additional thoughts I want to remember from this activity:

Continued Professional Development

Objectives of Activity:

1. Reflect on areas of professional/clinical development.
2. Identify areas that I think are important to focus my continuing professional development which includes the psychosocial aspect.
3. Develop a plan to expand my professional/clinical skills.

Introduction to Activity:

Professional development is an instrument of lifelong learning. It is essential to strengthening and maintaining professional competence. This activity will focus on professional development. Standards of Practice will be briefly introduced but it is covered in more detail in another activity session.

Duration: 20-30 minutes depending on the depth of the self-reflection and reflection on my personal experiences.

Activity Steps:

1. Complete the Continued Professional Development Self-Rating Tool – Table 1.2.
2. Use Table 1.3 to complete any additional self-assessments.
3. Go to Table 1.4, My Continued Professional Development and document on the following:
    a. Identify areas that I wish to work on,
    b. Goals relating to the area(s) I wish to work on, and
    c. Strategies to achieve my goals.
4. Complete reflection questions at the end of the activity.

Table 1.2: My Continued Professional Development Self-Rating Tool	
Areas of Focus: The areas of evaluation, intervention, documentation, outcomes/discharge are the focus in this activity. These statements provide an opportunity to reflect on my own practice and competences.	Scale 1= Never 2= Almost never 3= Sometimes 4= Almost always 5= Always
Evaluation	
1. I complete an OT Profile for each of my clients (if never skip to # 14 and answer a related question after #20).	1 2 3 4 5
2. When completing the OT Profile, I ask why the client is seeking services.	1 2 3 4 5
3. When completing the OT Profile, I ask what the client wants and needs to do (what is meaningful to them).	1 2 3 4 5
4. When completing the OT Profile, I ask the clients about occupations that are being disrupted.	1 2 3 4 5
5. When completing the OT Profile, I ask the client about their strengths in performing occupations and other daily activities.	1 2 3 4 5
6. When completing the OT Profile, I ask the client about their concerns in performing occupations and other daily activities.	1 2 3 4 5
7. When completing the OT Profile, I ask my client what their priorities are to their occupational performance.	1 2 3 4 5
8. When completing the OT Profile, I ask what the client values.	1 2 3 4 5
9. When completing the OT Profile, I ask about supports the clients has when engaging in tasks, activities, and occupations including cognitive, physical, and psychosocial.	1 2 3 4 5
10. When completing the OT Profile, I ask about barriers the clients has when engaging in tasks, activities, and occupations including cognitive, physical, and psychosocial.	1 2 3 4 5
11. When completing the OT Profile, I ask about the client's occupational history and experiences.	1 2 3 4 5
12. When completing the OT Profile, I ask about the client's patterns of daily living.	1 2 3 4 5
13. When completing the OT Profile, I ask about the client's interests.	1 2 3 4 5
14. I select and administer assessments that directly address occupational performance as identified in the OT Practice Framework (OTPF).	1 2 3 4 5
15. I select and administer assessments regarding client factors to include cognitive, physical, and psychosocial.	1 2 3 4 5

16. I select and administer assessments that address performance skills that include cognitive, physical, and psychosocial.	1 2 3 4 5
17. I select and administer assessments that address performance patterns.	1 2 3 4 5
18. I select and administer assessments that address context and environment.	1 2 3 4 5
19. I take all information gathered from the evaluation process and summarize what was discussed and observed to the client.	1 2 3 4 5
20. I collaborate with clients to develop goals for therapy.	1 2 3 4 5
** Why do I choose not to use the occupational profile as part of my assessment/evaluation process?	
Intervention	
21. My interventions assist my clients in participating in meaningful occupations.	1 2 3 4 5
22. My interventions assist my clients with changes or coping with the environment.	1 2 3 4 5
23. I adapt my interventions in response to physiological, behavioral, or emotional changes in my clients.	1 2 3 4 5
24. I assist my clients to reach a state of physical well-being.	1 2 3 4 5
25. I assist my clients to reach a state of mental well-being.	1 2 3 4 5
26. I assist my clients to reach a state of social well-being.	1 2 3 4 5
Documentation	
27. I use terminology from the OTPF when documenting.	1 2 3 4 5
28. I use terminology that is recognized by third party reimbursement sources when documenting.	1 2 3 4 5
29. I use facility-approved acronyms when documenting.	1 2 3 4 5
30. I use accepted third party acronyms when documenting.	1 2 3 4 5
31. I use CPT codes that address physical, cognitive, and psychosocial interventions.	1 2 3 4 5

Outcomes/Discharge		
32. I select outcome measures that address occupational performance.		1 2 3 4 5
33. I select outcome measures that address participation.		1 2 3 4 5
34. I select outcome measures that address role competence.		1 2 3 4 5
35. I select outcome measures that address quality of life.		1 2 3 4 5
36. I select outcome measures that address well-being.		1 2 3 4 5
37. I select outcome measures that address health and wellness.		1 2 3 4 5
38. I review the goals and outcomes with the clients prior to discharging services.		1 2 3 4 5
Other		
39. I review literature on current evidence-based practice.		1 2 3 4 5
40. I provide services that are grounded in AOTA, Federal and State standards of practice.		1 2 3 4 5
41. I keep up with new/revised statues regarding occupational therapy in the state(s) I work in.		1 2 3 4 5
42. I keep up with new/revised federal legislation regarding occupational therapy services.		1 2 3 4 5
43. I use NBCOT website for resources to develop my practice.		1 2 3 4 5
44. I know what the continuing education requirements are for the state(s) I work in.		1 2 3 4 5
45. I create continuing education goals each year to assist in professional development.		1 2 3 4 5
46. I review my continuing education goals every 3 months.		1 2 3 4 5
47. I adhere to the code of ethics when working with clients and colleagues.		1 2 3 4 5
48. I reach out to colleagues or others in my facility if I am struggling with an ethics issue.		1 2 3 4 5
49-54 How well do I use the 6 interpersonal approaches recommended for the therapeutic relationship? Rate myself with a 1 being rarely used or not comfortable using to 5 which means the approach is used often and that I am comfortable using it (Taylor, 2008).		
49.	Empathizing	1 2 3 4 5
50.	Collaborating	1 2 3 4 5
51.	Motivating/encouraging	1 2 3 4 5
52.	Problem solving	1 2 3 4 5

53.	Instructing/coaching	1	2	3	4	5
54.	Advocating	1	2	3	4	5

Refection of Practice

1. What are the areas where I scored 1 and 2s?

2. Which of these do I wish to prioritize for my goals?

3. What are my plans to address the other areas in the near future?

Table 1.3:
My Continued Professional Development Plan

This form can be helpful in:

1. Identifying and organizing the areas I want to work on,
2. Develop goals to assist in increasing professional development in the area, and
3. Identifying strategies on how I plan to accomplish my goals.

Results from *Continued Professional Development Self-Rating* or other assessments	**Goals to Further Professional Development**	**Strategies to Reach Goals**

For continued personal and professional growth, I will consider reflecting on the following questions:

What did I learn about myself and therapeutic use of self regarding my clients?

Self-directed: What can I take from this assessment to increase my learning process?

Experience: What experiences do I have that I can draw from to strengthen my skills as a holistic practitioner?

How can I challenge myself to stay accountable to work on continuing my professional development to address the mental health needs of my clients?

What are 2 motivating reasons to do this?

Additional thoughts I want to remember:

Optional Activities for Professional Development

Continued Professional Development Self-Assessment

Objectives of Activity:

1. To use the National Board of Certification in Occupational Therapy (NBCOT) self-assessments to review.
2. To assist in my reflection of my continued professional development.

Introduction of Activity:

To use the National Board of Certification in Occupational Therapy (NBCOT) self-assessments to review and assist in my reflection of my continued professional development. This is similar to the activity listed in section “Continued Professional Development” but it has specific areas that look at certain practice areas such as:

a. older adults,
b. orthopedics,
c. new therapist/student, and
d. experienced therapist.

I can take the one that best fits my practice area.

Duration: 30-45 minutes

Activity Steps

1. Follow each link for the appropriate self-assessment for my practice area, using the NBCOT self-assessment tools.
2. While completing the assessment, use Table 1.5 to reflect on the answers from the assessment. This is designed to help me identify my areas of strength, challenges, and motivating factors.

General Practice Therapist: https://secure.nbcot.org/selfassess/default7.aspx?testid=7.

Older Adult Practice Area: https://secure.nbcot.org/selfassess/default2.aspx?testid=2.

Orthopedic Practice Area: https://secure.nbcot.org/selfassess/default3.aspx?testid=3.

New Therapist/Student: https://www.nbcot.org/en/Students/Study-Tools/Self-Assessments.

Outside of NBCOT

Additional Self-Assessments

Additional self-assessments that are available for continued professional development can be found in the link below. Choose an area of interest or one from the following list: Select Mindfulness, Self-Awareness, Stress Level, Motivation, Evaluations (Many Kinds), Goals-Setting Personal Goals, or Personal Wellness.

https://managementhelp.org/personaldevelopment/self-assessments.htm

Table 1.4: NBCOT Self-Assessment Areas of Strength and Challenge Areas		
	Domain, Task, & Brief	**Motivation to Increase Confidence in Areas**
Strengths		
Challenges		
Thoughts/reflections		

Licensure Renewal

Objectives of Activity

1. To be informed of renewal standards at the state and national level.
2. To view a sample template for a renewal log to track my continued professional education requirements.

Introduction to Activity

This activity presents information on state and the NBCOT licensure renewal requirements. It also provides a sample of a continuing education log which can be adapted and used to track my continuing education requirements. This activity connects with the sections of this guide titled: “Continued Professional Development” and “Continued Professional Development Self-Assessment”.

Duration: 5-10 minutes

Activity Steps

1. Read through information below on licensure renewal by state and national certification renewal.
2. Review Table 1.5 for an example of a renewal log.

Licensure Renewal by State

States differ with their standards of certification renewal standards. AOTA has a list for every state with the qualifications and requirements to obtain a license. It does not however, have the requirement of continued professional education standards that are required for every individual state. The best way to find the number of hours required for my state is search their website for licensure requirements.

National Certification Renewal

NBCOT holds occupational therapists to a standard of obtaining 36 credit hours every three years with credited proof. The official NBCOT.org website offers resources and tools that I can use to advance my competence (NBCOT, n.d., para. 1).

NBCOT has provided a resource to continue to keep track of continuing education with notes on what competencies I am working toward. Alternative options include using Word or Excel. A sample chart has been created for me in Table 1.5. I can review the NBCOT site for a wide variety of available renewal activities that will count toward credit hours.

Table 1.5 Sample Completed Certification Renewal Log

Date Attended	Details of CPT Activity	Total Learning Time/Units Earned	What did I learn?	Impact for my facility	Further Education Available in this Area	State/ National Level
01-16-2020	Level I fieldwork direct supervision	5 days/1 unit (national) 8hrs/1 unit (state MN)	I have access to the UND library as a fieldwork supervisor	Current research available	Read through Peer-reviewed articles on current research	National State
01-25-2020	NBCOT Self-Assessment Tool(s)	1 unit per tool (x3)/3 Units	Personal areas of Strengths & Weaknesses	Areas of Strengths & Weaknesses	Continue to go to additional trainings to further refine my skills	National

03-19-2020	Attended professional conference (AOTA)	1hr=1unit (x12)/12 units	Additional training in specific area of practice	New knowledge of available interventions	New areas to expand knowledge	National/ State (MN)

NBCOT Additional Resources

There are additional resources available through the NBCOT website. Several of these include the:

1. Navigator,
2. NBCOT practice standards/code of conduct,
3. Licensure renewal, and
4. Certification renewal activities chart.

Within the certification renewal activities chart, there is a list of activities, competency assessment units, and verification documentation. To access more information about additional activities, please access the NBCOT handbook for more details.

Standards of Practice

Objectives of Activity:

1. To refresh my knowledge on the various standards of practice that impact our profession.
2. To complement the last unit by adjusting the focus to more specific standards from AOTA and my state.

Introduction to Activity:

"Because of the increasing pressure for accountability related to healthcare and social service outcomes, employers, third-party payers, community agencies, business and industry **all expect practitioners to remain competent and knowledgeable of the new developments in the field of occupational therapy** and in related contextual areas involving local, state, national and global communities" (Moyers, 2010, p. 475).

For this activity we will focus on AOTA Standards of Practice and NBCOT Standards of Practice.

AOTA'S standards of practice are the requirements for the delivery of occupational therapy services. The licensure laws for Occupational Therapy, in all 50 states, does reflect the standards set by the AOTA to varying degrees. AOTA's standards are placed into four categories:

1. Professional Standing and Responsibility;
2. Screening, Evaluation, Reevaluation;
3. Intervention Process; and
4. Transition, Discharge, and Outcome Measurement.

NBCOT's Standards of Practice consist of four sections:

1. Practice Domains;
2. Code of Professional Conduct;
3. Supervision; and
4. Documentation.

Duration: 20-40 minutes

Activity Steps:

1. Locate the state standards of practice. These can be found on each state's licensure boards website. They can also be located at NBCOT.com.
2. Take the quiz about Standards of Practice, listed in the activity section below.
3. Reflect on the questions at the end of the activity.

Activity

Quizlet is designed to help people study and learn material (Quizlet, n.d.). These options include flashcards, tests, and games. Quizlet has 300 million study sets now that are already made and available on the site (Quizlet, n.d.). We chose a Quizlet to provide you with another way to study or learn. Please note that to access Quizlet, you might be required to create an account with the website. The account is free unless you want to expand for Quizlet Plus.

AOTA Standards of Practice Quizlet

1. Steps:
    a. Type in Quizlet.com.
    b. Type in Occupational Therapy Standards of Practice.
    c. Choose the type of activity (flashcards, test, games, etc.).
    d. A second option is to go to: https://quizlet.com/329592031/aota-standards-of-practice-for-occupationaltherapy-flash-cards/.
2. Complete the Quizlet and review the answers.

3. Re-take the same Quizlet or a different related one, to see how much information I have retained.

Answers Correct (1st attempt): _____

Answers Correct (2nd attempt): _____

NBCOT Standards of Practice Quizlet

1. Steps:
    a. Type in Quizlet.com.
    b. Type in NBCOT Standards of Practice.
    c. Choose the type of activity (flashcards, test, games, etc.).
    d. A second option is to go to: https://quizlet.com/181931721/nbcot-standards-of-practice-flash-cards/.
2. Complete the Quizlet and review the answers.
3. Re-take the same quizlet or a different related one, to see how much information I have retained.

Answers Correct (1st attempt): _____

Answers Correct (2nd attempt): _____

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: How do the standards of practice influence my practice at my facility?

Self-directed: What standard could be applied more frequently at my facility?

Experience: What experiences do I have that I that I can draw from as a holistic practitioner?

How can I challenge myself to learn more about the standards of practice?

What are my motivations for applying these standards of practice?

Additional thoughts I want to remember:

Code of Ethics and Core Values

Objectives of Activity:

1. To review the code of ethics and core values of occupational therapy. This is another way to demonstrate my continued competence.
2. To assess how the code of ethics and core values are addressed in my clinical practice.
3. To understand how to use the code of ethics to guide my practice especially when striving to address mental health needs of my clients in a physical disability setting.

Introduction to Activity:

In school, we learned about the code of ethics and how the core values should align with those of our profession. In this activity, there is a chart that assists in combining the core values and code of ethics. This should help with the continued application of these values into my practice at my facility.

Duration: 20-40 minutes

Activity Steps:

1. Read through the principles and descriptions of the code of ethics and core values on pages 41-45.
2. Fill in the definitions of the core values of occupational therapy on pages 44-45.
3. Reflect and fill in examples of how I would apply these values at my facility on pages 44-45.
4. Reflect on the questions on pages 46-47.

Code of Ethics – Principles of Standards of Conduct

The code of ethics is not always at the forefront of our minds when we think about interventions with clients. For many of us the code of ethics and core values are central to our practice. However, things change and the code of ethics and core values are updated with terminology and requirements/approaches being added and deleted. The challenge is keeping current and aware of these changes or, at the very least, getting reacquainted with the terms again.

All healthcare professionals including occupational therapists are exposed to ethical situations on a daily basis. “Ethics is about reflecting, thinking, use critically reasoning, justifying, acting on, and evaluating decisions” (Doherty, 2014, pg. 414). Dealing with ethical situations can be sometimes easier said than done such as when a practitioner is in moral distress. Purtilo & Doherty (2011) define moral distress as “an ethical problem that occurs when practitioners know the right thing to do but cannot achieve it because of external barriers or uncertain about the outcome” (as cited in Doherty, 2014, pg.414). Some examples of moral distress, that occupational therapists can come across, include issues with reimbursement, upholding confidentiality, clients and therapist agreeing on goals, and doing what is best for the client and institution at the same time (as cited Doherty, 2014, 2014). Bias or prejudgments about individuals or populations can also result in ethical dilemmas and violations. This can be difficult for occupational therapists and may, in fact, cause an internal crisis. In a study by Penny, Ewing, Hamid, Shutt, & Walter (2014), 224 occupational therapists were surveyed and almost half of respondents stated that they had left a position due to moral distress or considered leaving but had not done so at the time of the study. The finding from this study suggest that education along with other coping strategies can prevent moral distress (Penny et al., 2014).

As practitioners, we can shape the moral space of our environment in different ways (AOTA, 2016d). These include identifying themes and trigger for conflict, obtain and maintain professional standards, and continue using effective communication (AOTA, 2016d). Having these ethical dilemmas can lead to moral distress for

practitioners which can lead to decreasing our ability to provide appropriate care within our practice setting (AOTA, 2016d).

As part of education, reviewing the Code of Ethics would one of the first steps to take in preventing moral distress. The Code of Ethics is the set of guiding principles occupational therapists use to provide strong, client-centered care. The Code serves two purposes:

1. The first is that it provides core values for members to follow to provide ethical actions within our profession (AOTA, 2015).
2. The second includes Principles and Standards that are enforced standards of conduct for American Occupational Therapy Association members (AOTA, 2015).

Staying within these principles ensures that as therapists, we are providing ethical care. The following are the Principles and Standards of Conduct that are enforceable for professional behavior (AOTA, 2015, pg. 153-160). Additional code of ethics activities has been included in the Optional Activities section located on page 48 This also includes interesting books that can be read as a part of my professional development and reasoning through ethical dilemmas.

Core Values

A value is defined as a belief from which a person is committed (Kanny, 1993). Values can be shared by a group of people or within a profession as a whole (Kanny, 1993). These values are reflected through an individual's actions and attitudes (Kanny, 1993). Within the Code of Ethics, there are seven core values:

Altruism	**Equality**
Freedom	**Justice**
Dignity	**Truth**
Prudence	

Each one of these core values can be connected with any of the principles of the Code of Ethics and within all of our interactions with clients and colleagues. Using the definitions listed in Table 1.6 and the information we just reviewed, please:

1. Fill in the definition of each core value in the second column.
2. Write examples of how the core values and code of ethics principles apply in my practice. I have resources available at AOTA & NBCOT.
3. Remember that these core values paired with a code of ethics in this table can be interchangeable or standalone within practice.

Table 1.6 CODE OF ETHICS & CORE VALUES		
Code of Ethics/The Principles and Standards of Conduct that are enforceable for professional behavior include the 5 listed in this column. Each of these has been defined for me.	**Core Values: The core value listed in this column can connect to any of the Principles and Standards of Conduct in the first column. They are just situated this way to get me thinking more about their application to my setting and practice.**	**What are some examples of how these can be seen in my practice/department? We started out with 1 example for each.**
1.Beneficence refers to the overall concern for the well-being and safety of their clients. This includes performing appropriate evaluations and reevaluations of the clients, maintaining professional competency, and referring our clients to the proper providers when appropriate. Beneficence is an action I take for safety and well-being.	• Altruism:	Code Example: Using gait belts and putting up the bed rails.
2.Nonmaleficence is refraining from actions that cause harm. Therapists include this in their practice by not bartering for services and avoiding inflicting injuries on the clients. Nonmaleficence is when I avoid an action. Not avoiding patients or ignoring their needs	• Dignity:	Code Example: Providing services to a client even when I may not agree with their values and beliefs.
3.Autonomy refers to respecting the rights of the client to self-determination, privacy, confidentiality, and consent. This includes treating the client with respect, disclosing risks and benefits to them, and establishing a collaborative relationship	• Equality:	Code Example: The client has the right to collaborate in the development of his or her goals.

4.Justice is promoting fairness and objectivity in the delivery of the services. Therapists are to advocate for clients, maintain awareness of laws that guide occupational therapy, and continue to maintain credentials as a therapist.	• Freedom:	Code Example: I treat all my clients the same regardless of race, ethnicity, relation, sexual orientation, socioeconomic class, age, language, educational level etc.
5.Veracity is providing comprehensive, accurate, and objective information when representing the profession. Therapists include these into their practice by accurately documenting sessions and maintaining truthfulness and privacy of the client. This means telling the truth and being accurate.	• Justice:	Code Example: I gave the results of testing truthfully as well as the prognosis.
	• Prudence:	
	• Truth:	

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: What information is most important think I learned from this activity?

Self-directed: How can I improve my overall integration of the code of ethics into my practice?

Experience: What experiences do I have that I can draw from when I am in in an ethical situation?

How can I challenge myself to learn more ethics and apply it to my work?

What are some motivating reasons to learn/do this?

Additional thoughts or information I want to remember:

Optional Activities & Resources for Code of Ethics & Core Values

I may want additional readings that can assist in understanding ethics. The following is a list of a few articles that can assist with learning about ethics and different ways to look at ethics in practice.

Table 1.7 Recommended Articles
American Occupational Therapy Association. (2015). Occupational therapy code of ethics. *American Journal of Occupational Therapy, 69*(Suppl. 3), 6913410030. http://dx.doi.org/10.5014/ajot.2015.696S03
American Occupational Therapy Association. (2019). *Ethical considerations for productivity, billing, and reimbursement* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/reimbursement-productivity.pdf
American Occupational Therapy Association. (2018). *Cultural competence and ethical practice* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/AOTA-CulturalCompetenceAdvisory-Author-correction-5-2-18.pdf
American Occupational Therapy Association. (2016). *Social justice and meeting the needs of clients* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Social-Justice-Meeting-Client-Needs.pdf
American Occupational Therapy Association. (2016). *Outdated and obsolete tests and assessment instruments* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Outdated-and-Obsolete-Assessment-Instruments.pdf
American Occupational Therapy Association. (2016). *Balancing patient rights and practitioner values* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Balancing-Patient-Rights.pdf
American Occupational Therapy Association. (2019). *Ethical issues related to payment for service delivery* [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Ethical-Issues-Concerning-Payment-for-Services.pdf
Drolet, M.-J. (2018). Empowering occupational therapists and colleagues in overcoming moral distress. *Occupational Therapy Now*, *20*(3), 15–17. Retrieved from

http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=129606581&site=ehost-live&custid=s9002706

Kanny, E (1993). Core values and attitudes of occupational therapy practice. *The American Journal of Occupational Therapy 47*(12).1085-1086. https://doi.org/10.5014/ajot.47.12.1085

Penny, N. H., Ewing, T. L., Hamid, R. C., Shutt, K. A., & Walter, A. S. (2014). An investigation of moral distress experienced by occupational therapists. *Occupational Therapy in Health Care*, *28*(4), 382–393. https://doi.org/10.3109/07380577.2014.933380

Penny, N. H., Bires, S. J., Bonn, E. A., Dockery, A. N., & Pettit, N. L. (2016). Moral distress scale for occupational therapists: Part 1. instrument development and content validity. *American Journal of Occupational Therapy, 70*(4), p1–p8. https://doi.org/10.5014/ajot.2015.018358

Slater D, & Brandt L. (2009). Combating moral distress. *OT Practice, 14(*2), 13–18. Retrieved from http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=105252524&site=ehost-live&custid=s9002706

The following is a sample case study. This sample case study will give me a guide in how to answer the questions that are related to the scenario presented. Please read through the sample case study to be provided with a guide of how to fill out the following case study located on page 52.

Sample Case Study

Modified from Anthony Yuill website at:
https://www.theotpractice.co.uk/news/our-experts-blog/mental-health-and-physical-disability-why-they-go-hand-in-hand

Referral

1. Simon was referred to me by his community caseworker.
2. I am a home health occupational therapist.

Occupational Profile

1. Simon is a 34-year-old builder who lives with his family. His caregiver is his partner who works as a part-time employee at HomeGoods. He has 2 children of the ages of 11 and 5. Simon's involvement was severely limited once he was discharged from the hospital. He became withdrawn and avoided social situations. He has been having trouble continuing to concentrate on things that he feels are important and has begun to rely on his partner to take over many of the household tasks while Simon watched TV all day due to his continued flashbacks of the incident. This began to have a physical strain on his relationship with his partner. Simon has been unable to return back to work and from this, Simon has suffered significant financial hardship. He was then diagnosed with depression and prescribed anti-depressants.

Incident

Simon was involved in a workplace incidence on a building site. He suffered from major trauma including fractures to his pelvis and ankle, and significant lacerations to his right knee. Simon received in-patient services while he was admitted to the hospital.

OT Intervention Questions

1. Simon's main goal is to return back to work. What are some of the other areas of life that will need to be addressed before Simon is able to return back to work?

ANSWER: Increase concentration levels, reduce fatigue and anxiety, and the halt the cessation of all his previous leisure pursuits. He appears to be lacking in productive daily routines and has a slow recovery process as he is not involved in any type of rehabilitation at the moment. There may need to be some continued referral for a psychologist to assist Simon with his flashbacks.

2. What mental health strategies will the occupational therapist teach Simon to assist him in moving forward in his recovery?

ANSWER: Coping skills, explore the relationship between his inactivity and his activity levels prior to his incident, reviewing his reasoning of why he would like to return back to work, strategies to improve his mood and motivation to continue with rehabilitation.

3. How will improving Simon's mental health status improve his chances of becoming independent in his occupations?

ANSWER: Improvement within his mental health status will improve his motivation to continue with his recovery toward returning to work, improving his relationship with his social supports within his environment, which will all improve Simon's overall quality of life.

Application Case Study

1. Read the AOTAs Code of Ethics.
2. Go through the activity to test my knowledge. Please reference the sample case presented prior to filling out the questions listed below.
3. Reflect on the questions at the end of the activity.
4. Scenario:

   I am working on Jake's discharge papers from the acute care hospital.

   a. Occupational Profile
      i. Jake is an 89–year-old who is living in his two-bedroom farmhouse when he fell and broke his hip. Jake is a one-week post-surgery in an acute hospital.
   b. Client Factors & Performance Skills
      i. Jake would like to continue living in his farmhouse with his wife, Opal, who is 85. Opal is worried about having to make the drive into town for Jake's therapy and what would happen if he were to fall again, as she would not be able to help him up.
      ii. Jake has been unable to transfer himself to the commode independently and is not aware of his weight-bearing restrictions.
      iii. During a meeting with the medical team, Jake states that he refuses to go to a nursing home because he belongs at home with his wife.
      iv. Jake later discloses his distrust of the medical staff and his anxiety about returning home. Jake asks you to keep this discussion private between the two of you.

1.) What part of the Code of Ethics would I apply to this situation?

_____

_____

2.) What actions would I take to address the Code of Ethic[s] that I have listed above?

_____

_____

_____

_____

_____

_____

3.) What additional information would I want?

_____

_____

_____

_____

Empathy

Objectives of Activity:

1. To explore my thoughts on the role of empathy in the therapeutic relationship.
2. To reflect and enhance my understanding of empathy, therapeutically, to maximize my clients' satisfaction and outcomes. Using an empathetic approach allows the clients to perceive the therapist as a competent and compassionate health care provider (Abreu, 2011).

Introduction to Activity:

We all want to provide the best treatment we can to our patients, and one of the ways that we do this is by using empathy. A survey Taylor, Lee, and Kielhofner (as cited in Abreu, 2011) found that empathy was the least used mode during the creation of the therapeutic relationship. Why do I think that is? There is a common belief that individuals, who enter a healthcare profession, including occupational therapy, have the skills essential for developing a therapeutic relationship. The literature is not supporting this assumption.

Duration: 30-60 minutes

Activity Steps:

1. Read: Sharma, K.A. & Clark, A.J. (2018). Empathy matters, the importance of imagination in occupational therapy. *American Occupational Therapy Association (7)* 18-20.
    a. I can find this article on AOTA.org and it does not require a membership to access.
2. Complete the guiding questions as I am reading the Sharma & Clark article.

3. Complete the following case study designed to apply the information presented in the Sharma & Clark article. See pages 50-51 for a sample completed case study.

4. Reflect on personal/professional skills regarding the therapeutic use of empathy in my practice.

EMPATHY

The concept of empathy is taught in OT schools as, a *way of respectfully listening to our clients and proving to them that we care.* Taylor defined empathy as:

> "Striving to understand the client's thoughts, feelings, and behaviors while suspending any judgment while ensuring that the client verifies and experiences the therapist's understanding as truthful and validating" (2008, p. 53).

Peloquin (as cited in Taylor, 2008), identified key points in the process of developing and utilizing empathy therapeutically. Peloquin (2003) stated that empathy is:

- A communication of fellowship
- A turning of the soul toward the client
- Recognition of how one is similar to the client and how the client is unique
- Entry into the client's experience
- Connection with the feelings of the client
- The power to recover from that connection and maintain strength to continue therapeutic work. (as cited in Taylor 2008, p.12)

Therapists should be putting in a significant about of time and effort to understand a situation from the client's perspective (Taylor, 2008). Therapists should also observe how clients are communicating and adapt their approach to match the client's needs (Taylor, 2008). Using these techniques will allow me to become more aware of what the client is looking for, therefore becoming a better therapist.

As an occupational therapist, empathy is shown to clients every day as the therapeutic relationship is built (Sharma & Clark, 2018). An important part of being involved in the therapeutic relationship, is being able to understand a client's ability and disability from their perspective (Sharma & Clark, 2018). This means understanding the client's physical embodiment of the impairment, interpersonal experience, emotional experience, and psychological experience (Taylor, 2008). Clients may have real fears for their future including areas in work, familial roles, or financial concerns (Spence,

2019). As occupational therapists, we are to use interventions that also incorporates the psychological aspect of people, as that effect of illness or injury is personal for them (Spence, 2019).

> Practitioners may holistically envision the lived experience of a client in the past before a disability, in the present situation, and in future scenarios linked to relevant goal-setting and therapeutic procedures. Visualizing how clients feel about particular situations in which occupations have been impaired is one potential way occupational therapy practitioners can foster greater attentiveness and empathy (Sharma & Clark, 2018, para. 7).

Article Reflection		
Table 1.8: Guiding Questions, Interactions, & Personal Experiences that can Assist in the Empathetic Process Fill in the Table with the guiding questions (located in the article), the interactions; my experiences and what I learned. How do I create empathy when working with clients?		
Questions from the Article	Interactions from the Article	My Experiences in How I Create Empathy
Example: *How do others like me cope and adapt?*	*Shared resilience stories as a source of inspiration and motivation*	

1. Summary of my thoughts on this article.

_____

_____

_____

_____

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: How does empathy play a role in how I treat clients?

Self-directed: How can I enhance my application of using empathy with my clients?

Experience: What experiences do I have that I can draw from to strengthen my skill of using empathy?

How can I challenge myself to learn more about applying empathy with my client's mental health?

What are some motivating reasons to learn/do this?

Additional thoughts I want to remember:

Optional Activities for Empathy

Individuals may want additional activities or readings to understand empathy. The following includes a case study that I can review along with readings which can assist in increasing my knowledge on empathy. Please refer to the sample case study on pages 50-51 if needed.

Application Case Study

The next activity we have developed is a case study. This case study is designed to provide an opportunity to apply the information presented in the Sharma & Clark article.

I. Referral
   a. Andrea was referred to you by her physician. The physician's referral is under *Eval & Treat*.

II. Occupational Profile
   a. Andrea is an 18-year-old female with a rotator cuff injury that is two days post-op. Andrea is in her senior year of high school and has accepted a scholarship to play softball at the university.

III. Client Factors & Performance Skills
   a. Andrea reports feeling anxious about returning back to playing softball and the possibility of losing her scholarship.
   b. Andrea has been having numbness in her shoulder related to her surgery. This has inhibited her from putting upper body and lower body clothing on as she is feeling anxious about injuring the surgical site.

1.) How could I address Andrea's anxieties?

_____

_____

_____

_____

2.) Who could I refer Andrea to for any additional questions she may have?

_____

_____

_____

_____

_____

_____

Here are eight ways, by Andrew Sobel, to strengthen my own empathy:

1. Challenge myself. ...
2. Get out of my usual environment. ...
3. Get feedback. ...
4. Explore the heart not just the head. ...
5. Walk in others' shoes. ...
6. Examine my biases. ...
7. Cultivate my sense of curiosity. ...
8. Ask better questions.

Table 1.9 Recommended Articles
Abreu, B. C. (2011). Eleanor Clarke Slagle lecture. Accentuate the positive: reflections on empathic interpersonal interactions. *American Journal of Occupational Therapy*, *65*(6), 623–634. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=104599018&site=ehost-live
Dehn-Hindenberg A. (2007). The importance of communication and empathy in the therapy process: the needs of patients in occupational therapy. *Ergotherapie & Rehabilitation*, *46*(7), 5–10. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=106162721&site=ehost-live
Sharma, K. A. & Clark, A. J. (2018). Empathy matters: the importance of imagination in occupational therapy. *American Occupational Therapy Association (7).*18–20.
Allen, P., & Kelly, A. (2014). The missing link: The connection between physical and mental health. Retrieved from https://www.benefitscanada.com/benefits/health-wellness/the-missing-link-49009.
Alejandro, S. (2018). The Relationship Between Occupational Therapy and Mental Health. Retrieved from https://www.rehabalternatives.com/2018/02/01/occupational-therapists-addressing-mental-health-in-physical-rehabilitation/.
Chamberlain, M. (Producer). (2018, June 28). OT's role in mental health and depression in a physical disability setting [Audio podcast]. Retrieved from https://seniorsflourish.com/otmentalhealth/

Cultural Competency

Objectives of Activity:

1. To gain respect and understanding of diverse cultures and appreciation of each of my clients' and colleagues' unique qualities and skills.
2. To challenge internal biases that may affect my practice.
3. To enhance my knowledge of other cultures.

Introduction to Activity:

"Cultural competence requires self-awareness, cultural humility, and the commitment to understanding and embracing culture as central to effective practice" (National Association of Social Workers, 2015, pg. 4, para. 1). Understanding culture is essential to identifying occupations that are meaningful to the client. It is also essential to helping you avoid ethical dilemmas and adhering to the Code of Ethics. Cultural competency is a challenging yet vital area within occupational therapy's scope of practice. Every facility is impacted by culture by co-workers, clients, and your own personal beliefs.

Duration: It truly is a lifelong process.

Activity Steps:

1. Table 1.10 We have compiled a list of possible resources so I can begin my cultural journey. Within AOTA specifically, there are also the following resources:
    a. Cultural Competency Tool Kits - These are full of videos, documentaries, articles, books, websites, etc. https://www.aota.org/Practice/Manage/Multicultural/Cultural-Competency-Tool-Kit.aspx
2. Table 1.11 is a reflective piece to review the value I found within the book, article, or video.
3. Complete the Self-Assessment for Cultural Competency forms at https://www.asha.org/practice/multicultural/self/. There are 3 of them and they are very beneficial when looking at a clinical setting and practice. They are:

a. A personal reflection,
b. Self-evaluation of my department policies and procedures, and
c. the last is on the way my services are delivered.

Table 1.10: Cultural Competency Resources

Commercial Video or Documentary	Books/Articles
https://www.nytimes.com/watching/lists/social-issue-documentaries	https://www.goodreads.com/list/show/144668.Culture_
https://theculturetrip.com/asia/articles/top-12-documentaries-that-will-open-your-mind-to-other-cultures/	https://www.goodreads.com/shelf/show/culture
https://www.thegoodtrade.com/features/must-see-global-documentariesi	https://www.goodreads.com/list/show/138779.Culture_Published_in_Decade_1990s
https://www.isba.org/sites/default/files/teachers/teachingdiversitywithfilm.pdf	https://www.goodreads.com/list/show/126028.Culture_Published_in_Decade_2010s
https://americanenglish.state.gov/files/ae/resource_files/48_2-etf-intercultural-training-with-films.pdf	https://www.goodreads.com/list/show/42336.Social_Justice_Books_About_Class_and_Education
https://docs.google.com/document/d/13Rz2aQ03YdEqlq9l8OnBjR0IVaH6gkDK43r8nzfdnTs/edit?usp=sharing	https://www.goodreads.com/list/show/130930.Culture_Published_in_Decade_2000s
	https://www.goodreads.com/list/show/115223.Nonfiction_on_Religion_and_Religious_Belief
	https://www.goodreads.com/list/show/120321.Diversity_Equity_Inclusion_and_Culture
	https://www.goodreads.com/list/show/113510.Books_that_Explore_Cultural_Differences

Table 1.11: Cultural Competency Self-Reflection			
Title of the Piece	Like or Dislike	What did I learn?	How can I apply the knowledge to my facility?

Self and Institutional Assessment Tools

1. http://mighealth.net/eu/images/0/0b/Banc.doc by Marjory Bancrof
    a. Self-Assessment for Cultural Competence Includes cultural competence checklists, a cultural competence awareness assessment and a questionnaire about “How Does Your Caseload Compare?” Assesses demographic and caseload changes related to culturally/linguistically diverse (CLD) populations.
2. Cultural Competence Self-assessment Checklist: http://rapworkers.com/wp-content/uploads/2017/08/cultural-competence-selfassessment-checklist-1.pdf
3. National Standards for Culturally and Linguistically Appropriate services (CLAS) IN Health and Health Care: https://thinkculturalhealth.hhs.gov/clas
4. Office of Minority Health: https://minorityhealth.hhs.gov/

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: How does empathy play a role in how I treat clients?

Self-directed: How can I enhance my application of using empathy with my clients?

Experience: What experiences do I have that I can draw from to strengthen my skill of using empathy?

How can I challenge myself to learn more about applying empathy with my client's mental health?

What are some motivating reasons to learn/do this?

Additional thoughts I want to remember:

UNIT II

Evaluation

The purpose of Unit II is to connect the previous section where we focused on how to view our clients through a holistic lens and bring it into the evaluation and documentation processes. This unit focuses more on application working toward building stronger therapeutic relationships with my clients. This unit is divided into three sections:

1. Occupational Profile,
2. Stress Management, and
3. Assessments/Screens.

The Occupational Profile was chosen because it provides common occupational therapy terminology. AOTA (n.d.) states that the occupational profile is the first step in improving the quality of occupational therapy services and demonstrating the profession's distinct value to other health care providers, reviewers, and payers.

Stress management was chosen because there is a strong link between stress and incurring any type of disability, yet it is often not addressed in a physical disability setting. Depression, anxiety, and other mental health concerns often accompany a physical disability, and holistic treatment services should work to manage all aspects of mental wellbeing and disability together.

The final section is on assessments and screens. These are resources provided for me to reference and hopefully incorporate, to address mental health & wellness directly and daily. Implementing these areas into my practice can contribute to strengthening the therapeutic relationship with a more positive impact via holistic care.

Occupational Profile

Objectives of Activity:

1. To be a refresher on the benefits of using the profile as a primarily part of my evaluation process.
2. To review the connection of the Occupational Therapy Practice Framework to the Profile and our distinct value as occupational therapists.

Introduction to Activity:

We are all aware of the Occupational Profile if we stay current in our profession. At the beginning of this unit, there was a brief introduction to the importance and value of the occupational profile. This activity will reflect on all aspects of the Occupational Profile and to assist in application of the profile with clients.

Duration: 30-60 minutes depending on the depth of my self-reflection.

Activity Steps:

1. Read the paragraph(s) listed below to learn about the benefits of using the Occupational Profile. I can also go to the AOTA.org website: https://www.aota.org/Practice/Manage/Reimb/occupational-profile-document-value-ot.aspx
2. Please use the Occupational Therapy Practice Framework (OTPF) as I go through the Occupational Profile.
   a. I need to be a member of AOTA to access the OTPF.
3. Go through Table 2.1 in each section.
4. Identify where I already address each area and the areas that could strengthened.
   a. Outline the boxes for strengths.
   b. Circle areas of weakness.
5. Please pick 2 areas in the OTPF that I do on a regular basis and 2 that are challenging to cover during evaluation and write them into Table 2.2. In the table

also write how I can change/add the areas that are challenging into my evaluation process.

6. For continued personal and professional growth, please consider reflecting on the following questions:

Occupational Profile Effectiveness

The Occupational Profile was created by the AOTA to be used as a template within practice (Simmons, Guberman, & Aranha, 2018). This template assists occupational therapists to focus on restoring, maintaining, and developing a client's identity (Simmons, Guberman, & Aranha, 2018). It is designed to work on client-therapist collaboration to enhance client-centered care (Simmons, Guberman, & Aranha, 2018). A qualitative study, by Simmons, Guberman, and Aranha (2018), had OT students use the Occupational Profile in a semi-structured interview with their patients with a mental health condition. The overarching themes that came from this study were:

1. a "gain of rich information"
2. "understanding client's perspective of self"
3. "building rapport"
4. "provided scaffolding for client reflection"

(Simmons, Guberman, & Aranha, 2018). From this study, it was found that the Occupational Profile is a useful tool to generate rich details from the client's perspective which is more meaningful because it engages the client much more (Simmons, Guberman, & Aranha, 2018).

The profile demonstrates occupational therapy practitioners' commitment to clients as collaborators in the occupational therapy process and facilitates client-centered practice. In addition, the 2017 occupational therapy evaluation and re-evaluation *CPT*® codes require the inclusion of an occupational profile (AOTA, n.d.-b).

<table>
<tr><th colspan="5">Table 2.1 Occupational Profile</th></tr>
<tr><td rowspan="6">Client Report

Note: the numbers with the letter S in front of them are actually the page numbers in the OTPF</td><td colspan="3">Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities? (This may include the client's general health status.)</td><td rowspan="11">Evaluation, re-evaluation and intervention does include:
1. Performance Deficits: the inability to complete activities due to lack of skills in one or more of the categories (physical, cognitive or psychosocial)

2. Physical Skills: impairment of body structure or body function (e.g. balance, mobility, strength, endurance, fine or gross motor coordination, sensation, dexterity)

3. Cognitive Skills: the ability to attend, perceive, think, understand, problem-solve, mentally sequence, learn & remember resulting the ability to organize occupational performance in a timely and safe manner. These skills are observed when: (1) a person attends to & selects, interacts with & uses task tools & materials; (2) carries out individual actions & steps; (3) modified performance when problems are encountered.</td></tr>
<tr><td colspan="3">Occupations in which the client is successful (p. S5) and what barriers are affecting his or her success?</td></tr>
<tr><td colspan="3">What are the client's personal interests and values (p. S7)?</td></tr>
<tr><td colspan="3">What is the client's occupational history (i.e., life experiences)?</td></tr>
<tr><td colspan="3">What are the client's patterns of engagement in occupations, and how have they changed over time? What are the client's daily life roles? (Patterns can support or hinder occupational performance.) (p. S8)</td></tr>
<tr><td></td><td colspan="3">What aspects of the client's environments or contexts does he or she see as:</td></tr>
<tr><td></td><td></td><td>Supports to occupational engagement</td><td>Barriers to occupational engagement</td></tr>
<tr><td rowspan="2">Environment</td><td>Physical (p. S28) (e.g., buildings, furniture, pets)</td><td></td><td></td></tr>
<tr><td>Social (p. S28) (e.g., spouse, friends, caregivers)</td><td></td><td></td></tr>
</table>

Context	Cultural (p. S28) (e.g., customs, beliefs)			4. Psychosocial Skills: interpersonal interactions, habits, routines & behaviors Each of these areas can incorporate the mental wellness status of a client and nothing differs concerning billing.
	Personal (p. S28) (e.g., age, gender, SES, education)			
	Temporal (p. S28) (e.g., stage of life, time, year)			
	Virtual (p. S28) (e.g., chat, email, remote monitoring)			
	Consider: occupational performance—improvement and enhancement, prevention, participation, role competence, health and wellness, quality of life, well-being, and/or occupational justice.			
Client goals				

Refer to the Occupational Therapy Practice Framework for additional information

Table 2.2 Strengths and Challenges with Incorporating OTPF into Evaluation

Area from Occupational Profile Template	*Completed in Majority of Evaluations (✓if yes)*	*Challenging to Incorporate into Evaluations (✓ if yes)*	*How can I change/add this to my evaluation process?*

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: What parts of the Occupational Profile are relevent to my place of work? Why? What parts are not and why?

Self-directed: How can I incorporate more components of the Occupational Profile in my practice?

Experience: What are some barriers I have seen in utilizing the Occupational Profile in my practice area? What strategies can I use to overcome these barriers?

How can I challenge myself to include more aspects of the Occupational Profile in regards to mental health?

What are some motivating reasons to incorporate the Occupational Profile or more components of it into my practice at my facility?

Additional thoughts I want to remember:

Stress Management

Objectives of Activity:

1. To reflect on the role stress plays in my client's well-being and impacts the outcomes they can achieve.
2. To reflect on how I can help my clients manage their stress.

Introduction to Activity:

As discussed prior, stress plays a significant role in all aspects of our lives. This is more pronounced when we are faced with significant life challenges such as a health issue. Think about myself. If I incurred a physical disability, how would that impact my psychological well-being?

Duration: 15-20 minutes

Activity Steps:

1. Complete the Table 2.3 while reflecting on my practice.
    a. Table 2.3 is a self-assessment of how I think my clients are experiencing and managing stress.
    b. Use Table 2.4 to assist in filling out Table 2.3. This table is also a quick list for me to refer to in my daily practice.
2. Fill in the open spaces within the table to answer the questions listed. This will help me begin thinking about how I see my clients' stress.
3. Review Table 2.5.
    a. It is a questionnaire I could use to gain awareness of how my clients are experiencing stress and related mental health symptoms. Please feel free to use this form directly with clients. Free to edit and change the form as needed. It is an excellent tool to informally assess my client's stress levels while building the therapeutic relationship. Please use Table 2.4 with clients as a checklist to assist in filling out Table 2.5.
4. Complete the reflection questions about the application of these tables in my daily practice.

Table 2.3: Assessment of Stress Management Strategies and Interventions for My Clients		
Orientation: List some reasons why my clients may be experiencing stress.	•	•
How will stress effect my client's outcomes?		
Motivation: Would helping my clients learn about how to cope with stress benefit them?	Yes	No/Why?
Readiness: Do I have the skills, resources and confidence to help my clients deal with stress?	Yes	No/Why?
What skills do I need to strengthen?		
What resources do I have?		
Where can I find resources to supplement my knowledge about stress management?	•	•
Additional Thoughts:		

Table 2.4: General Reaction to Stress: used in conjunction with Table 2.3		
Physical Reaction Checklist	What are the physical signs of stress? □ Racing heart □ Shaking hands □ Shaky legs □ Clenching fists □ Reddening of the skin □ Headaches □ Tenseness □ Muscle spasms □ Others	 □ Headache □ Chest pain □ Fatigue □ Change in sex drive □ Upset stomach □ □ □ □
	What are the emotional signs of stress? □ General feelings of anxiety □ Feeling overwhelmed □ Inability to focus □ Avoidance behaviors □ Inability to make decisions □ Fight or flight response □ Acting out □	 □ Feeling restless □ Lack of motivation □ Irritability □ □ □ □ □
	What are some of the health-related conditions that can be brought on by stress? □ Inability to sleep □ Excessive sleep □ Binge eating □ Loss of appetite □ Irrational behaviors □ Bouts with depression □ Mood disorders □	 □ Anxiety □ Digestive □ □ □ □ □ □
	What are **my** resources: □ □ □ □ □	

(Mayo Clinic, 2019)

Table 2.5: Stress Management Self-Assessment for Clients

	Answers	Notes
What are some ways I am experiencing stress?		
How do I think stress affects my daily life?		
What strategies do I have to cope with stress in my life?		
What resources do I use already in where I live? (grab bars, non-slip mats, community psychologist)		
What strategies do I think would be helpful to learn?		
What additional resources do I think would be helpful to have?		
Additional Thoughts:		

Reflect on these tables:

a. How can the information gained from these tables strengthen my practice?
b. What can I do in my daily practice to be mindful of the stress my clients have?
c. Explain how the client's stress may impact my evaluations/interventions and client outcomes?

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: Why is awareness of stress important to my practice?

Self-directed: How can I take this information and apply it to practice?

Experience: What experiences have I had that I can draw on in regards to managing my own and my client's stress?

How can I challenge myself to address my client's stress when looking at mental health?

What are some motivating reasons to learn/do this?

Additional thoughts I want to remember:

Assessments/Screens

Objectives of Activity:

1. Familiarize myself with assessments/screens that are available to address psychosocial health and wellness of my clients.
2. Identify possible assessments/screens I would like to incorporate.

Introduction to Activity:

In this section, there are several assessments and screenings that could be useful in my practice to address mental health in my physical disability settings.

Duration: 15-30 minutes

Activity Steps:

1. Look through the table at the assessments, evaluations, and screens listed below.
2. Complete the pros/cons below each assessment/screening tool to see if it could be a possibility or not in my setting.

Table 2.6: Assessment & Screening Tool Information				
Assessment/ Screening Tool	Description & Components	Information it Obtains	Where to access & cost?	How long does it take?
Beck Depression Inventory-II (BDI-II)	-Interview-based questionnaire -Questions: 21 -Topic: behavioral characteristics of depression -4 symptom-related statements, rated 0-3 -Time Period: Symptoms over 2 weeks	Severity of depression	$ 95-150 for a starter kit https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Beck-Anxiety-Inventory/p/100000251.html	5 to 10 minutes
Pros to Using **Cons to Using**				
Cancer Coping Questionnaire (CCQ)	-Self-report questionnaire -Questions: 21 related to 5 coping methods Rating: 1-4 scale ** Only use with those that are in a close relationship**	Measures coping strategies used by individuals with cancer	https://www.oxfordclinicalpsych.com/ Free www.interscience.wiley.com cost to assess article	Not Listed
Pros to Using **Cons to Using**				

COPE Inventory (COPE) **Brief COPE (Brief COPE)**	-Self-report, Checklist, or Interview -15 scales -COPE Questions: 60 statements -Brief COPE Questions: 28 statements -Rating: 1-4 for each statement	Identifying patterns of coping with stress	http://www.midss.org/content/cope-inventory Free	Not Listed
Pros to Using **Cons to Using**				
Coping Responses Inventory (CRI)	-Self-report, Checklist, or Interview -Items: 48, Scales: 8 -Rating: 1-4 for each statement	Identify approaches and methods of coping	Introductory Kit: $245+ https://www.parinc.com/Products/Pkey/69	10-15 minutes
Pros to Using **Cons to Using**				

General Self-Efficacy Scale (GSES)	- Self-administered rating scale -10 items -Rating: 1-4	Measures Self-Efficacy to predict the ability of an individual to cope with daily stress as well as stressful events	http://userpage.fu-berlin.de/~health/engscal.htm Free https://www.psytoolkit.org/survey-library/generalized-self-efficacy-gse.html	4 minutes on average
Pros to Using **Cons to Using**				
Milton Behavioral Medicine Diagnostic	-Self-report Items: 165; true/false Categories: 7 -Norm-referenced	Identifies psychosocial factors that affect medical patient's treatment outcomes	Manual: $45-70 Profile Reports: $23 per client (can get for less if buying more than 4)	20-25 minutes
Pros to Using **Cons to Using**				

Reynolds Depression Screening Inventory	-Self-report or oral rating scale -Administration: Individual OR Groups -Items: 19 -Rating: 1-4	Screens for depression symptoms	https://www.parinc.com/Products/Pkey/358 Introductory Kit: $109	5-10 minutes
Pros to Using **Cons to Using**				
Stress Profile	-Self-Report -Items: 123 -Categories: 7 -Scoring: 1-5 OR 1-6 OR True/False	Identify characteristic and behaviors which contribute or protects an individual from stress-related illness	https://www.wpspublish.com/the-stress-profile Kits: $152	20-30 minutes
Pros to Using **Cons to Using**				

Ways of Coping Questionnaire	-Interview or self-report checklist -Items: 66 items -Scales: 8 -Rating: 0-3	Assess coping processes	https://www.mindgarden.com/158-ways-of-coping-questionnaire#horizontalTab1 Manual: $50-60 Additional Cost per person that it is administered to	Not stated
Pros to Using **Cons to Using**				

(Asher, 2014; Trautmann Boop, 2014)

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: What information is most applicable to my facility from the charts above?

Self-directed: How can I find fundings to afford new asessments? Where can I find funding opportunities?

Experience: What assessments have I learned about in the past, but had forgotten about?

How can I challenge myself to incorporate new assessments into my evaluation process?

What are some motivating reasons to find more assessments for my facility?

Additional thoughts I want to remember:

UNIT III

Documentation

A review of the literature identifies billing/reimbursement as a primary barrier to providing holistic care, as cited by OTs. In Unit III, we focus on how to effectively use documentation to bill for my services, while addressing my client's mental wellness needs. Unit III has two sections with interactive activities and alternative resources that will assist in guiding me back to a more holistic practice. These sections include:

1. Billing and
2. CPT Codes.

Billing

Objectives of Activity:

1. To reflect on billing terminology in documentation that I am using in practice.
2. To gain an additional understanding of the connection between billing, documentation and the occupational profile. Using the profile as part of my evaluation report demonstrates the unique value of OT and that I am looking at the client holistically. I am not billing for psychosocial interventions, I am billing for OT intervention services.
3. To promote more confidence with documentation of mental health in my physical disability setting.

Introduction to Activity:

Billing is one of the areas therapists report that they struggle with especially when incorporating mental health and wellness.

Duration: 15-20 minutes

Activity Steps:

1. Look at terminology listed in Table 3.1.
2. Fill in terminology I already use within my documentation at my facility into the empty boxes.
    a. HINT: I can use terms from the OTPF.
3. Reflect on the questions below the Table 3.2 on how using the information in the table would impact my facility.
4. After finishing the activity, Table 3.1 can be used as a reference for terminology within my documentation in my practice setting.

Table 3.1: Descriptive Billing Terms		
Documenting Mental Health Treatment	□ Empathy/Empathetic □ Redirect □ Establish □ Facilitate □ Refer □ Organizes □ Notices/responds □ Accommodates □ Replies □ Expresses emotions □ Habits □ Values □ Orientation □ Temperament □ □	□ Inform within the scope of practice, refer to appropriate discipline □ Attends □ Initiates □ Inquires □ Terminates □ Adjusts □ Concludes/disengages □ Questions □ Transitions □ Routines □ Higher Cognition □ Experiences self and time □ □
Describing the Client's Behavior	□ Aggressive □ Agitated □ Angry □ Anxious □ Confused □ Elevated mood □ Euphoric □ Expresses □ Hostile □ Cooperative □ Explosive □ Guarded □ Hostile □ Hyperverbal □ Hypervigilant □ Limit testing □ Resistive □ Considerate □ Polite □ Laughing	□ Impulsive □ Inappropriate □ Inconsistent □ Obsessive □ Preoccupied □ Withdrawn □ Attention seeking □ Attentive □ Calm □ Crying □ Wandering □ Paranoid □ Threatening □ Habits □ Roles □ Routines □ Caring □ Joking □ □
Describing the Client's Cognition	□ Forgetful □ Inattentive □ Learns from his/her mistakes □ Perseverates □ Problem-solves □ Refuses □ Inquires □ Initiates	□ Attention □ Memory □ Perception □ Emotional □ Terminates □ Places self □ Discloses □ Heeds

	□ Continues □ Sequences □ Approaches □ Regulates □	□ Transitions □ □ □ □
Describing the Client's Affect	□ Agitated □ Angry □ Apathetic □ Fearful □ Hostile □ Labile □ Pleasant □ Sad □ Stressed □ □ □	□ Avoidant □ Elevated □ Excited □ Flat □ Incongruent to Topic □ Nervous □ Relaxed □ Tearful □ □ □
Describing the Client's Mood	□ Dysphoric □ Euphoric □ Expansive □ Manic □ Incongruent to Topic □ Cheerful □ Humorous □ Interested □ Optimistic	□ Fearful □ Grandiose □ Hostile □ Sad □ Sullen □ Calm □ Hopeful □ Peaceful □ Confident
Resources	□ (Nagel, 2019; Sames, 2015; AOTA, 2014)	□ □ □

Additional Resources for Billing Terminology

The previous tables listed terminology that I can use for billing. Table 3.2 list other resources that I can view at my leisure to enhance my documentation vocabulary.

Table 3.2: Websites for Billing Terminology	
Website	Link
Lit Charts	https://www.litcharts.com/literary-devices-and-terms/mood
Dept. of Word Lists	https://www.vocabulary.com/articles/wl/get-into-the-mood-with-100-feeling-words/
PDF	https://mrafisher.weebly.com/uploads/1/5/7/7/15778366/describe_words-_behavior__personality.pdf
Your Dictionary	https://grammar.yourdictionary.com/word-lists/list-of-words-that-describe-behavior.html

CPT Codes

Objectives of Activity:

1. To learn how to document addressing the psychosocial needs of my clients within my physical disability setting.
2. To learn how to give the rationale that ties it back to the occupation in my documentation.

Introduction to Activity:

CPT codes are used by virtually all payers in the healthcare system. Understanding CPT coding is essential for documentation and to ensure reimbursement.

Duration: 15-20 minutes

Activity Steps:

1. Read through the CPT Codes paragraph listed below.
2. Look at CPT codes listed in Table 3.2.
3. Fill in the empty boxes for Billing Terms from Table 3.1 that could be used for each one of the sections.
4. Fill in the used in practice box with my experiences at my facility.
5. Reflect on the questions below the Table 3.2 on how using the information in the table would impact my facility.
6. After finishing the activity, Table 3.2 can be used as a reference when documenting in my practice setting.

CPT Codes

The following CPT codes are used in physical disability settings. The descriptions of these codes also include reference to cognitive and psychosocial skills. All of the terms that were chosen for billing, are defined in detail within the OTPF. Please have the OTPF available to reference. In the spaces below, write a goal that would incorporate mental health into a physical disability setting. Feel free to add my own in additional boxes at the end of the chart. These authors contacted an AOTA representative to clarify that these CPT codes can be used to address mental health within the physical dysfunction setting. The email exchange is listed in Appendix D.

These examples are from *The New Grad's Guide To Occupational Therapy CPT Codes* by Lloyd-Randolfi (2018) and *Medical Billing and Coding - Procedure code, ICD CODE* (n.d.). Additional information on CPT Codes can be found on the AOTA website under the Advocacy & Policy tab, Coding and Billing.

Table 3.3 CPT Codes			
Billing Codes	**Description**	**Billing Terms** Table 3.1	**Used in Practice** How can I use these in my documentation?
Evaluation (97165)	This looks at an evaluation with moderate complexity which identifies **1-3 performance deficits** relating to physical, cognitive or psychosocial skills that result in activity limitations and/or participation restrictions	☐ ☐ ☐ ☐ ☐ ☐	
Evaluation (97166)	This looks at an evaluation with moderate complexity which identifies **3-5 performance deficits** relating to physical, cognitive or psychosocial skills that result in activity limitations and/or participation restrictions	☐ ☐ ☐ ☐ ☐ ☐	
Evaluation (97167)	This looks at an evaluation with moderate complexity which identifies **5 or more performance deficits** relating to physical, cognitive or psychosocial skills that result in activity limitations and/or participation restrictions	☐ ☐ ☐ ☐ ☐ ☐	

Re-evaluation (97168)	Using re-evaluation to assess whether physical, cognitive, or psychosocial skills that result in activity limitations and/or participation are still being restricted	☐ ☐ ☐ ☐ ☐ ☐	
Therapeutic Activities (97530)	Activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities to improve performance in a progressive manner. The activities are usually directed at a loss or impairment of mobility, strength, balance, coordination or cognition. Includes “dynamic activities” that are designed to improve functional performance for ADLs. This may include functional mobility, bed mobility, step-ups/stair negotiation, throwing a ball, golf club, car transfer training, and high/low reaching.	☐ ☐ ☐ ☐ ☐ ☐	
Self-Care (97535)	This looks at training and improving performance in ADLs, working on	☐ ☐	

	compensatory strategies, using adaptive equipment, facilitating meal prep or self-feeding, etc. Can also use this to educate clients and families on wound care, edema control, activity modification, improving the home environment for safety, or transfers (getting on/off the toilet or in to shower)	☐ ☐ ☐ ☐	
Cognitive Intervention (97129) **Additional Cognitive Intervention (97130)**	As of 2020, OTs will no longer be billing 97127 for Cognitive Skills. 97129 will be used to address cognitive function interventions (attention, memory, problem-solving etc.) for the first 15 minutes. If sessions proceed longer than 15 minutes, please used 97130 for each additional 15 minutes.	☐ ☐ ☐ ☐ ☐	

(Lloyd-Randolfi, 2018; Medical Billing and Coding - Procedure code, ICD CODE, n.d.).

For continued personal and professional growth, I will consider reflecting on the following questions:

Need to know: How do the codes/terminology that my facility uses compare to these codes listed above?

Self-directed: How can I use these codes//terminology in my facility when documenting services?

Experience:What can I draw from my experiences of interventions that can assist in addressing mental health?

How can I challenge myself to use these codes and terminology in my documentation?

What motivates me to change the way I am billing with codes or using terminology in documentiation to address my clients mental health?

Additional thoughts I want to remember:

Appendices

A: Outcome Measure	The purpose of the outcome measure address and assess the effectiveness of this guide within the physical dysfunction setting. The goal of this assessment is to promote application within the setting and self-reflection of the use of this guide.
B: Answers to Activities	Includes all of the answers to the activities that have been used throughout the guide.
C: Additional Case Studies	Includes links to case studies with application questions within the chart. These activities give the opportunity for additional case study practice for addressing mental health with different types of clients.
D: AOTA Email Exchange	Includes screenshots of the conversation from the authors with AOTA for official mental health billing terms and CPT codes.

Appendix A

Outcome Measure

Guide to Assess Usefulness

Object of Activity:

This activity is used to share the overall usefulness and personal opinions with the authors of the ***Redirected Mindset: A Guide to a More Holistic Practice in Physical Rehabilitation.***

Purpose of the Activity:

Having a resource is only as good as those who use it and adapt it. One important area that this project encourages is the application of these materials into practice. With this information being placed into practice, the overall usefulness of the guide lies with the individual applying this guide. The authors appreciate all feedback on their work and will use this feedback to adjust and add to the current guide to increase its usefulness applicability within the field.

Duration: 20-60 minutes

Activity:

1. Use personal reflection to fill out the rating forms for each section of the guide.
    a. If there was an area that was skipped over or did not apply to my facility, please select the not applicable.
2. Provide personal and constructive insight within the blank space provided.
3. Send a scanned copy of the completed rating sheets to both emails listed below.
    a. Ashley.m.malina@gmail.com
    b. Sara.ann.anderson@gmail.com

Purpose

Evaluate the overall purpose of this guide as a whole.					
Rating: 0 (did not at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings 0**	**1**	**2**	**3**	**N/A**
Rate how I think this information is supported by updated and relevant evidence.	0	1	2	3	NA
Rate the readability of the literature review.	0	1	2	3	NA

Unit 1

Please rate how beneficial each activity was for my clinical competency knowledge.					
Rating: 0 (did not help at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings 0**	**1**	**2**	**3**	
Reflective strength chart (Table 1.1).	0	1	2	3	NA
Continued professional development self-rating tool (Table 1.2).	0	1	2	3	NA
Continued development plan (Table 1.3).	0	1	2	3	NA
Optional activities for professional development (Table 1.4 & 1.5 included).	0	1	2	3	NA
Quizlet for standards of practice.	0	1	2	3	NA
The code of ethics and core values activity (Table 1.6).	0	1	2	3	NA
The optional activities for the code of ethics (Table 1.7 included).	0	1	2	3	NA
Empathy article reflection guide (Table 1.8).	0	1	2	3	NA
Optional activities for empathy (Table 1.9 included).	0	1	2	3	NA
Cultural competency (Table 1.10; Table 1.11).	0	1	2	3	NA

Unit 2

Section 1: Please rate how beneficial each activity was for my knowledge.					
Rating: 0 (did not help at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings 0**	**1**	**2**	**3**	
Occupational Profile (Table 2.1; Table 2.2).	0	1	2	3	NA
Stress management strategies and interventions for my clients (Table 2.3).	0	1	2	3	NA
General reaction to stress (Table 2.4).	0	1	2	3	NA
Stress management for clients (Table 2.5).	0	1	2	3	NA
Assessments & screening tool information (Table 2.6).	0	1	2	3	NA

Section 2: If I used this unit's information in the clinic, please complete section 2. If not, please continue to the next unit.					
Rating: 0 (did not help at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings**				
	0	**1**	**2**	**3**	
Occupational Profile (Table 2.1).	0	1	2	3	NA
Stress Management for clients (Table 2.3).	0	1	2	3	NA
General Reaction to Stress (Table 2.4).	0	1	2	3	NA
Assessments & Screening Tool Information (Table 2.5).	0	1	2	3	NA

Unit 3

Section 1: Please Rate how beneficial each activity was for my knowledge.					
Rating: 0 (did not help at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings**				
	0	**1**	**2**	**3**	
Descriptive billing terms (Table 3.1).	0	1	2	3	NA
Optional activities for billing terminology (Table 3.2).	0	1	2	3	NA
CPT codes (Table 3.3).					
Section 2: If I used this unit's information in the clinic, please complete section 2. If not, please continue to the next unit.					
Rating: 0 (did not help at all)-3 (helped/learned a lot), N/A: not applicable	**Ratings**				
	0	**1**	**2**	**3**	
Descriptive billing terms (Table 3.1).	0	1	2	3	NA
Optional activities for billing terminology (Table 3.2).	0	1	2	3	NA
CPT codes (Table 3.3).	0	1	2	3	NA

General Questions

General Questions
How did the additional reflection questions after each section impact my learning?
Describe the ease of use. Was the amount of information enough, too much, or not enough for each section?

What are additional areas that I would have preferred to be included in this guide?
Additional Notes and Recommendations on any of the above units.

Thank you for taking time to completing the Guide to Assess Usefulness! The authors of this guide appreciate the feedback and welcome additional thoughts, comments, and ideas. Please reference the beginning of the Guide to Assess Usefulness to locate the email addresses to send the results to.

Appendix B
Answers to Case Studies

Page 50: Case Study: Code of Ethics

1. All are applicable in this scenario, but it would depend on the rationale placed behind each Code of Ethics. Examples include:
    a. Beneficence: Overall safety of the patient, ex. Transfers.
    b. Nonmaleficence: Safety in transfers and having assistance with getting up if a fall occurs.
    c. Autonomy: Respecting the patient's right to choose not to go to a nursing home.
    d. Justice: The possibility advocating for the patient for what they want. Also allow the patient to understand my objective professional opinion and why I documented the information as you did.
    e. Veracity: Explaining to the patient what is being documented and why it has to be documented to be discussed with other members of the team for safety purposes.
2. There may be a variation of answers.
3. Individual Preference

Page 60: Case Study: Empathy

1. Empathizing, encouraging, collaborating, problem-solving, advocate at a later point.
2. Answers will be variable. Some examples include:
    a. Paraphrase, Probe, Reflect
    b. Resources available
    c. Talk about what OT can do
    d. Refer to alternative disciplines that can assist her
3. Answers will be variable. Some examples include:
    a. Physical Therapy
    b. Sports Medicine

c. Athletic Trainer
d. Counselor
e. Local Support Groups
f. The University

Appendix C
Additional Case Studies

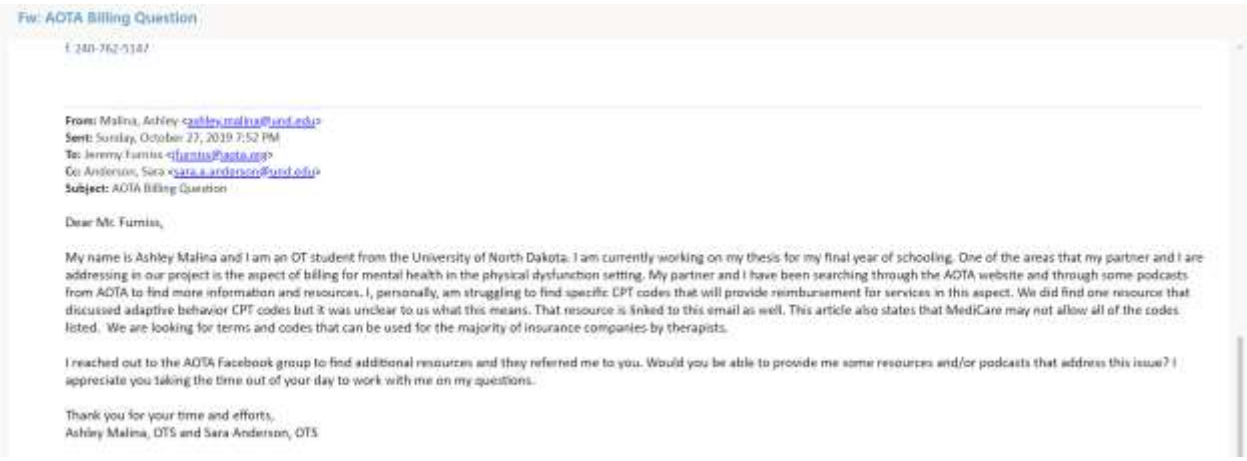
In Table 4.1, additional resources have been created for self-directed additional learning through case studies. Feel free to use the terms, websites, and questions listed below and add my own in the empty boxes at the end.

Table 4.1 Additional Case Studies		
Websites	Terms to find Case Studies	Questions to ask myself in case studies
https://www.theotpractice.co.uk/news/tags/case-study	practice scenarios for occupational therapist	1.How can I address possible mental health components that the client has not brought up?
https://assesshealthcareers.ca/occupational-therapists/part-5-case-scenarios/	practice case studies for occupational therapy students' examples	2.What resources do I have available to assist in address the client's mental health?
http://publish.uwo.ca/~shobson/scenario12.html	*insert patient diagnosis* (ex. total hip replacement) case study occupational therapy	3.What type of assessments are available to assess my client's mental health?
https://www.theotpractice.co.uk/news/our-experts-blog/case-study-neurological-rehabilitation		4.What code of ethics area am I addressing when I plan interventions with this client?
http://thewillowsrehab.com/case-study-ramapo-center-rehabilitation-nursing-july-2016/		5.What type of billing codes should I use for proper reimbursement for services?

Appendix D

When the authors of this guide were gathering information, they questioned if there were CPT codes that should be used in the physical disabilities setting when addressing mental health components of the person. Below is the communication between the authors and an AOTA representative addressing this question.

(M. Wright, personal communication, October 28, 2019)



Fw: AOTA Billing Question

t: 240-762-5147

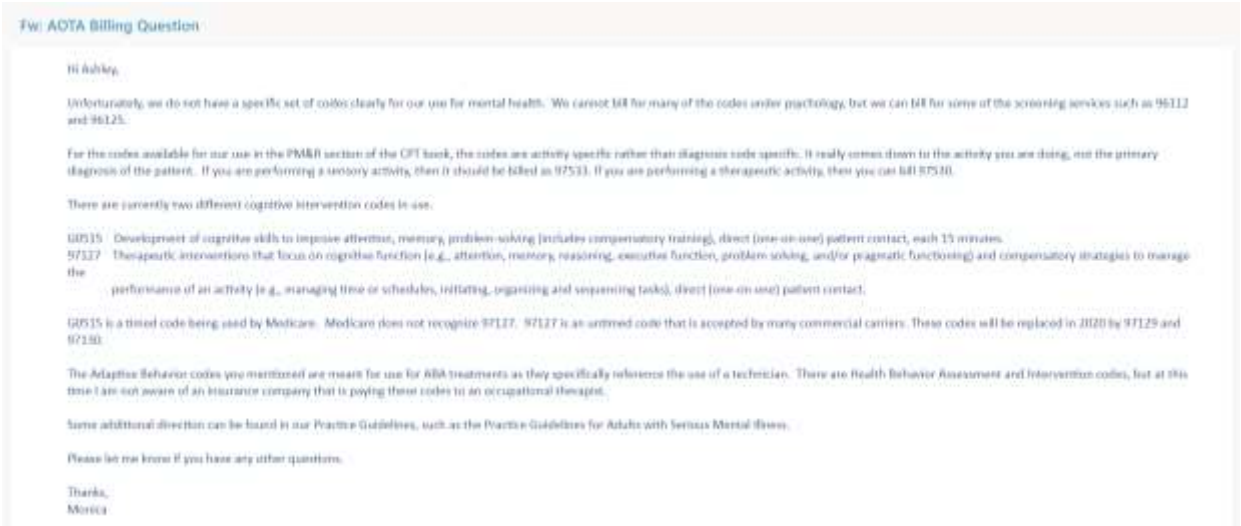
From: Malina, Ashley <ashley.malina@und.edu>
Sent: Sunday, October 27, 2019 7:52 PM
To: Jeremy Furniss <jfurniss@aota.org>
Cc: Anderson, Sara <sara.a.anderson@und.edu>
Subject: AOTA Billing Question

Dear Mr. Furniss,

My name is Ashley Malina and I am an OT student from the University of North Dakota. I am currently working on my thesis for my final year of schooling. One of the areas that my partner and I are addressing in our project is the aspect of billing for mental health in the physical dysfunction setting. My partner and I have been searching through the AOTA website and through some podcasts from AOTA to find more information and resources. I, personally, am struggling to find specific CPT codes that will provide reimbursement for services in this aspect. We did find one resource that discussed adaptive behavior CPT codes but it was unclear to us what this means. That resource is linked to this email as well. This article also states that MediCare may not allow all of the codes listed. We are looking for terms and codes that can be used for the majority of insurance companies by therapists.

I reached out to the AOTA Facebook group to find additional resources and they referred me to you. Would you be able to provide me some resources and/or podcasts that address this issue? I appreciate you taking the time out of your day to work with me on my questions.

Thank you for your time and efforts,
Ashley Malina, OTS and Sara Anderson, OTS



Fw: AOTA Billing Question

Hi Ashley,

Unfortunately, we do not have a specific set of codes clearly for our use for mental health. We cannot bill for many of the codes under psychology, but we can bill for some of the screening services such as 96112 and 96125.

For the codes available for our use in the PM&R section of the CPT book, the codes are activity specific rather than diagnosis code specific. It really comes down to the activity you are doing, not the primary diagnosis of the patient. If you are performing a sensory activity, then it should be billed as 97533. If you are performing a therapeutic activity, then you can bill 97530.

There are currently two different cognitive intervention codes in use.

G0515 Development of cognitive skills to improve attention, memory, problem-solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes.
97127 Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact.

G0515 is a timed code being used by Medicare. Medicare does not recognize 97127. 97127 is an untimed code that is accepted by many commercial carriers. These codes will be replaced in 2020 by 97129 and 97130.

The Adaptive Behavior codes you mentioned are meant for use for ABA treatments as they specifically reference the use of a technician. There are Health Behavior Assessment and Intervention codes, but at this time I am not aware of an insurance company that is paying these codes to an occupational therapist.

Some additional direction can be found in our Practice Guidelines, such as the Practice Guidelines for Adults with Serious Mental Illness.

Please let me know if you have any other questions.

Thanks,
Monica

References

Abreu, B. C. (2011). Eleanor Clarke Slagle lecture. accentuate the positive: reflections on empathic interpersonal interactions. *American Journal of Occupational Therapy*, *65*(6), 623–634. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=104599018&site=ehost-live

Alejandro, S. (2018). The relationship between occupational therapy and mental health. Retrieved from https://www.rehabalternatives.com/2018/02/01/occupational-therapists-addressing-mental-health-in-physical-rehabilitation/.

Allen, P., & Kelly, A. (2014). The missing link: The connection between physical and mental health. Retrieved from https://www.benefitscanada.com/benefits/health-wellness/the-missing-link-49009.

American Occupational Therapy Association. (n.d.-a). Cultural competency tool kits. Retrieved from https://www.aota.org/Practice/Manage/Multicultural/Cultural-Competency-Tool-Kit.aspx

American Occupational Therapy Association. (n.d.-b). Improve your documentation with AOTA's occupational profile template. Retrieved from https://www.aota.org/Practice/Manage/Reimb/occupational-profile-document-value-ot.aspx

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd Edition). *American Journal of Occupational Therapy,* 68 S1-S48. doi: 10.5014/ajot.2014.682006.

American Occupational Therapy Association. (2015). Occupational therapy code of ethics. *American Journal of Occupational Therapy, 69*(Suppl. 3), 6913410030. http://dx.doi.org/10.5014/ajot.2015.696S03

American Occupational Therapy Association. (2016a). Balancing patient rights and practitioner values [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Balancing-Patient-Rights.pdf

American Occupational Therapy Association (2016b). Mental health promotion, prevention, and intervention: across the lifespan [PDF file]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/MentalHealth/Distinct-Value-Mental-Health.pdf

American Occupational Therapy Association. (2016c). Outdated and obsolete tests and assessment instruments [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Outdated-and-Obsolete-Assessment-Instruments.pdf

American Occupational Therapy Association. (2016d). Role of occupational therapy ethics rounds in practice [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Role-of-Occupational-Therapy-Ethics-Rounds-in-Practice.pdf

American Occupational Therapy Association. (2016e). Social justice and meeting the needs of clients [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Social-Justice-Meeting-Client-Needs.pdf

American Occupational Therapy Association (2017). Mental health promotion, prevention, and intervention in occupational therapy practice. *American Journal of Occupational Therapy, 71*(Suppl. 2), 7112410035. https://doi. org/10.5014/ajot.2017.716S03

American Occupational Therapy Association. (2018). Cultural competence and ethical practice [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/AOTA-CulturalCompetenceAdvisory-Author-correction-5-2-18.pdf

American Occupational Therapy Association. (2019*).* Ethical considerations for productivity, billing, and reimbursement [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/reimbursement-productivity.pdf

American Occupational Therapy Association. (2019). Ethical issues related to payment for service delivery [Advisory opinion]. Retrieved from

https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Ethical-Issues-Concerning-Payment-for-Services.pdf

American Speech-Language-Hearing Association. (2020). Self-assessment for cultural competence. Retrieved from https://www.asha.org/practice/multicultural/self/.

Anderson, S., & Malina, A. (2020, February 9). Cultural competency commercial videos or documentaries [Web log post]. Retrieved from https://docs.google.com/document/d/13Rz2aQ03YdEqlq9l8OnBjR0IVaH6gkDK43r8nzfdnTs/edit?usp=sharing

Asher, I. (2014). *Asher's occupational therapy assessment tools: An annotated index* (4th ed.). Bethesda, MD: American Occupational Therapy Association, Inc.

Assess Health Careers Canada. (n.d.). Part 5 - case scenarios. Retrieved from https://assesshealthcareers.ca/occupational-therapists/part-5-case-scenarios/

Bancroft, M. (n.d.). A listing of cultural competence assessment tools [Word Document]. Retrieved from http://mighealth.net/eu/images/0/0b/Banc.doc

Beck, A.T. (n.d.). *Beck Anxiety Inventory*. Retrieved from https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-&-Biopsychosocial/Beck-Anxiety-Inventory/p/100000251.html

Björklund, A., Svensson, T., & Read, S. (2006). Holistic and biomedical concepts of health: A study of health notions among Swedish occupational therapists and a suggestion for developing an instrument for comparative studies. *Scandinavian Journal of Occupational Therapy,13*(3), 141-150. doi:10.1080/11038120500527923

Bresi-Ando, J. (2017, March 16). Case study: Neurological rehabilitation [Web log post]. Retrieved from https://www.theotpractice.co.uk/news/our-experts-blog/case-study-neurological-rehabilitation

Carver. (n.d.). Measurement instrument database for the social sciences. Retrieved from https://www.midss.org/content/cope-inventory

Chamberlain, M. (Producer). (2018, June 28). OT's role in mental health and depression in a physical disability setting [Audio podcast]. Retrieved from https://seniorsflourish.com/otmentalhealth/

Chandler, M. (n.d.). Occupational therapy in mental health: An overview of 6 typical settings [Web log post]. Retrieved from https://www.myotspot.com/occupational-therapy-in-mental-health/

Chris. (2017, March 26). Psychological approaches in physical disability settings [Web log post]. Retrieved from https://thepracticaloccupationaltherapist.wordpress.com/2017/03/26/psychological-approaches-in-physical-disability-settings/

Christian, K. (2018, February 1). 11 globally-focused documentaries that expand our horizons & educate us about the world [Web log post]. Retrieved from https://www.thegoodtrade.com/features/must-see-global-documentaries

Christiansen, C. H., & Haertl, K. (2014). A contextual history of occupational therapy. In B. A. B. Schell, G., Gillen, & Scaffa, M. (Eds.), *Willard and Spackman's occupational therapy* (12th ed., pp. 9-34). Philadelphia: Lippincott Williams & Wilkins.

Cole, M. B., & Tufano, R. (2008). Occupational therapy's broadening horizons. In *Applied theories in occupational therapy a practical approach* (pp. 3–21). Thorofare, NJ: SLACK Incorporated.

Dehn-Hindenberg A. (2007). The importance of communication and empathy in the therapy process: The needs of patients in occupational therapy. *Ergotherapie & Rehabilitation*, *46*(7), 5–10. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=106162721&site=ehost-live

Doherty, R. (2014). Ethical practice. In *Willard & Spackman Occupational Therapy* (12th ed., pp. 413–424). Baltimore, MD: Lippincott Williams & Wilkins.

Drolet, M.-J. (2018). Empowering occupational therapists and colleagues in overcoming moral distress. *Occupational Therapy Now*, *20*(3), 15–17. Retrieved from

http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=129606581&site=ehost-live&custid=s9002706

Dunton, W. R. (1918). The principles of occupational therapy. *Public Health Nurse*, *10*(8), 316–321. Retrieved from https://archive.org/details/publichealthnurs108nati

Finding the correct meaning of “holistic” [Web log post]. (2009, March 18). Retrieved from https://meaningfuloccupation.wordpress.com/2009/03/18/finding-the-correct-meaning-of-holistic/

Finlay, L. (2001). Holism in occupational therapy: Elusive fiction and ambivalent struggle. *American Journal of Occupational Therapy,55*(3), 268-276. doi:10.5014/ajot.55.3.268

Folkman, S., & Lazarus, R. S. (n.d.). *Ways of Coping Questionnaire*. Retrieved from https://www.mindgarden.com/158-ways-of-coping-questionnaire#horizontalTab1

Free Management Library. (2020, February 2). Various self-assessments for personal and professional development [Web log post]. Retrieved from https://managementhelp.org/personaldevelopment/self-assessments.htm

Goodreads. (2020, February 9). Books that explore cultural differences [Web log post]. Retrieved from https://www.goodreads.com/list/show/113510.Books_that_Explore_Cultural_Differences

Goodreads. (2020, February 8). Culture [Web log post]. Retrieved from https://www.goodreads.com/list/show/144668.Culture_

Goodreads. (2020, February 9). Culture published in decade: 1990s [Web log post]. Retrieved from https://www.goodreads.com/list/show/138779.Culture_Published_in_Decade_1990s

Goodreads. (2020, February 9). Culture published in decade: 2000s [Web log post]. Retrieved from https://www.goodreads.com/list/show/130930.Culture_Published_in_Decade_2000s

Goodreads. (2020, February 9). Culture published in decade: 2010s [Web log post]. Retrieved from https://www.goodreads.com/list/show/126028.Culture_Published_in_Decade_2010s

Goodreads. (2020, February 9). Diversity, equity, inclusion, and culture [Web log post]. Retrieved from https://www.goodreads.com/list/show/120321.Diversity_Equity_Inclusion_and_Culture

Goodreads. (2020, February 9). Nonfiction on religion and religious belief [Web log post]. Retrieved from https://www.goodreads.com/list/show/115223.Nonfiction_on_Religion_and_Religious_Belief

Goodreads. (2020, February 9). Popular culture books [Web log post]. Retrieved from https://www.goodreads.com/shelf/show/culture

Goodreads. (2020, February 9). Social justice: books about class education [Web log post]. Retrieved from https://www.goodreads.com/list/show/42336.Social_Justice_Books_About_Class_and_Education

Illinois State Bar Association. (n.d.). Teaching diversity with film [PDF file]. Retrieved from https://www.isba.org/sites/default/files/teachers/teachingdiversitywithfilm.pdf

Kanny, E (1993). Core values and attitudes of occupational therapy practice. *The American Journal of Occupational Therapy 47*(12).1085-1086. https://doi.org/10.5014/ajot.47.12.1085

Kearney, P. (2004). The influence of competing paradigms on occupational therapy education: A brief history. Retrieved from https://www.newfoundations.com/History/OccTher.html

Kristenpnnr23. (n.d.). AOTA standards of practice for occupational therapy. [Web log post]. Retrieved from https://quizlet.com/329592031/aota-standards-of-practice-for-occupationaltherapy-flash-cards/

Kielhofner, G. (2004). *Conceptual foundations of occupational therapy* (3rd ed.). Philadelphia: FA Davis.

Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy revised and updated*. New York, NY: Cambridge, The Adult Education Company.

LitCharts. (n.d.). Mood. Retrieved from https://www.litcharts.com/literary-devices-and-terms/mood

Lloyd-Randolfi, D. (2018). The new grad's guide to occupational therapy cpt codes. Retrieved from https://covalentcareers.com/resources/occupational-therapy-cpt-codes/.

Mayo Clinic. (2019, April 4). Stress symptoms: Effects on your body and behavior. Retrieved from https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress-symptoms/art-20050987

McColl, M. A. (1994). Holistic occupational therapy: Historical meaning and contemporary implications. *Canadian Journal of Occupational Therapy,61*(2), 72-77. doi:10.1177/000841749406100202

Medical Billing and Coding - Procedure code, ICD CODE. (n.d.). CPT code 97532, 97535, 97520, 97533. Retrieved from http://www.whatismedicalinsurancebilling.org/2016/09/cpt-code-97532-97535-97520-97533.html.

Melanie_parker7. (n.d.). NBCOT standards of practice [Web log post]. Retrieved from https://quizlet.com/181931721/nbcot-standards-of-practice-flash-cards/

MinorityHealth. (n.d.). Culturally and linguistically appropriate services. Retrieved from https://thinkculturalhealth.hhs.gov/clas

Moos, R. H. (n.d.). Coping Response Inventory: CRI. Retrieved from https://www.parinc.com/Products/Pkey/69

Moorey, S. & Greer, S. (n.d.). Cancer Coping Questionnaire (21-item version) - oxford clinical psychology. Retrieved from https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199605804.001.0001/med-9780199605804-appendix-006

Moyers, P (2010). Competence and professional development. In Sladyk, K., Jacobs, K., & MacRae, N. (Eds.), *Occupational therapy essentials for clinical competence* (pp.476-484). Thorofare, NJ: SLACK Incorporated.

Muir, S. (2012). Occupational therapy in primary health care, we should be there. *American Journal of Occupational Therapy. 66(*5). 506-510

Nagel, A. (2019, May 20). Words and phrases to document skilled intervention and professional judgement *[*List of words and phrases to document skilled intervention and professional judgement]. Copy in possession of Ashley Malina.

National Board for Certification in Occupational Therapy [NBCOT]. (n.d.). Certification Renewal. Retrieved from https://www.nbcot.org/Certificants/Certification.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant general practice self-assessment. Retrieved from https://secure.nbcot.org/selfassess/default7.aspx?testid=7.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant older adult practice area. Retrieved from https://secure.nbcot.org/selfassess/default2.aspx?testid=2.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant orthopedic practice area. Retrieved from https://secure.nbcot.org/selfassess/default3.aspx?testid=3.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant physical disability practice area. Retrieved from https://secure.nbcot.org/selfassess/default4.aspx?testid=4.

National Board for Certification in Occupational Therapy. (n.d.). Self-assessment. Retrieved from https://www.nbcot.org/en/Students/Study-Tools/Self-Assessments.

National Association of Social Workers. (2015). Standards and indicators for cultural competence in social work practice [Brochure]. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=PonPTDEBrn4%3D&portalid=0

Nowack, K. M. (n.d.). The Stress Profile™. Retrieved from https://www.wpspublish.com/the-stress-profile

Office of Minority Health. (n.d.). Retrieved from https://minorityhealth.hhs.gov/

Ontario Council of Agencies Serving Immigrants. (n.d.). *Cultural Competence Self-Assessment Checklist* [PDF file]. Retrieved from http://rapworkers.com/wp-content/uploads/2017/08/cultural-competence-selfassessment-checklist-1.pdf

Penny, N.H., Ewing, T.L., Hamid, R.C., Shutt, K.A., & Walter, A.S. (2014). An investigation of moral distress experienced by occupational therapists. *Occupational Therapy in Health Care, 28*(4), 382-393. doi: 10.3109/07380577.2014.933380

Quizlet Inc. (n.d.). Quizlet. Retrieved January 19, 2020, from https://quizlet.com/mission

Reed, K. (2006). Occupational therapy values and beliefs the formative years: 1904-1929. *OT Practice*, 21-25.

Reed, K., & Peters, C. (2006). Occupational therapy values and beliefs, part II: The great depression and war years: 1930-1949. *OT Practice,* 17-22.

Reynolds, W. M., & Kobak, K. A. (n.d.). Reynolds Depression Screening Inventory: RDSI. Retrieved from https://www.parinc.com/Products/Pkey/358

Roell, C. (2010). Intercultural training with films [PDF file]. Retrieved from https://americanenglish.state.gov/files/ae/resource_files/48_2-etf-intercultural-training-with-films.pdf

Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2016). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review, 1–19.* https://doi.org/10.1177/1077558716666981

Sames, K. M. (2015). Documenting occupational therapy practice (3rd ed.). Boston, MA: Pearson.

Schkade, J. K., & Schultz, S. (1992). Occupational adaptation: Toward a holistic approach for contemporary practice, part 1. *American Journal of Occupational Therapy,46*(9), 829-837. doi:10.5014/ajot.46.9.829

Schwarzer, R., & Jerusalem, M. (n.d.). *The General Self-Efficacy Scale (GSE)*. Retrieved from http://userpage.fu-berlin.de/~health/engscal.htm

Simmons, K., Guberman, E., & Aranha, K. (2018). A qualitative pilot study exploring the benefits of using the occupational profile template for novice clinicians. *American Journal of Occupational Therapy 72*(4_Supplement_1):7211505141. https://doi.org/10.5014/ajot.2018.72S1-PO6048

Slater D, & Brandt L. (2009). Combating moral distress. *OT Practice, 14(*2), 13–18. Retrieved from http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=105252524&site=ehost-live&custid=s9002706

Sharma, K. A. & Clark, A. J. (2018). Empathy matters: The importance of imagination in occupational therapy. *American Occupational Therapy Association (7).*18–20.

Smith, M. K. (1999). 'Andragogy', the encyclopedia of informal education. Retrieved from: http://www.infed.org/lifelonglearning/b-andra.htm.

Sobel, A (2020, January 27) Eight ways to improve your empathy. [Web log post]. Retrieved from: https://andrewsobel.com/eight-ways-to-improve-your-empathy

Spence, B. (2019, June 7). The role of empathy in occupational therapy [Web log post]. Retrieved from http://info.staffingplus.com/the-role-of-empathy-in-occupational-therapy

Stoffel, V. C., Reed, K. L., & Brown, C. (2019). The unfolding history of occupational therapy in mental health. In Brown, C., Stoffel, V. C., & Munoz, J. P. (Eds.), *Occupational therapy in mental health* (2nd ed., pp. 14-27). Philadelphia: F.A. Davis Company.

Taylor, R. R. (2008). *The intentional relationship – Occupational therapy and use of self*. Philadelphia, PA: FA Davis Company

Terry, M., & Westcott, L. (2012). Are occupational therapists in acute general hospitals addressing psychological wellbeing? *British Journal of Occupational Therapy, 75*(6), 296-298. doi:10.4276/030802212X13383757345265

The OT Practice Experts in Therapy. (2019, February 8). Articles about case study. Retrieved from https://www.theotpractice.co.uk/news/tags/case-study

The Willows at Ramapo Rehabilitation & Nursing Center. (2016). Case study: Ramapo center for rehabilitation and nursing (July 2016). Retrieved from http://thewillowsrehab.com/case-study-ramapo-center-rehabilitation-nursing-july-2016/

Thinkmap, Inc. (2014, November 14). Get into the mood with 100 feeling words. Retrieved from https://www.vocabulary.com/articles/wl/get-into-the-mood-with-100-feeling-words/

Trautmann Boop, C. (2014). Table of assessments: Listed alphabetically by title. In *Willard & Spackman's Occupational Therapy* (12th ed., pp. 1190–1228). Baltimore, MD: Lippincott Williams & Wilkins.

Townsend, E. (1998). Reflections on... Occupational therapy language: Matters of respect, accountability and leadership. *Canadian Journal of Occupational Therapy, 65*(1), 45–50. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=107276786&site=ehost-live

Tully, S. (2019). Psychosocial concerns with physical disabilities. In Brown, C., Stoffel, V. C., & Munoz, J. P. (Eds.), *Occupational therapy in mental health* (2nd ed., pp. 264-280). Philadelphia: F.A. Davis Company.

U.S. Department of Education, Office of Vocational and Adult Education. (2011). *Just write! Guide*. Washington, DC: Corley, M.

Western Health Sciences, School of Occupational Therapy. (n.d.). Case scenario 12 - mr. bob white. Retrieved from http://publish.uwo.ca/~shobson/scenario12.html

White, S. (2020, February 9). 12 documentaries that explore different cultures [Web log post]. Retrieved from: https://theculturetrip.com/asia/articles/top-12-documentaries-that-will-open-your-mind-to-other-cultures/

Words that describe behavior [PDF file]. (n.d.). Retrieved from https://mrafisher.weebly.com/uploads/1/5/7/7/15778366/describe_words-_behavior__personality.pdf

YourDictionary. (2018, September 29). List of words that describe behavior. Retrieved from https://grammar.yourdictionary.com/word-lists/list-of-words-that-describe-behavior.html

Yuill, A. (2019, April 1). Mental and physical health: Why they go hand in hand [Web log post]. Retrieved from https://www.theotpractice.co.uk/news/our-experts-blog/mental-health-and-physical-disability-why-they-go-hand-in-hand

Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B., & Taleghani, F. (2015). Effective factors in providing holistic care: A qualitative study. *Indian Journal of Palliative Care*, *21*(2), 214–224. https://doi-org.ezproxylr.med.und.edu/10.4103/0973-1075.156506

CHAPTER V

Summary

Providing holistic care in the physical disability setting can be achieved by improving the therapist's competence and comfort level by addressing mental health and wellness in their practice. In summary, the purpose of the guide is to provide evidence-based, current information to practitioners to increase their knowledge and application of holistic practice. The guide gives therapists information and time to reflect on competency, evaluation, and documentation. Our primary focus is on the practice areas of occupational therapists in physical disabilities setting. The guide was created to increase the competency of occupational therapists in holistic care and provide therapists with applicable information to be used within their practice.

Strengths

There are several strengths to this product:

1. The guide has at least one activity per topic and has an area after each activity with reflection questions relating to the topic.
2. The reflection questions give the therapists the chance to think over the activity and how the activity and information given will impact their practice.
3. The guide provides information containing evidence-based terminology and assessments that can be used for reimbursement for evaluation and documentation.

4. There is a section on culture. The culture section gives the therapist resources to materials which they can use to increase their knowledge and understanding of those they see in practice.
5. The guide contains a self-measured outcome chart for therapists to fill out after they have reviewed the guide in its entirety. Therapists are encouraged to share their perspectives and answers with the authors for further adaptations of this guide.

Limitations

1. There was limited research available for this particular topic and subtopics. The authors utilized many databases, textbooks, and the world wide web to find information on the topics in this project.
2. The authors found that finding usable billing terms, definitions, and processes to bill mental health and wellness within the physical disability setting was a challenge. The authors of this project reached out to AOTA for assistance in their search. The email exchange is in Appendix D as a reference in support of the billing section of the product.
3. Physical disability settings continue to use differing terminology for billing terms and there is not a standard definition for the term holistic care.

Recommendations

1. It would be helpful to know what information was most beneficial and how the product could be adapted to make it more applicable. After receiving some guidance from therapists in the field, we are hoping to be able to adapt the guide to be more applicable. As the guide becomes updated with therapists' input, we

hope that there can be a paper published within Occupational Therapy Practice to share our findings and the guide. This information would be collected by using the outcome measure to obtain the effectiveness of the guide, which can be found in Appendix A.

2. A potential roadblock could include finding occupational therapists who are willing to take time to go through the guide and implement the areas into their practice. To overcome this potential roadblock, the authors will reach out to the occupational therapy department to find available therapists to use the guide and evaluate.
3. Adding additional assessments that are already used within different setting placements.
4. Reach out to more therapists within the physical disability setting throughout the creation process to obtain additional guidance.
5. Add more on the impact of the culture on mental health and how to be more culturally competent.
6. Add a section on context and environment and how it impacts how the therapist addresses their clients holistically.

REFERENCES

Abreu, B. C. (2011). Eleanor Clarke Slagle lecture. Accentuate the positive: Reflections on empathic interpersonal interactions. *American Journal of Occupational Therapy, 65*(6), 623–634. Retrieved from http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=104599018&site=ehost-live&custid=s9002706

Alejandro, S. (2018). The relationship between occupational therapy and mental health. Retrieved from https://www.rehabalternatives.com/2018/02/01/occupational-therapists-addressing-mental-health-in-physical-rehabilitation/

Allen, P., & Kelly, A. (2014, May 8). The missing link: The connection between physical and mental health [Web log post]. Retrieved from https://www.benefitscanada.com/benefits/health-wellness/the-missing-link-49009

American Addiction Centers (Ed.). (2019, October 1). The potential dangers of untreated mental health disorders [Web log post]. Retrieved from https://deserthopetreatment.com/co-occurring-disorders/going-untreated/

American Occupational Therapy Association. (n.d.-a). About occupational therapy. Retrieved from https://www.aota.org/About-Occupational-Therapy.aspx

American Occupational Therapy Association. (n.d.-b). Cultural competency tool kits. Retrieved from https://www.aota.org/Practice/Manage/Multicultural/Cultural-Competency-Tool-Kit.aspx

American Occupational Therapy Association. (n.d.-c). Improve your documentation with AOTA's occupational profile template. Retrieved from https://www.aota.org/Practice/Manage/Reimb/occupational-profile-document-value-ot.aspx

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain & process 3rd edition. *American Journal of Occupational Therapy, 68* (Supplement.1), S1-S48. doi: 10.5014/ajot.2014.682006

American Occupational Therapy Association. (2015). Occupational therapy code of ethics. *American Journal of Occupational Therapy, 69*(Suppl. 3), 6913410030. http://dx.doi.org/10.5014/ajot.2015.696S03

American Occupational Therapy Association. (2016a). Balancing patient rights and practitioner values [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Balancing-Patient-Rights.pdf

American Occupational Therapy Association. (2016b). Mental health promotion, prevention, and intervention: Across the lifespan [PDF file]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/MentalHealth/Distinct-Value-Mental-Health.pdf

American Occupational Therapy Association. (2016f). New occupational therapy evaluation coding overview [PDF file]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Advocacy/Federal/Evaluation-Codes-Overview-2016.pdf

American Occupational Therapy Association. (2016g). Occupational therapy's role in mental health recovery [PDF file]. Retrieved from https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/MH/Facts/Mental%20Health%20Recovery.pdf

American Occupational Therapy Association. (2016c). Outdated and obsolete tests and assessment instruments [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Outdated-and-Obsolete-Assessment-Instruments.pdf

American Occupational Therapy Association. (2016d). Role of occupational therapy ethics rounds in practice [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Role-of-Occupational-Therapy-Ethics-Rounds-in-Practice.pdf

American Occupational Therapy Association. (2016e). Social justice and meeting the needs of clients [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Social-Justice-Meeting-Client-Needs.pdf

American Occupational Therapy Association. (2017). Mental health promotion, prevention, and intervention in occupational therapy practice. *American Journal of Occupational Therapy, 71*(Suppl. 2), 7112410035. https://doi. Org/10.5014/ajot.2017.716S03

American Occupational Therapy Association. (2018a). Cultural competence and ethical practice [Advisory opinion]. Retrieved from

https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/AOTA-CulturalCompetenceAdvisory-Author-correction-5-2-18.pdf

American Occupational Therapy Association. (2018b). Physical agent and mechanical modalities. *American Journal of Occupational Therapy, 72*(Suppl. 2), 7212410055. https://doi.org/10.5014/ajot.2018.72S220

American Occupational Therapy Association. (2019a). Ethical considerations for productivity, billing, and reimbursement [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/reimbursement-productivity.pdf

American Occupational Therapy Association. (2019b*).* Ethical issues related to payment for service delivery [Advisory opinion]. Retrieved from https://www.aota.org/~/media/Corporate/Files/Practice/Ethics/Advisory/Ethical-Issues-Concerning-Payment-for-Services.pdf

American Speech-Language-Hearing Association (2020) *Self-assessment for cultural competence.* Retrieved from https://www.asha.org/practice/multicultural/self/

Anderson, S., & Malina, A. (2020, February 9). Cultural competency commercial videos or documentaries [Web log post]. Retrieved from https://docs.google.com/document/d/13Rz2aQ03YdEqlq9l8OnBjR0IVaH6gkDK43r8nzfdnTs/edit?usp=sharing

Asher, I. (2014). Asher's occupational therapy assessment tools: An annotated index (4th ed.). Bethesda, MD: American Occupational Therapy Association, Inc.

Assess Health Careers Canada. (n.d.). Part 5-case scenarios. Retrieved from https://assesshealthcareers.ca/occupational-therapists/part-5-case-scenarios/

Bancroft, M. (n.d.). A listing of cultural competence assessment tools [Word Document]. Retrieved from http://mighealth.net/eu/images/0/0b/Banc.doc

Beck, A.T. (n.d.). *Beck Anxiety Inventory*. Retrieved from https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-&-Biopsychosocial/Beck-Anxiety-Inventory/p/100000251.html

Bresi-Ando, J. (2017, March 16). Case study: Neurological rehabilitation [Web log post]. Retrieved from http://www.theotpractice.co.uk/news/our-experts-blog/case-study-neurological-rehabilitation

Brown, C. & Carroll, J. (2016). Use of assessments in occupational therapy physical disability settings. *Occupational Therapy Capstones*, 31. Retrieved from https://commons.und.edu/ot-grad/31

Björklund, A., Svensson, T., & Read, S. (2006). Holistic and biomedical concepts of health: A study of health notions among Swedish occupational therapists and a suggestion for developing an instrument for comparative studies. *Scandinavian Journal of Occupational Therapy,13*(3), 141-150. doi:10.1080/11038120500527923

Centers for Disease Control and Prevention. (2020). About chronic diseases. Retrieved from https://www.cdc.gov/chronicdisease/about/index.htm

Centers for Disease Control and Prevention. (2018). Mental health: Learning about mental health. Retrieved from https://www.cdc.gov/mentalhealth/learn/index.htm

Carver. (n.d.). Measurement Instrument Database for the Social Sciences. Retrieved from https://www.midss.org/content/cope-inventory

Chamberlain, M. (Producer). (2018, June 28). OT's role in mental health and depression in a physical disability [Audio podcast]. Retrieved from http://seniorsflourish.com/otmentalhealth/

Chandler, M. (n.d.). Occupational therapy in mental health: An overview of 6 typical settings [Web log post]. Retrieved from https://www.myotspot.com/occupational-therapy-in-mental-health/

Chris. (2017, March 26). Psychological approaches in physical disability settings [Web log post]. Retrieved from https://thepracticaloccupationaltherapist.wordpress.com/2017/03/26/psychological-approaches-in-physical-disability-settings/

Christian, K. (2018, February 1). 11 globally-focused documentaries that expand our horizons & educate us about the world [Web log post]. Retrieved February 8, 2020, from https://www.thegoodtrade.com/features/must-see-global-documentaries

Christiansen, C. H., & Haertl, K. (2014). A contextual history of occupational therapy. In B. A. B. Schell, G., Gillen, & M. E. Scaffa (Eds.), *Willard and Spackman's occupational therapy* (12th ed., pp. 9-34). Philadelphia: Lippincott Williams & Wilkins.

Cole, M. B., & Tufano, R. (2008). Occupational therapy's broadening horizons. In *Applied theories in occupational therapy a practical approach* (pp. 3–21). Thorofare, NJ: SLACK Incorporated.

Colman, W. (1990). Evolving education practices in occupational therapy: The war emergency courses, 1936-1954. *American Journal of Occupational Therapy, 44*(11), 1028-1036. https://doi.org/10.5014/ajot.44.11.1028

Dehn-Hindenberg A. (2007). The importance of communication and empathy in the therapy process: The needs of patients in occupational therapy. *Ergotherapie & Rehabilitation, 46*(7), 5–10.

Doherty, R. (2014). Ethical practice. In *Willard & Spackman occupational therapy* (12th ed., pp. 413–424). Baltimore, MD: Lippincott Williams & Wilkins.

Drolet, M. J. (2018). Empowering occupational therapists and colleagues in overcoming moral distress. *Occupational Therapy Now, 20*(3), 15–17. Retrieved from http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=129606581&site=ehost-live&custid=s9002706

Dunton, W. R. (1918). The principles of occupational therapy. *Public Health Nurse, 10*(8), 316–321. Retrieved from https://archive.org/details/publichealthnurs108nati

Finding the correct meaning of "holistic". (2009, March 18). Retrieved from https://meaningfuloccupation.wordpress.com/2009/03/18/finding-the-correct-meaning-of-holistic/

Finlay, L. (2001). Holism in occupational therapy: Elusive fiction and ambivalent struggle. *American Journal of Occupational Therapy, 55*(3), 268-276. doi:10.5014/ajot.55.3.268

Free Management Library. (2020, February 2). Various self-assessment for personal and professional development [Web log post]. Retrieved from https://managementhelp.org/personaldevelopment/self-assessments.htm

Folkman, S., & Lazarus, R. S. (n.d.). *Ways of Coping Questionnaire.* Retrieved from https://www.mindgarden.com/158-ways-of-coping-questionnaire#horizontalTab1

Gillette, N. & Kielhofner, G. (1979). The impact of specialization on the professionalization and survival of occupational therapy. *American Journal of Occupational Therapy*, *33*, 20-28.

Goodreads. (2020, February 9). Books that explore cultural differences [Web log post]. Retrieved from https://www.goodreads.com/list/show/113510.Books_that_Explore_Cultural_Differences

Goodreads. (2020, February 8). Culture [Web log post]. Retrieved from https://www.goodreads.com/list/show/144668.Culture_

Goodreads. (2020, February 9). Culture published in decade: 1990s [Web log post]. Retrieved from https://www.goodreads.com/list/show/138779.Culture_Published_in_Decade_1990s

Goodreads. (2020, February 9). Culture published in decade: 2000s [Web log post]. Retrieved from https://www.goodreads.com/list/show/130930.Culture_Published_in_Decade_2000s

Goodreads. (2020, February 9). Culture published in decade: 2010s [Web log post]. Retrieved from https://www.goodreads.com/list/show/126028.Culture_Published_in_Decade_2010s

Goodreads. (2020, February 9). Diversity, equity, inclusion, and culture [Web log post]. Retrieved from

https://www.goodreads.com/list/show/120321.Diversity_Equity_Inclusion_and_Culture

Goodreads. (2020, February 9). *Nonfiction on religion and religious belief* [Web log post]. Retrieved from https://www.goodreads.com/list/show/115223.Nonfiction_on_Religion_and_Religious_Belief

Goodreads. (2020, February 9). *Popular culture books* [Web log post]. Retrieved from https://www.goodreads.com/shelf/show/culture

Goodreads. (2020, February 9). Social justice: Books about class education [Web log post]. Retrieved from https://www.goodreads.com/list/show/42336.Social_Justice_Books_About_Class_and_Education

Illinois State Bar Association. (n.d.). Teaching diversity with film [PDF file]. Retrieved from https://www.isba.org/sites/default/files/teachers/teachingdiversitywithfilm.pdf

Kanny, E (1993). Core values and attitudes of occupational therapy practice. *The American Journal of Occupational Therapy 47*(12).1085-1086. https://doi.org/10.5014/ajot.47.12.1085

Kearney, P. (2004). The influence of competing paradigms on occupational therapy education: A brief history. Retrieved from https://www.newfoundations.com/History/OccTher.html

Kielhofner, G. (2004). *Conceptual foundations of occupational therapy* (3rd ed.). Philadelphia: FA Davis.

Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy revised and updated*. New York, NY: Cambridge, The Adult Education Company.

Kristenpnnr23. (n.d.). AOTA standards of practice for occupational therapy [Web log post]. Retrieved from https://quizlet.com/329592031/aota-standards-of-practice-for-occupationaltherapy-flash-cards/

LitCharts. (n.d.). Mood. Retrieved from https://www.litcharts.com/literary-devices-and-terms/mood

Lloyd-Randolfi, D. (2018). The new grad's guide to occupational therapy cpt codes [Web log post]. Retrieved October 27, 2019, from https://covalentcareers.com/resources/occupational-therapy-cpt-codes/

Mariano, C., Metzler, C., & McGuire, M. J. (2018). More to celebrate: New evaluation codes recognize OT clinical decision making; now it's up to you! [Web blog post]. Retrieved from https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/News/2018/New-Evaluation-Codes-Recognize-OT-Clinical-Decision-Making.aspx

Mayo Clinic. (2019, April 4). Stress symptoms: Effects on your body and behavior. Retrieved from https://www.mayoclinic.org/healthy-lifestyle/stress- management/in-depth/stress-symptoms/art-20050987

McColl, M. A. (1994). Holistic occupational therapy: Historical meaning and contemporary implications. *Canadian Journal of Occupational Therapy,61*(2), 72-77. doi:10.1177/000841749406100202

Medical Billing and Coding - Procedure code, ICD CODE. (n.d.). CPT code 97532, 97535, 97520, 97533. Retrieved from http://www.whatismedicalinsurancebilling.org/2016/09/cpt-code-97532-97535-97520-97533.html

Melanie_parker7. (n.d.). NBCOT standards of practice [Web log post]. Retrieved from https://quizlet.com/181931721/nbcot-standards-of-practice-flash-cards/

MinorityHealth. (n.d.). Culturally and linguistically appropriate services. Retrieved from https://thinkculturalhealth.hhs.gov/clas

Moorey, S. & Greer, S. (n.d.). *Cancer Coping Questionnaire* (21-item version) - Oxford Clinical Psychology. Retrieved from https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199605804.001.0001/med-9780199605804-appendix-006

Moos, R. H. (n.d.). *Coping Response Inventory: CRI*. Retrieved from https://www.parinc.com/Products/Pkey/69

Moyers, P (2010). Competence and professional development. In Sladyk, K., Jacobs, K., & MacRae, N. (Eds.), *Occupational therapy essentials for clinical competence* (pp.476-484). Thorofare, NJ: SLACK Incorporated

Muir, S. (2012). Occupational therapy in primary health care: We should be there. *American Journal of Occupational Therapy*, *66*(5), 506–510. doi: 10.5014/ajot.2012.665001

Nagel, A. (2019, May 20). Words and phrases to document skilled intervention and professional judgement *[*List of words and phrases to document skilled intervention and professional judgement]. Copy in possession of Ashley Malina.

National Board for Certification in Occupational Therapy. (n.d.). National Board for Certification in Occupational Therapy. Retrieved from https://www.nbcot.org/en/Certificants/Certification#Self-Assessments

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant older adult practice area. Retrieved from https://secure.nbcot.org/selfassess/default2.aspx?testid=2.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant orthopedic practice area. Retrieved from https://secure.nbcot.org/selfassess/default3.aspx?testid=3.

National Board for Certification in Occupational Therapy. (n.d.). Occupational therapist registered OTR® domain, task, and skill statements for the OTR® certificant physical disability practice area. Retrieved from https://secure.nbcot.org/selfassess/default4.aspx?testid=4.

National Board for Certification in Occupational Therapy. (n.d.). Self-assessment. Retrieved from https://www.nbcot.org/en/Students/Study-Tools/Self-Assessments

National Association of Social Workers. (2015). Standards and indicators for cultural competence in social work practice [Brochure]. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=PonPTDEBrn4%3D&portalid=0

Nowack, K. M. (n.d.). *The Stress Profile™*. Retrieved from https://www.wpspublish.com/the-stress-profile

Office of Minority Health. (n.d.). Retrieved from https://minorityhealth.hhs.gov/

Ontario Council of Agencies Serving Immigrants. (n.d.). *Cultural Competence Self-Assessment Checklist* [PDF file]. Retrieved from http://rapworkers.com/wp-content/uploads/2017/08/cultural-competence-selfassessment-checklist-1.pdf

Penny, N. H., Bires, S. J., Bonn, E. A., Dockery, A. N., & Pettit, N. L. (2016). Moral distress scale for occupational therapists: Part 1. instrument development and content validity. *American Journal of Occupational Therapy*, 70(4), p1–p8. https://doi.org/10.5014/ajot.2015.018358

Penny, N.H., Ewing, T.L., Hamid, R.C., Shutt, K.A., & Walter, A.S. (2014). An investigation of moral distress experienced by occupational therapists. *Occupational Therapy in Health Care, 28*(4), 382-393. doi: 10.3109/07380577.2014.933380

Quizlet Inc. (n.d.). Quizlet. Retrieved January 19, 2020, from https://quizlet.com/mission

Reed, K. (2006). Occupational therapy values and beliefs the formative years: 1904-1929. *OT Practice, 11*(7), 21–25.

Reed, K., & Peters, C. (2006). Occupational therapy values and beliefs, part II: The great depression and war years: 1930-1949. *OT Practice, 11*(18), 17-22.

Reynolds, W. M., & Kobak, K. A. (n.d.). *Reynolds Depression Screening Inventory: RDSI*. Retrieved from https://www.parinc.com/Products/Pkey/358

Roell, C. (2010). Intercultural training with films [PDF file]. Retrieved from https://americanenglish.state.gov/files/ae/resource_files/48_2-etf-intercultural-training-with-films.pdf

Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2016). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review, 74*(6), 668–686. doi: 10.1177/1077558716666981

Sames, K. M. (2015). Documenting occupational therapy practice (3rd ed.). Boston, MA: Pearson.

Schkade, J. K., & Schultz, S. (1992). Occupational adaptation: Toward a holistic approach for contemporary practice, part 1. *American Journal of Occupational Therapy*,*46*(9), 829-837. doi:10.5014/ajot.46.9.829

Schwarzer, R., & Jerusalem, M. (n.d.). *The General Self-Efficacy Scale (GSE).* Retrieved from http://userpage.fu-berlin.de/~health/engscal.htm

Simmons, K., Guberman, E., & Aranha, K. (2018). A qualitative pilot study exploring the benefits of using the occupational profile template for novice clinicians. *American Journal of Occupational Therapy, 72*(4 Supplement 1):7211505141. https://doi.org/10.5014/ajot.2018.72S1-PO6048

Sharma, K. A. & Clark, A. J. (2018). Empathy matters: The importance of imagination in occupational therapy. *American Occupational Therapy Association* (7), 18–20.

Slater D, & Brandt L. (2009). Combating moral distress. *OT Practice, 14*(2), 13–18. Retrieved from http://ezproxylr.med.und.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=105252524&site=ehost-live&custid=s9002706

Smith, M. K. (1999). 'Andragogy', the encyclopedia of informal education. Retrieved from: http://www.infed.org/lifelonglearning/b-andra.htm.

Sobel, A. (2020, January 27). Eight ways to improve your empathy [Web log post]. Retrieved from: https://andrewsobel.com/eight-ways-to-improve-your-empathy

Spence, B. (2019, June 7). The role of empathy in occupational therapy [Web log post]. Retrieved from http://info.staffingplus.com/the-role-of-empathy-in-occupational-therapy

St Catherine University Online OTA. (2017, April 12). OT vs PT: The difference between fields of occupational therapy and physical therapy [Web log post]. Retrieved from https://otaonline.stkate.edu/blog/fields-occupational-therapy-and-physical-therapy-whats-difference/

Stoffel, V. C., Reed, K. L., & Brown, C. (2019). The unfolding history of occupational therapy in mental health. In Brown, C., Stoffel, V. C., & Munoz, J. P. (Eds.), *Occupational therapy in mental health: A vision for participation* (2nd ed., pp. 14-27). Philadelphia: F. A. Davis Company.

Taylor, R. R. (2008). *The intentional relationship – Occupational therapy and use of self.* Philadelphia, PA: FA Davis Company

Terry, M., & Westcott, L. (2012). Are occupational therapists in acute general hospitals addressing psychological wellbeing? *British Journal of Occupational Therapy, 75*(6), 296-298. doi:10.4276/030802212X13383757345265

Thedevotedyogi (2019, January 1). What is occupational therapy? [Web log post]. Retrieved from https://www.thedevotedyogi.com/blog-1/2018/10/6/what-is-occupational-therapy

The OT Practice Experts in Therapy. (2019, February 8). Articles about case study. Retrieved from https://www.theotpractice.co.uk/news/tags/case-study

The Willows at Ramapo Rehabilitation & Nursing Center. (2016). Case study: Ramapo center for rehabilitation and nursing (July 2016). Retrieved from http://thewillowsrehab.com/case-study-ramapo-center-rehabilitation-nursing-july-2016/

Thinkmap, Inc. (2014, November 14). Get into the mood with 100 feeling words. Retrieved from https://www.vocabulary.com/articles/wl/get-into-the-mood-with-100-feeling-words/

Townsend, E. (1998). Reflections on... Occupational therapy language: Matters of respect, accountability and leadership. *Canadian Journal of Occupational Therapy, 65*(1), 45–50. Retrieved from https://search-ebscohost-com.ezproxylr.med.und.edu/login.aspx?direct=true&db=ccm&AN=107276786&site=ehost-live

Trautmann Boop, C. (2014). Table of assessments: Listed alphabetically by title. In *Willard & Spackman's Occupational Therapy* (12th ed., pp. 1190–1228). Baltimore, MD: Lippincott Williams & Wilkins.

Tully, S. (2019). Psychosocial concerns with physical disabilities. In Brown, C., Stoffel, V. C., & Munoz, J. P. (Eds.), *Occupational therapy in mental health* (2nd ed., pp 264-280). Philadelphia: F. A. Davis Company.

U.S. Department of Education, Office of Vocational and Adult Education. (2011). *Just write! Guide*. Washington, DC: Corley, M.

Watching. (2020, February 8). Compelling social issue documentaries [Web log post]. Retrieved from https://www.nytimes.com/watching/lists/social-issue-documentaries

Western Health Sciences, School of Occupational Therapy. (n.d.). Case scenario 12 - mr. bob white. Retrieved from http://publish.uwo.ca/~shobson/scenario12.html

White, S. (2020, February 9). 12 documentaries that explore different cultures [Web log post]. Retrieved from: https://theculturetrip.com/asia/articles/top-12-documentaries-that-will-open-your-mind-to-other-cultures/

Wisconsin Department of Health Services. (n.d.). Occupational therapy procedure codes. Retrieved from https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=87&s=2&c=10&nt=Occupational+Therapy+Procedure+Codes

Words that describe behavior [PDF file]. (n.d.). Retrieved from https://mrafisher.weebly.com/uploads/1/5/7/7/15778366/describe_words-_behavior__personality.pdf

YourDictionary. (2018, September 29). List of words that describe behavior. Retrieved from https://grammar.yourdictionary.com/word-lists/list-of-words-that-describe-behavior.html

Yuill, A. (2019, April 1). Mental and physical health: Why they go hand in hand. [Web log post]. Retrieved from https://www.theotpractice.co.uk/news/our-experts-blog/mental-health-and-physical-disability-why-they-go-hand-in-hand

Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B., & Taleghani, F. (2015). Effective factors in providing holistic care: A qualitative study. *Indian Journal of Palliative Care, 21*(2), 214–224. https://doi.org/10.4103/0973-1075.156506