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Translated Evidence-Based Mental Health Toolkit for Skilled Nursing Facilities

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Translated Evidence-Based Mental Health Toolkit for Skilled Nursing Facilities

By

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A culminating capstone project report submitted to the faculty of Dominican University of California in partial fulfillment of the requirements for the degree of Master's in Occupational Therapy

Dominican University of California

San Rafael, CA

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Abstract

More than 500,000 adults with a serious mental illness (SMI) receive long term care (LTC) in a skilled nursing facility (SNF) (Grabowski, Aschbrenner, Feng, & Mor, 2009). During the residents' stay in a SNF, they may experience limited access to meaningful occupations. The LTC environment impacts routines and occupations for the residents in a SNF. The institutionalized structure within a SNF may perpetuate a lack of autonomy and stigma for residents with a SMI (Choi, Ransom, Wyllie, 2008; Sullivan & Williams, 2017). Occupational therapy (OT) services provided in a SNF are often limited to therapeutic exercises, therapeutic activities, and activities of daily living skills (Rafeedie, Metzler, & Lamb, 2018). OT practitioners are not focusing on interventions related to the mental health needs of residents and are not operating within the full scope of OT practice. Although SNFs are not traditionally considered a primary mental health setting, increased numbers of residents with SMI (527 U.S. 581, 1999) have resulted in a need for OT practitioners to redefine their role in the SNF to include mental health assessments and interventions. Utilizing effective approaches that consider the residents' needs and preferences, while accommodating for the rigidity of the SNF environment can improve mental health (Choi, Ransom, Wyllie, 2008). Therefore, this project includes the most current evidence-based mental health assessments and interventions using the Person Environment Occupation (PEO) model and recovery approach as a guideline to best practice (Noyes & Lannigan, 2019). Evidence-based assessments and interventions were organized into a toolkit for OT practitioners to use in the context of a SNF and address the needs of the residents with a SMI. The toolkit was presented in a workshop for OT practitioners working in SNFs. The goal of the project is to contribute to the OT field by providing evidence-based tools for OT practitioners to utilize as part of their mental health interventions in SNFs.

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Introduction

Approximately 10.4 million adults with a serious mental illness (SMI) live in the United States (U.S.) (National Institute of Mental Health, 2017). In the U.S., more than 500,000 adults with a SMI live in a skilled nursing facility (SNF) (Grabowski, Aschbrenner, Feng, & Mor, 2009). Adults with a SMI require a supportive environment with skilled services to promote their recovery. Cost, time, education, and insurance reimbursement are barriers to adequate mental health services in the SNF (Muramatsu & Goebert, 2011). Occupational therapy (OT) practitioners can analyze the relationship between the resident with a SMI, the SNF environment, and occupations to address resident's barriers to health and well-being.

The OT Practice Framework (OTPF) [American Occupational Therapy Association (AOTA), 2014] includes psychosocial factors within the domain of OT. OT practitioners who work in primary mental health settings utilize a variety of evidence-based mental health interventions. However, OT practitioners in SNFs frequently underutilize their full scope of practice by limiting interventions to therapeutic exercise, therapeutic activities, and activities of daily living (Rafeedie, Metzler, & Lamb, 2018). These limited interventions highlight a gap in OT service delivery in SNFs. There's an opportunity to increase awareness of OT interventions that align with the OTPF and the identified clinical needs of the growing number of individuals with SMI who live in SNFs. In order to meet the needs of residents with SMI, evidence-based mental health assessments and interventions that address stigma, social isolation, and lack of autonomy need to be translated for use within the context of a SNF and OT practice. The purpose of this project is to develop a mental health toolkit for SNF-based OT practice and educate OT practitioners on the use of contextually relevant evidence-based mental health tools for residents with a SMI within a SNF.

Literature Review

Serious Mental Illness in the Skilled Nursing Facilities

Bipolar disorder, schizophrenia, or major depression are conditions categorized as a SMI in the *OT Practice Guidelines for Adults Living with a Serious Mental Illness* (Noyes & Lannigan, 2019). The National Institute of Mental Health (NIHM) defines a SMI as a mental, behavioral or emotional disorder that results in a functional impairment, which limits an individual in one or more major life activities (NIMH, 2017). The conditions represented within the definition of a SMI may vary in the literature. However, a consistent defining characteristic is a significant decrease in functional impairment. Therefore, in addition to bipolar disorder, schizophrenia, or major depression; other conditions such as anxiety may be part of the definition of SMI (Grabowski, Aschbrenner, Feng, & Mor, 2009). For the purposes of this project, SMI will be defined as individuals with a diagnosis of bipolar disorder, schizophrenia, or major depression (Noyes & Lannigan, 2019), or any individual that results in a significant functional impairment in one or more major life activities (NIMH, 2017).

The population of residents with SMI in SNFs is increasing, resulting in the need for mental health interventions. Table 1 illustrates the increased population of residents with SMI receiving LTC services in SNFs at the time of admission.

Table 1 Percentages of Serious Mental Illness at a Long-Term Care (LTC) Admission Across 50

	Age Group			
	Middle Aged		Older Adults	
	2000	2008	2000	2008
Depressive Symptoms	27.4%	40.2%	22.6%	30.8%
Bipolar Disorder	3.5%	6.6%	.09%	1.3%
Schizophrenia	6.6%	7%	1.1%	1%

Note. Adapted from "A Profile of Middle-Aged and Older Adults Admitted to Nursing Homes: 2000-2008," by N. A. Miller, L. M. Pinet-Peralta, and K. T. Elder, 2012, Journal of Aging & Social Policy, 24(3), p. 282.

Skilled Nursing Facilities

SNFs provide LTC and post-acute care services to individuals who have sustained an injury, are chronically ill or are unable to take care of daily living needs [U.S. Department of Health and Human Services (USDHHS), n.d.]. Licensed healthcare practitioners work within a SNF to achieve or sustain both quality of life and physical function through nursing and rehabilitation services (Harris-Kojetin, Sengupta, Park-Lee & et al., 2016). In the literature, the terms SNF and LTC are both used interchangeably for residents who receive LTC services in a SNF as compared to those who receive short term post-acute care. LTC may also include assisted living facilities and nursing homes. For the purposes of this project, SNF will be used as a term to define the environment where residents with a SMI receive LTC services.

SNFs play an important role within the healthcare continuum in the U.S., the population SNFs serve has shifted over time to address the societal need for mental health services. Initially, SNFs rarely provide mental health services to adults with SMI. However, the U.S. Supreme Court case of *Olmstead vs. L.C.* (527 U.S. 581, 1999) led to the deinstitutionalization of adults

with SMI into the community and residential care settings. Adults with a SMI often have exacerbations of SMI or behavioral symptoms which may require hospitalization. Adults with a SMI would benefit from supportive care at the community level instead of hospitalization and institutionalization, but community level support is frequently unavailable (Barry, Robison, Wakefield, & Glick, 2018). The Supreme Court case unintentionally resulted in an increase of symptoms for adults with SMI and a need for higher levels of care, leading to a growing population of adults with SMI in SNFs.

The increased need for mental health services in the SNF setting has presented obstacles to the staff. Policies and regulations in SNFs are designed around the needs of older adults with physical conditions. Therefore, SNFs are challenged to meet the needs of adults with a SMI. Staff at the SNFs may attempt to limit the admission of adults with SMI due to concerns related to the care of residents with SMI (Barry, Robion, Wakefield, & Glick, 2018).

Within SNFs, the population of residents varies by gender, age, race, and ethnicity. A report generated by USDHHS (2016) collected data from national surveys across the country from 2013-2014 and included information on 1,340,700 residents living in LTC facilities. Table 2 merges information collected from the report to describe the characteristics of residents living in LTC facilities across the country. The table is categorized by gender, age, race and ethnicity. According to Table 2, 84.9% of residents that live within a LTC facility are above the age of 65 years.

Table 2 Characteristics of Residents in Long Term Care in the United States from 2013-2014 by Age, Race, & Sex

		Percentages of Users
Race & Ethnicity		
	Hispanic	5.2%
	Non-Hispanic: white	76.1%
	Non-Hispanic: black	14.0%
	Other	4.7%
Sex		
	Men	33.2%
	Woman	66.8%
Age Group		
	Younger than 64 years old	15.1%
	65-74 years old	16.1%
	75-84 years old	27.2%
	85 years and over	41.6%

Note. Adapted from "Long Term care Providers and Service Users in the United States: Data from the National Study of Long-Term care providers, 2013-2014" by L Harris-Kojetin, M. Sengupta, E. Park-Lee, R. Valvarde, C. Caffrey, V. Rome, and J. Lendon, 2016, Vital Health Stat 3(38), p. 36-37-38.

SNF environments affect mental health recovery due to the rigid culture and environment that includes regimented rules and regulations (Sullivan & Williams, 2015; Brandburg, Symes, Mastel-Smith, Hersch, & Walsh, 2012; Ransom, & Wyllie, 2008). Coping strategies that incorporate a residents' preferences may prevent isolation, which is a contributing factor to mental well-being (Choi, Ransom, & Wyllie (2018). Incorporating coping strategies into resident care may require modification of the institutional environment, and training for the staff. Understanding the resident's lived experience while receiving LTC services in a SNF is an

important factor to consider. Choi, Ransom, & Wyllie (2008) examined residents' understanding of depressive symptoms and coping strategies within the SNF. Residents cited the loss of privacy due to common shared spaces such as the bathroom, bedrooms, dining and activity rooms as important factors impacting mental well-being. Residents also reported the lack of autonomy and meaningful activities due to rigid schedules and misaligned facility values. In addition, the authors reported that residents had feelings of rejection and inferiority leading to isolation within the facility because of the feeling of being trapped or confined (Choi, Ransom, & Wyllie, 2008). The move to the institution is a difficult transition that begins the residents' loss of independence and autonomy (Sullivan & Williams, 2015). OT practitioners can assist residents to identify opportunities and barriers in the SNF environment. OT practitioners can also support residents to advocate for changes to their care, routines and environments. The OTPF (2014) outlines the OT practitioner uses methods that are "occupation-based, client-centered, contextual, and evidence-based" to promote recovery (AOTA, 2014, p. S3).

For residents with a SMI, stigma is another important factor to consider when transitioning into a SNF. In a qualitative study by Tzouvara, Papadopoulos & Randhawa (2017), residents with a SMI had a deeper sense of self-stigma due to their awareness of their condition. Self-stigmatization is the "internalization process of negative public stereotypes to oneself characterized by shame, secrecy, discrimination and social withdrawal" (Tzouvara, Papadopoulos & Randhawa, 2017, p. 403). The study revealed residents avoiding and fearing fellow residents with a SMI due to the perception that adults with a SMI are "aggressive, violent, and lacking control" (Tzouvara, Papadopoulos & Randhawa, 2017, p. 406). The resident experiences internal and external stigma which influences the resident's sense of belonging and recovery.

Group interventions are therapy modality that may serve to lessen the stigma between residents and staff by providing a sense of community (Noyes & Lannigan, 2019).

Mental health workers. SNFs provide skilled nursing and rehabilitation services for the residents. Psychiatrists, social workers, nurses, and OT practitioners are health care professionals who frequently work in SNFs to provide services for residents with a SMI. Each healthcare provider has a designated role and together they form an interprofessional therapeutic support team for residents living in a SNF. The following healthcare providers' role was examined: psychiatrist, social service directors, and nursing. The literature identified specific limitations and concerns for each healthcare profession involved in the care of residents with SMI in the SNF setting.

Psychiatrists. The role of the psychiatrist in a SNF setting is to provide accessible care to residents and provide education to staff. A psychiatrist's scope of practice includes pharmacological treatment, psychotropic medication review, and psychotropic medication monitoring for residents. A psychiatrist's ability to evaluate, treat, review, and monitor residents allows staff to feel confident and safe in the SNF setting. Educational trainings provided by the psychiatrist increase confidence, comfortability, and competence of the staff when working with residents with SMI (Muramatsu & Goebert, 2011). Psychiatric services can be a crucial resource in a SNF setting. However, limitations in Medicaid and funding result in a lack of financial incentives for psychiatric providers "to provide services to nursing facilities and for nursing facilities to take" in residents with SMI (Muramatsu & Goebert, 2011, p. 124). Since reimbursements and funding are important factors to providing psychiatric care, solutions on how to provide more affordable mental health interventions will need to be explored to resolve this concern.

Social service directors. The role of a social service director is to transition individuals into a SNF and connect individuals with tangible services to support their physical and mental health. According to Bonifas (2011), 120 SNF social service directors from Washington State reported limited knowledge and understanding of the conditions of residents with a SMI. In many states, social service directors in SNFs are not required to have a college degree (Nurse Alliance of California, n.d.). In this study, social worker directors were evaluated on their geriatric mental health knowledge using the Mary Starke Harper Aging Knowledge Exam (MSHAKE) as a scale. The MSHAKE assesses knowledge of in normal aging, SMI, and dementia on as a 25-item questionnaire (Santo-Novak, 2001). Based on the results of the MSHAKE, social service directors understand the general concepts of the SMI and dementia. However social service directors have limited knowledge related to the mental health aspects of residents. This is evident by their underperformance on a few mental health questions such as "persons with early-stage dementia often think 'someone is out to get them," where 60.8% of the social directors answered incorrectly (Bonifas, 2011, p. 818). The author recommended refocusing social service director courses, providing continuing education to expand social service director's skills in understanding mental health, implementing evidence-based interventions, and participating in transdisciplinary collaboration (Bonifas, 2011).

Nurses. Nursing staff are integral to all aspects of the SNF care and services. At a SNF, nursing staff consists of nursing assistants, licensed vocational nurses, registered nurses, and a director of nursing (Corazzini et al, 2015). The registered nurses' role is to manage and oversee the compressive care plans for the residents in a SNF. One component of the care plan is medication management which includes: (1) administering psychotropic medication and (2) monitoring medication regimens (Stuart, 2013). The director of nursing (DON) often makes the

decision of whether to admit a resident with a SMI. The DON is responsible to determine if the facility is prepared to meet the specific needs of each admitted resident. The DON may deny admission if the resident has a history of "psychiatric and behavioral problems" or if the DON believes the facility or the staff are not equipped to meet the needs of the resident (Muramatsu & Goebert, 2011, p. 120).

In a study consisting of 51 LTC facilities in Hawaii, 25 directors of nursing and 99 other staff leaders in a SNF responded to a survey to understand the need for mental health services. The directors of nursing voiced concerns about the absence of mental health consultation regarding SMI and non-pharmacological interventions within the facility (Muramatsu & Goebert, 2011). According to Muramatsu & Gobert (2011), the results of the survey indicate a need for transdisciplinary collaboration to support the needs of residents with a SMI in a SNF. Within the scope of OT practice, OT practitioners are trained and qualified to implement occupation-based, non-pharmacological interventions and participate in transdisciplinary collaboration. OT practitioners can partner with the nursing team to build the nursing staff's skills and confidence when caring for residents with a SMI.

Occupational therapy practitioners. The role of OT practitioners in a SNF is to implement interventions to promote health and well-being. OT interventions in SNFs have primarily concentrated on functional mobility, activities of daily living (ADLs), and fall prevention in the LTC of a SNF (AOTA, 2015; Rafeedie, Metzler, & Lamb, 2018). The current OT interventions are not sufficient to address the needs of LTC residents with SMI living in a SNF. OT practitioners are not utilizing mental health interventions and have expressed concerns that they lack the support needed to practice client-centered interventions in a SNF due to limitations in insurance reimbursements. The perceived lack of insurance reimbursement

perpetuates the gap in service delivery "between OT practices in the SNF and AOTA Standards of Practice" (Kennedy, Maddock, Sporrer, & Greene, 2002, p. 7). The OTPF (2014) states that OT practitioners can understand a resident's performance in occupations by evaluating client factors, such as including the resident's psychological functions. Furthermore, the OTPF specifies occupation-based or occupation-focused interventions as methods to promote mental well-being. Since mental health is within the OT scope of practice, OT practitioners should include mental health interventions in addition to the current OT interventions practiced in a SNF (AOTA, 2014).

OT practitioners can utilize *The Practice Guidelines for Adults Living with a SMI* to promote successful implementation of evidence-based mental health interventions (Noyes & Lannigan, 2019). *The Practice Guideline* consists of best practice tools based on the recovery model to support client-centered, quality care for residents with SMI (Noyes & Lannigan, 2019). Evidence-based practice empowers the OT practitioner to document mental health interventions for reimbursement. OT practitioners' roles have the potential to be redefined in a SNF by translating the best practice tools used in primary mental health settings into SNF practice. In some cases, OT practitioners are using mental health assessment and interventions, but lack the confidence to document these services. Education and advocacy are also an aspect of OT interventions in a SNF (AOTA, 2015). OT practitioners address environmental and contextual aspects of occupational performance when providing interventions for residents receiving LTC services in a SNF (AOTA, 2015). The OT practitioner may provide education to the staff on how psychosocial factors, behaviors, habits, and routines enable occupational engagement (AOTA, 2014). The OT practitioner may also advocate for changes to policies and procedures in the SNF in order to create an environment that supports occupational engagement. Education through

transdisciplinary collaboration between OT practitioners and staff would address the needs of staff seeking mental health training and non-pharmacological interventions to increase confidence when working with residents (Muramatsu & Goebert, 2011).

Insurance and reimbursement models. Reimbursement is crucial for a SNF to operate and provide services. In the SNF setting, reimbursement for OT skilled therapy services occurs when OT practitioners use CPT codes to categorize and bill the time spent on treatments. Between 2014 to 2016, OT practitioners billed the CPT code for therapeutic exercise 9,594,480 times, therapeutic activities 13,020,360 times, and self-care or ADLs 8,311,520 times (Rafeedie, Metzler, & Lamb, 2018). These frequently documented coding categories illustrate the OT practitioners' limited scope of practice in a SNF.

Many OT practitioners lack the knowledge and skills to document mental health interventions as a part of their OT treatment sessions. This lack of knowledge related to documentation may limit the provision of OT mental health services, despite the clinical need of the residents or the OT practitioner's skills to incorporate mental health tools.

Many OT practitioners hold an outdated belief that residents need to make steady progress in therapy to qualify for Medicare reimbursement. The *Jimmo v. Sebelius* settlement agreement discusses the outdated understanding of Medicare requirements based on the erroneous "improvement standard" [Centers for Medicare & Medicaid Services (CMS), 2014]. Previously residents were denied services based on the "absence of potential for improvement or restoration" (CMS, 2014, p. 1). The settlement agreement outlines that individuals may require skilled therapy to maintain, prevent or slow further deterioration because of long standing habits. OT practitioners may benefit from guidance and training for services provided to individuals with chronic conditions including many SMIs.

Evidence-Based Approaches for Addressing the Needs of Residents with SMI

The recovery model is an approach to best serve adults with SMI (Noyes & Lannigan, 2019). The Substance Abuse and Mental Health Service Administration (SAMHSA) is a branch of the US Department of Health & Human Services who took the recovery model perspective and developed a working definition of recovery for adults with a SMI. SAMHSA defines recovery as "a process of change through which [adults with a SMI] improve their health and wellness, live a self-directed life, and strive to reach their own potential" (SAMHSA, 2012, p. 3). SAMHSA identified ten fundamental principles. The ten principles are person-driven, many pathways, relational, culture, address trauma, hope, responsibility, holistic, respect, and peer support (Noyes & Lannigan, 2019). The principles align closely with OT practice by encompassing client-centeredness and strengths-based language, which reinforces the notion that OT mental health services for residents with SMI are aligned with the OT scope of practice. The recovery model approach guided the selection of best practice mental health tools for adults with a SMI. SAMHSA provided three guidelines for identifying an appropriate evidence-based best practice tool. Best practice tools must be supported by a valid theoretical framework, empirical evidence, and informed experts (Center for Substance Abuse Prevention, 2007).

Empirical evidence indicates that cognitive impairments, including dementia are frequently occurring comorbidities among individuals with SMI living in a SNF. OT practitioners should consider the cognitive abilities of residents with cognitive impairment when selecting and implementing interventions. In the study by Mansbach, Mace & Clark (2014), 477 participants in the U.S. who resided in either a SNF or an assisted living facility were referred for neuro-cognitive evaluations to determine a mild cognitive impairment. Of the 477 participants, 24% of the participants met the criteria for mild cognitive impairment. The mental health tools

are appropriate for individuals with higher levels of cognition. If a resident with a SMI demonstrates cognitive difficulties, increased skilled support is necessary and may include modification of the assessment or intervention.

The following mental health tools took into consideration best practice guidelines and the needs of the residents with a SMI in a SNF. Additionally, tools were selected, based on their ability to be modified to meet the cognitive needs of the resident. The selected best practice tools are Motivational Interviewing (MI), Canadian Occupational Performance Measure (COPM), Interest Checklists, Wellness Recovery Action Plan (WRAP), life skills group, and the Goal Attainment Scale (GAS), all of which fulfill SAMHSA's three stated guidelines.

Motivational interviewing. MI is a clinical approach used to collaborate with a participant to facilitate intrinsic motivation to accomplish goals related to behavior change for mental health improvement (Lewis, Larson, & Korcuska, 2017). "The spirit of MI" is to (1) express empathy, (2) evoke a "change talk," (3) accept the client's values and wishes, affirm and honor autonomy in their current life, and (4) show compassion through self-efficacy (Lewis, Larson, & Korcuska, 2017; Brown & Stoffel, 2011). MI is a tool that promotes routines by finding meaningful occupations and change behavior of residents in order to engage within their environmental contexts. Choi & Lee (2018) analyzed the effects of using MI in group therapy with adults with schizophrenia. The results from the study indicated that MI used with group art therapy was effective for reducing negative symptoms, increasing motivation, improving interpersonal relationships, enhancing personal hygiene, and promoting program participation in adults with schizophrenia (Choi & Lee, 2018). Within a SNF, residents with SMI may benefit from OT practitioners and other staff utilizing MI during interactions. MI can facilitate residents'

sense of person-driven and responsibility in a SNF through increased social participation and problem-solving abilities.

Canadian occupational performance measure. The COPM is an assessment created by OT practitioners and occupational scientists. A semi-structured interview is used to gather information about the individuals' occupational concerns in ADLs, productivity, and leisure. The participant rates their occupational performance, assesses their satisfaction and eventually reassess their concerns (Kirsh & Cockburn, 2009). The COPM requires the OT practitioner to facilitate a conversation with the individual to identify their own occupational performance problems. Based on the identified occupational performance problem, the OT practitioner and participant can create intervention plans (Pan, Chung, & Hsin-Hwei, 2003). The COPM aligns with the recovery model through person-driven methods.

The COPM could be used to address environmental barriers occurring in the SNFand the resident's lack of autonomy identified by Choi, Ransom, & Wyllie, (2008). The authors examined the validity and reliability of the COPM (Pan, Chung, & Hsin-Hwei, 2003). The results from the study demonstrated that a client-centered approach is necessary for successful implementation of the COPM in mental health practice (Pan, Chung, & Hsin-Hwei, 2003). A client centered approach could increase a resident's sense of autonomy within the SNF. Kirsh & Cockburn (2009) explored the COPM as a potential tool used for recovery-oriented, psychiatric rehabilitation. The COPM allows the individual to "identify their occupational performance in settings and groups of their choice" (Krish & Cockburn, 2009, p. 174). The OT practitioner can create an opportunity for the individual to have autonomy over their occupations and the environment, which can promote recovery. OT practitioners working in a SNF can assess

residents with a SMI with the COPM to enable person-driven and holistic interventions to address lack of autonomy and environmental barriers.

Leisure. OT practitioners can implement the Interest Checklist as an assessment. The interest checklist mainly focuses on leisure activities (MOHO, 2019). There is an adapted version of the Interest Checklist known as the Modified Interest Checklist. The Modified Interest Checklist is used to understand the individuals' past and present activities. The individual is asked to indicate their level of interest for each activity, whether the individual has a strong, some, and no interest. After the assessment, the individual will collaborate with the OT practitioner on their intervention plan (Heasman & Gaurav, 2008). OT practitioner can expand their scope of practice outside of therapeutic exercises, therapeutic activities, and ADLs by using leisure assessments such as the Interest Checklist.

Iwasaki et. al explored how the role of leisure facilitates recovery in individuals with a SMI. The study discussed the importance of individuals participating in leisure because leisure is associated with individualized experiences, feelings, and meaning. Participation in leisure activities is a predictor of recovery and overall health because the activities facilitate meaning, improve the ability to cope with stress, and reduce boredom. Leisure must be a preferred, meaningful activity that actively engages the individual (2014). The SNF environment limits a resident's freedom to create their own schedule due to established facility routines, which then impacts a resident's opportunity for engagement in leisure activities. OT practitioners who incorporate leisure into the OT process promote recovery model principles of relational, culture, and person driven. OT practitioners can encourage an increased sense of autonomy through leisure (Iwasaki, et al., 2014).

Wellness recovery action plan. The Wellness Recovery Action Planning (WRAP) is a self-directed and self-management intervention used to assist individuals of all ages with strategies to promote wellness and recovery (Advocates for Human Potential, 2018). The WRAP involves the completion of six components to create an individualized plan. The components are (1) Wellness Toolbox: the individual identifies resources to promote wellness and uses the resources to create a daily maintenance plan, (2) Triggers & Stressors: the individual identifies and plans for triggers and stressors, (3) Warning Signs: the individual identifies early warning signs of a crisis approaching and plans for additional support if necessary, (4) Breaking down: the individual identifies signs when things are breaking down from their wellness plan, (5) Crisis: the individual creates a plan for when a crisis occurs, which may include allowing another person to step in and make decisions for the individual, (6) Post-crisis: the individual plans for transitioning out of crisis, which includes stating when people are to step out of the crisis plan. After completing the WRAP process, individuals are equipped with coping skills for current and future challenges (Mak, Chan, Pang, Chung, Yau, & Tang, 2016). The WRAP was created by Mary Ellen Copeland and is recognized by SAMHSA as an evidence-based practice (Advocates for Human Potential, 2018). Person-driven, responsibility, and many pathways are recovery model principles that connect with the WRAP. The OT practitioner can empower the resident with a SMI to advocate for themselves and “enact responsibility for their own recovery” within the SNF environment (Noyes and Lannigan, 2019, p. 6). Both the recovery model and the WRAP acknowledge that recovery is nonlinear. WRAP accounts for non-linear recovery by having the resident with a SMI prepare plans for times when wellness cannot be maintained.

Mak et al. (2016), investigated the effectiveness of the Wellness Recovery Action Planning (WRAP). One hundred and eighteen individuals participated in this study. Fifty-nine of the participants were in recovery of their mental health illness while the other fifty-nine participants were matched controls. The participants in recovery were placed in an eight session WRAP program hosted by certified WRAP professionals. As indicated by assessments given before and after the sessions, participants "reported a significant increase in perceived social support" (Mak et al., 2016). The WRAP is supported by evidence to increase social participation, motivation, personal responsibility to recovery, self-regulation, and empowerment (Mak et al., 2016).

A randomized controlled trial by Cook et al (2013), measured the WRAP's impact over time compared to an education intervention. One hundred and forty-three individuals with SMI participated in the study. Seventy-two participants received the WRAP intervention while seventy-one participants were in the control group who received the Choosing Wellness, a nutrition education program. The individuals in the WRAP intervention group demonstrated an increased ability to maintain wellness on their own and utilized fewer mental health services compared to individuals in the education intervention group (Cook et al. 2013). Participants in the WRAP group were better equipped to maintain their daily wellness, resulting in a decreased need for seeking additional services over time. Although residents in a SNF may need caregiver support to use the WRAP, it would be a useful intervention to incorporate into a SNF. The WRAP empowers residents to maintain wellness using a person-driven approach.

Goal attainment scale. The Goal Attainment Scale (GAS) is a collaborative and individualized goal setting tool. The goals are created collaboratively by the participant and the facilitator. The objective of the GAS is to set and track the participant's chosen goals. GAS

accounts for different levels of performance using a scale that allows for small incremental changes. The scale determines if goals exceed, meet, or are below the participant's expectations. The scale is established using a 5-point scoring system, where each score corresponds with verbal descriptions of the goal. Goals are scored on a scale that ranges from -2 to +2. The score 0 on the scale is considered the "expected" goal and is generated by the individual. Scores of -1 and -2 are "a little" and "a lot" worse than expected respectively. Scores of +1 and +2 are "a little" and a "a lot" better than expected respectively. Lewis, Larson, & Korcuska, (2017) outlines the process of GAS in eight steps: (1) identifying objectives in treatment (2) identifying problem areas for the objectives in treatment (3) collaborating between therapist and client to identify reasonable actions that will support the expected outcome (4) determining the "expected" goal (5) setting expected level of outcome (6) identifying the action descriptions for each score of the scale.

In a clinical study by Tabak, Link, Holden & Granholm (2015), GAS was used to facilitate a measurement for personal recovery goals for individuals with SMI. The researchers created a series of adjusted GAS templates for individuals with a SMI. The adjusted GAS templates replaced the -2 to +2 goal scale with a 0-10 goal scale. The purpose of eliminating the negative portion of the scale was to promote hope and to focus on the positive progress of the individual with a SMI. The study showed building an individualized collaborative goal increases the participant's hope, motivation, and active engagement for recovery. Lewis, Larson, & Korcuska (2017) also emphasized collaboration as a key part of intervention that is essential in creating goals. GAS was used to strengthen the planning process in treatment. The collaboration between the facilitator and participant in the study increased intrinsic motivation and empowerment of the participant's own treatment. GAS aligns with the recovery principles of

person-driven, relational and hope. Thus, OT practitioners may find GAS beneficial for residents with a SMI, because the intervention encourages autonomy and collaboration in the resident's recovery.

Sensory modulation. Sensory modulation is the ability to regulate and respond appropriately to sensory input (Lipskaya-Velikovsky, Bar-Shalita, & Bart, 2015). An individual's behavioral response to sensory input may affect the individual's ability to adapt to everyday occupations. Therefore, a sensory modulation disorder (SMD) is an individual's inability to modulate, and manifests in "reduced participation in daily life occupations" (Lipskaya-Velikovsky, Bar-Shalita, & Bart, 2015, p. 131). Within SMD, response to stimulus includes sensory over-responsive (SOR) and sensory under-responsive (SUR).

In a controlled trial without randomization, Lipskaya-Velikovsky, Bar-Shalita, & Bart (2015) explored how sensory modulation (SM), cognition, and schizophrenia symptoms impact participation in daily life activities of individuals diagnosed with schizophrenia. The study consisted of eighty-one adults. Forty-nine adults diagnosed with schizophrenia were in the study group while thirty-two adults without a SMI were in the control group. Both groups were assessed for: (a) participation patterns using the Adults Subjective Assessment of Participation (ASAP), (b) sensory modulation processes using the Sensory Responsiveness Questionnaire (SRQ), (c) cognitive functioning using the Modified Mini Mental State Examination (3Ms) and the Trail Making Test (TMT) and (d) symptoms severity using The Positive and Negative Syndrome Scale (PANSS). After the assessments where completed the team of researchers evaluated the data between the two groups. A significant mean difference to under-responsivity patterns between the study group and the control group was found. The evidence suggests that individuals with schizophrenia may experience SMD with an under-responsive tendency. The

study group was also found to have participated in fewer activities compared to the control group. The study group did enjoy participating in activities just as much as the control group but were less satisfied with their performance of the activity. This finding emphasizes the study group was aware of their performance abilities and outcomes, but the process of "doing" was much more of a "rewarding process" (Lipskaya-Velikovsky, Bar-Shalita, & Bart, 2015, p. 135).

Residents encounter a variety of sensory experiences from the SNF environment. Sensory experiences can be the taste of flavored toothpaste during an oral hygiene task or cold-water during bathing. A resident with SMI may experience sensory modulation difficulties with everyday sensory experiences within a SNF which could affect occupational engagement. Occupational engagement during already established ADL interventions as mentioned by Rafeedie, Metzler, & Lamb (2018) could be further supported by exploring sensory experiences. OT practitioners can facilitate the process of identifying a resident's "own sensory tendencies, preferences, and patterns" (Champagne & Stromberg, 2004, p. 37). The study from Lipskaya-Velikovsky, Bar-Shalita, & Bart (2015) on sensory modulation supports the notion that understanding the relationship between sensory input and behavior response is important to evaluate. The evidence indicated that adults with SMI may experience SMD that impacts participation in everyday activities. The resident understanding their behavioral responses toward others and their environment could impact occupational engagement. According to Champagne & Stromberg (2004), a number of outcomes are shown when SMD is addressed: residents can decrease (1) anxiety, (2) pain, and (3) agitated behaviors. In addition, the resident can improve (1) concentration during tasks, (2) sleep, (3) comfort, and (4) relaxation (Champagne & Stromberg, 2004).

Life skills group. Life skills group encompasses a variety of skills needed to participate in the community life of the SNF and increase occupational performance. Skill topics to address in a life skills group includes social skills training, being aware of health and wellness, understanding triggers and coping mechanisms related to environmental factors, and exploring leisure occupations. Sensory modulation and leisure are potential group topics for a life skills group intervention. Group intervention combines social occupations with functional activities. The evidence indicates that group interventions increase interpersonal and assertive skills, reduces psychiatric symptoms, and develops social adjustment (D'Amico, Jaffe, & Gardner, 2018). Group interventions are found to be effective, efficient, and economical (Brown & Stoffel, 2019). Group participants benefit from a social environment and a sense of community by providing the opportunity to form personal relationships (Brown & Stoffel, 2019). Recovery principles that align with a life skills group include peer support and relational.

Summary and Conclusion

The demand for mental health interventions is growing and the need is especially acute in SNFs, since approximately 500,000 adults with a SMI live in a SNF across the U.S (Grabowski, Aschbrenner, Feng, & Mor, 2009). Based on the literature, psychiatrists, social service directors, nurses, and OT practitioners are all voicing concerns about the care provided to residents with an SMI who live in a SNF. Psychiatrists voiced concerns of insufficient reimbursement and funding when serving this population (Muramatsu & Goebert, 2011). Social service directors demonstrated a lack of training and knowledge when providing services to residents with an SMI (Bonifas, 2011). Whereas nurses expressed a need for non-pharmacological interventions (Muramatsu & Goebert, 2011). OT practitioners expressed not being client-centered (Kennedy, Maddock, Sporrer, & Greene, 2002) when interventions for residents are heavily focused on

functional mobility, ADLs, and therapeutic exercises in a LTC (AOTA, 2015; Rafeedie, Metzler, & Lamb, 2018). OT practitioners are commonly employed in SNFs and have the skills to incorporate mental health tools into their services. Reimbursement for OT services is available in the SNF setting, but a lack of skill and confidence in documenting services are some factors limiting OT practitioners from working in their full scope of practice. The OT practitioner's lack of knowledge in documenting mental health treatments creates a wider gap in service delivery for mental health interventions which is leading to a decrease in engagement in meaningful occupations for residents with SMI who receive LTC services in a SNF. Mental health services provided by OT practitioners working within their scope of practice are reimbursable by third-party payers. Reimbursable OT mental health services include: (1)education and collaboration with staff on how to communicate and care for residents with a SMI, (2) utilization of non-pharmacological interventions to improve participation and performance in daily activities, and (3)identification of self-regulation strategies to promote adaptive responses to the SNF environment. Using the recovery model approach for best practice, OT practitioners have the potential to administer occupation-based mental health interventions in a SNF (Brown, 2012). Evidence-based mental health tools that are shown to increase occupational engagement are MI, COPM, Interest Checklist, GAS, Life Skills Group, WRAP, and GAS. Translation of the mental health tools is necessary to align with the needs of residents with SMI who receiving LTC in a SNF. OT practitioners can utilize these translated evidence-based mental health tools to support the needs of residents with a SMI.

Statement of Purpose

A variety of factors contribute to the lack of appropriate services for residents with a SMI who receive LTC services in a SNF. The rigid and structured environment of a SNF impacts the mental health recovery of residents with a SMI (Choi, Ransom, Wyllie, 2008), who may need support to manage their responses to the environment and advocate for their needs. Healthcare practitioners in a SNF such as social service directors and nurses do not have the skills or education to provide appropriate mental health skilled services to residents with a SMI. Psychiatrists have the ability to provide appropriate services for residents with a SMI. However insufficient financial incentives from third party payers limit the services psychiatrists provide to residents with a SMI in a SNF (Muramatsu & Goebert, 2011). Unfortunately, OT practitioners further contribute to the gap of practice in mental health service delivery by limiting their scope of practice to ADLs, therapeutic exercises and therapeutic activities (Rafeedie, Metzler, & Lamb, 2018).

The barriers within a SNF environment contribute to the stigma, loss of autonomy and isolation experienced by residents with a SMI (Tzouvara, Papadopoulos & Randhawa, 2017). Within a SNF, OT practitioners could: (1) develop the skills to gain reimbursement for mental health services, (2) train staff on how to more effectively support residents with a SMI, and (3) provide mental health services for residents with a SMI. Therefore, the purpose of this project is to translate evidence-based mental health tools used in primary mental health settings, to a SNF context for OT practitioners who work with residents with a SMI. The tools align with the recovery model and address the barriers that impact the resident’s recovery and well-being. The toolkit will be presented to OT practitioners in a workshop with education about the supporting evidence, hands-on learning opportunities, and examples of how to document each of the mental

health tools. The workshop will educate OT practitioners on mental health tools to facilitate the recovery and well-being of residents with a SMI within a SNF.

Theoretical Framework

The Person-Environment-Occupation (PEO) model and the recovery model provide a lens from which to view the effect of the institutionalized structure of a SNF on residents with a SMI. The PEO model embodies OT values and practice. The model emphasizes the complex interaction of the person, environmental context, and occupation which influences occupational engagement (Law et al, 1996).

Person. A person's strengths and difficulties affect occupational performance. OT practitioners evaluate the person's specific client factors and performance skills rather than the diagnosis or symptoms impacting their occupational engagement. In addition, OT practitioners look at the resident's occupational profile which identifies the resident's occupational history, roles, and values (AOTA, 2019). While there are many client factors that affect residents with a SMI self-stigma and sensory modulation are especially important. The OT practitioner's role to address self-stigma and sensory modulation is to find coping strategies, identify sensory tools, and build on self-concepts that boosts hope, self-esteem, and self-regulation.

Environment. Within the environment "cultural, socio-economic, institutional, physical and social" factors are considered (Law, Cooper, Strong, Stewart, Rigby, & Letts, p. 16). Residents with a SMI lack control over the contextual factor within SNF. SNFs provide scheduled activities with little attention to what the resident finds meaningful. Daily routines are established based on the facilities' need to care for a large number of people in a systematic manner, minimizing opportunities to express preferences related to personal care and habits. Negative attitudes and stereotypes from the staff in regard to residents with a SMI are relevant factors in the social environment (Tzouvara, Papadopoulos & Randhawa, 2017). The SNF

environment reflects the external factors which may support or hinder occupational performance for the residents with a SMI.

Occupations. Occupations are meaningful activities that provide residents with a sense of identity when participating in their routines (Brown, 2009). Prior to living in a SNF, occupations in a resident's routines may include work, play, sleep, social participation, education, leisure, instrumental activities of daily living (IADLs), and ADLs (AOTA, 2014). According to the literature, full range of occupations within a SNF are not readily available and meaningful for the resident with a SMI. Residents lack control in their environment to participate in meaningful occupations outside of ADLs. OT practitioners can facilitate residents with SMI to have autonomy in choosing other occupations. The evidence supports leisure as an effective recovery strategy for mental health. Therefore, incorporating leisure exploration into intervention planning should be considered by OT practitioners. Due to the environmental constraints, modification of leisure occupations may be necessary to open opportunities for occupational engagement. Further considerations should be made by the OT practitioner to explore the impact of other occupations in a SNF to increase occupational engagement.

The recovery model guided the selection of tools for this project and is the best approach when treating residents with SMI (Noyes & Lannigan, 2019). The recovery model is "a process of change which individuals improve their health & wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012, p. 3). Each mental health tool aligns with at least one of the ten principles of the model. The recovery model consists of ten principles as shown in Table 3.

Table 3 Recovery Model Principles

Principle	Definition
Hope	Resident with a SMI uses hope as intrinsic motivation for the recovery process.
Person-Driven	Resident with a SMI is the primary decision maker in their life.
Many Pathways	Resident with a SMI's recovery is non-linear, and setbacks will occur.
Holistic	Resident with a SMI's recovery includes their spiritual, mental, and physical aspects of their life.
Peer-Support	Resident with a SMI benefits from other peer's mutual experiences.
Relational	Resident with a SMI's social support include people who assist with their sense of belonging, empowerment, community participation and autonomy.
Culture	Resident with a SMI have unique beliefs, traditions, and values shaping their individualized journey to recovery.
Addresses Trauma	Resident with a SMI's experience trauma influencing recovery and encouraging providers to use trauma-informed lens to increase sense of safety.
Strengths and Responsibility	Resident with a SMI, their family, and their community have a responsibility to provide opportunities, seek resources, and advocate during a resident's recovery.
Respect	Resident with a SMI will self-accept their path to recovery due to acceptance and appreciation from others.

Note. Adapted from "SAMHSA's working definition of recovery." by Substance Abuse and Mental Health Services Administration, 2014

The PEO and recovery models both "value a collaborative approach in which the individual receiving care identifies the goals of intervention. This shift in thinking moves [the practice] from an illness model that emphasizes a 'problem' that resides solely within the person to a belief that many of the barriers to recovery reside in the environment" (Brown & Stoffel, 2011, p 399). Therefore, concepts from both the recovery model and the PEO model influenced the selection of mental health interventions and additional materials this project.

Ethical Considerations

The Occupational Therapy Code of Ethics (The Code) of the AOTA is an official document and public statement guiding ethical matters within the occupational therapy practice (AOTA, 2015). Guidelines for ethical decision making and enforceable behaviors in the OT profession are outlined in the *Principles and Standards of Conduct* section of The Code. The Code has six principles: (1) Beneficence, (2) Nonmaleficence, (3) Autonomy and Confidentiality (4) Veracity, and (6) Fidelity. Beneficence, autonomy, and fidelity are principles that provide guidance on the ethical questions that arise in this project: How does the lack of mental health interventions in a SNF relate to the code of ethics? How does this project support OT practitioners in fulfilling their ethical responsibilities?

Principle 1: Beneficence refers to concepts such as altruism, humanity, and promoting well-being and safety (Scott & Reitz, 2013). This project is addressing beneficence by creating a toolkit that addresses the environmental factors contributing to the quality of life and wellness of residents with SMI in a SNF. OT practitioners have the knowledge and training to provide interventions specific to their client's needs and wants while still upholding the values of beneficence. OT practitioners who are not utilizing client-centered approaches and occupation-based interventions for residents with a SMI, in a SNF, are not fully upholding beneficence. The Code states OT practitioners should use "evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence based, current and within recognized scope of OT practice" (AOTA, 2015, p. 3). This is accomplished by following best practice guidelines when selecting mental health interventions to train the OT practitioners. Furthermore, to uphold beneficence this project protects the residents with a SMI who are participating by recognizing any potential risks and benefits of the interventions in this project.

Principle 2: Autonomy and Confidentiality states "OT practitioners shall respect the right of the individual to self-determination...within the bounds of accepted standards of care and to protect confidential information" (Scott & Reitz, 2013, p. 55). The intention of the interventions selected is to serve residents with SMI in a SNF who may lack decision making capacity and/or are vulnerable due to the institutionalized environment, while respecting the resident's autonomy. The principle of autonomy aligns with the self-directed principle found in the recovery model. Therefore, this project will uphold autonomy by educating OT practitioners of interventions that promote self-direction and person-centered.

Fidelity is defined as "occupational therapy personnel…[treating] clients, colleagues and other professionals with respect, fairness, discretion, and integrity" (Scott & Reitz, 2013, p. 97). The principle of fidelity promotes collaboration and communication between interprofessional teams for quality of care and safety of the residents (AOTA, 2015). In addition, the principle of fidelity focuses on the "importance of maintaining and nurturing professional relationships to facilitate the ultimate goal of enhanced client care" (Scott & Reitz, 2013, p. 98). Therefore, the recovery model perspective must be conveyed to other health practitioners during collaboration to enhance the care and decrease the stigma experienced by residents with a SMI. In addition, the principle of fidelity focuses on the "importance of maintaining and nurturing professional relationships to facilitate the ultimate goal of enhanced client care" (Scott & Reitz, 2013, p. 98). Therefore, the recovery model perspective must be conveyed to other health practitioners during collaboration to enhance the care and decrease the stigma experienced by residents with a SMI. Collaboration with nursing, psychiatrist, and social service directors at the SNF with whom OT practitioners work closely would support the principle of fidelity. The project implementation portion of this project entailed a needs assessment by interviewing staff

and residents at the SNF and building a toolkit for the OT practitioners to use at the facility. As the toolkit was created, respect for the opinions of the OT practitioners working at the SNF was crucial to providing a toolkit that is relevant for the setting. Surveys and interviews were used to ensure that the principle of fidelity was upheld.

The Occupational Therapy Code and Ethics Standards protects the public and reinforces The Principles and Standards of Conduct for OT practitioners to follow. Emphasizing principles of beneficence, autonomy, and fidelity will guide this project to make sure the workshops address the gap in practice and support OT practitioners in fulfilling their ethical responsibilities in a SNF.

The purpose of this project was to develop resources for the partnering agency, Ensign. In addition, the resources were utilized for the Occupational Therapy Association of California (OTAC) conference on October 17, 2019. Therefore, further ethical considerations of obtaining appropriate permissions to use the tools in the toolkit was necessary. Each mental health tool had their own terms and conditions outlined with their designated point of contact person for obtaining permissions. The following tools required permissions to use, modify or redistribute for the workshops: 1) MI, (2) GAS (3) COPM, and (4) Interest Checklist, (5) WRAP. MI required seeking permissions for use and redistribution of content from organization Motivational Interviewing Network of Trainers (See Appendix D). GAS is not copyrighted. However, permission from Dr. Naomi T. Tabak was sought for use and for the redistribution of her modified GAS template (See Appendix D). The COPM released permission to include COPM in the mental health toolkit as an informative resource but did not grant permission to redistribute the materials (See Appendix D). Interest Checklist released permission for the use of the assessment in the toolkit. In addition, the Interest Checklist required appropriate permission

to modify the content (See Appendix D). WRAP is trademarked. Advocates for Human Potential, Inc released permission of the WRAP for educational use only but did not release permission to redistribute materials (See Appendix D).

Methodology

Project Design

The design of the project consisted of a mental health toolkit and workshop. The intended purpose of the mental health toolkit and workshop was to educate participants on the use of evidence-based mental health tools within the unique SNF-based environment and context. The *OT Practice Guidelines for Adults Living with SMI* states that OT research is needed for adults with a SMI to address the current gap in evidence-based research. (Noyes & Lannigan, 2019). Cohesive evidence supporting interventions that are developed or implemented by OT practitioners is continually needed (Brown, 2012). Therefore, this project identified the most current evidence-based assessments and mental health interventions across multiple disciplines. These assessments and interventions were contextualized into a comprehensive toolkit for OT practitioners working in a SNF.

Mental health toolkit booklet. The development of the evidence-based mental health toolkit led to a tangible booklet. The toolkit includes: (1) recovery model principles, (2) a case study, and (3) one-page summaries of MI, COPM, WRAP, GAS, and life skill group protocols, (4) and an evidence table. The information was made available to the participants through informational handouts on the recovery model and cognitive considerations, a case-study, an evidence table, and one-page summaries of each assessment or intervention. The recovery model principles section has two pages. The first page comprises of definition of the recovery model principles. The second page states how the recovery model principles align with the mental health assessments and interventions. The case study was written to provide workshop participants an opportunity to apply the mental health tools for a resident with a SMI. Evidence tables were created for OT practitioners to inform their evidence-based practice. The mental

health assessments and interventions were summarized into one-page handouts. The one-page summaries provided OT practitioners with immediate instruction of the mental health tool, and included a statement of purpose, indications for use, materials needed, expected resident outcomes, sample documentation, and additional resources. The compiled toolkit included clinical approaches, mental health assessments, evidence-based interventions, and documentation guidance. In addition, the toolkit included the Super Modified Interest List as a separate document due to the tool consisting of 59 pages.

Workshop. The purpose of the workshop was to demonstrate how to implement the approaches, assessments, and interventions from the mental health toolkit booklet. The design of the workshop was meticulously planned by the project developers to ensure the content was organized and promoted participant engagement.

Since the target population of the workshop participants were adults, the project developers decided to utilize andragogy principles. Andragogy is an adult learning theory, which focuses on how the material presented to adult learners need to be (1) self-initiated, (2) person-centered, (3) relate to a need, and (4) self-directed. Participants can further their learning experience by providing their own personal experiences during the workshop (Bastable, Gramet, Jacobs, & Sopczyk, 2010). In both workshops the information was presented through PowerPoint and supplemented by the Mental Health Toolkit booklet. The presentation utilized a variety of learning modalities to fit the different learning styles of the OT practitioners. The pilot and OTAC workshops included a combination of lectures, discussions and interactive learning activities. Participants partook in the interactive portions of the presentation, asked questions, and conveyed experiences with others.

The project developers intended to present the content in an efficient and accurate method given the one-and-a-half-hour time frame for the pilot workshops and three hours for the OTAC presentation. The learning objectives of the pilot and OTAC Conference workshops were to: (1) demonstrate use of evidence-based mental health assessments and interventions from the toolkit to address the needs of a resident with SMI in SNF, (2) understand the importance of the recovery model in OT mental health services for residents with SMI in SNFs (3) document the need and rationale for OT mental health services for residents with SMI. The pilot workshop agenda was organized to follow the OT process. The OT process includes: (1) the evaluation process, (2) intervention process, and (3) outcome measures (AOTA, 2014). For each step of the process, the evidence-based tools selected aligned with the recovery model. Based on the feedback from the pilot workshops, the agenda for the OTAC Conference was modified and emphasized practice utilizing the mental health tools and documentation.

The content of the workshops differed slightly. Given the time length and space of the workshops the project developers had to decide how much of the content was to be interactive for the participants. In the pilot workshops, participants followed a case study to practice therapeutic use of self, MI, and COPM. The remaining content which included the Interest Checklist, life skills group protocols, and WRAP were presented as informative material. The project developers informed the participants of the description of the tool and resident outcomes. In the OTAC Conference, the project developers were given additional time and space to provide longer interactive activities. The content consisted of MI, Interest Checklist, GAS, and life skills group as the interactive material. Whereas Facilitated Sensory Plan and WRAP were presented as an informative manner.

Agency Description

This project was developed in collaboration with Ensign Facility Services and Ensign affiliated SNFs. Ensign is a corporation with over 200 affiliated skilled nursing facilities all over the U.S., they also own and operate senior living units, and hospice programs (Ensign Group, n.d.). This project was designed to meet the needs of residents with SMI who receive LTC services in SNFs and was implemented in Ensign affiliated facilities.

During an initial needs assessment conducted at an Ensign affiliated SNF in California, facility management and staff provided the development team with insight into the facility operational policies, procedures, and culture. As of Thursday, October 18, 2018, the SNF consisted of 35 long-term care residents and six short-term care patients. According to the facility administrator, approximately 85% of the beds were occupied by LTC residents, which demonstrated the growing demand for appropriate LTC services at this facility. Common conditions of residents who receive care at the facility included dementia, traumatic brain injuries (TBI), diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF) (J, personal communication, October 18, 2018). The needs assessment created a deeper understanding of the logistical challenges faced by the facility when caring for residents with a SMI. Interviews with the facility administrator, the OT practitioner, and LTC residents offered the program developers of this project insights that informed the creation of the mental health toolkit.

The discussion with the facility administrator provided contextual information regarding the SNF environment. The administrator described the complex process of transferring residents with a SMI from one SNF to another due to behavioral responses to the environment (J, personal

communication, October 18, 2018). Facilities who do not feel equipped to best serve the needs of residents with SMI may transfer the resident to another SNF.

Based on observations during the needs assessment, the culture of the SNF is influenced by set schedules for meals, social events, and self-care activities. The lived experiences of the residents indicated difficulties with accessing a variety of meaningful occupations. The OT practitioner at the facility noted that residents experienced social isolation, decreased motivation, difficulties with social interactions, and difficulties with behavioral responses. The evidence-based mental health toolkit includes interventions that support residents in managing their symptoms and the environmental conditions in a SNF.

Target Population

The target population for the project are OT practitioners who treat residents with SMI receiving LTC services in a SNF. The OT practitioners were invited to attend the workshop through postcards, flyers, Facebook postings, and an advertisement on the Ensign therapy website.

Project Development

The project addressed the gap in mental health service delivery for residents with a SMI in a SNF. The project developers ensured the gap in practice was addressed by using mental health assessments and interventions aligned with the OT scope of practice and the recovery model. The literature review and needs assessment guided the selection of the mental health tools to best serve the needs of residents with a SMI. The evidence-based mental health tools were specifically contextualized for a SNF into a toolkit for OT practitioners.

Literature review. The literature review illustrated barriers that affect occupational engagement for residents with a SMI, and a need to find relevant evidence based assessments

and interventions. In the literature, health care professionals from psychiatry, nursing, and social services expressed a gap in service delivery for residents with a SMI. In addition, a wide variety of mental health assessments and interventions exist in the literature. However, the literature revealed few OT based assessments and interventions that specifically addressed mental health needs. Therefore, the literature search for contextually relevant tools led the project developers to expand to the field of psychology when selecting approaches, assessments, and interventions for the mental health toolkit. Furthermore, the tools needed to align with recovery model principles and the OT scope of practice.

Needs assessment. The opportunity to interview an OT practitioner, residents, and the administrator during the needs assessment highlighted the barriers from the literature. The needs assessment provided insight on the social isolation, lack of autonomy, and lack of peer support for residents in a SNF. Based on the observations during the needs assessment, the mental health toolkit must be relevant, efficient, cost effective, and accessible for OT practitioners who work in SNFs.

The following two examples from the facility needs assessment reinforced the findings from the literature review and illustrated the gap in mental health service delivery. These examples elucidate the lack of mental health interventions for residents and the documentation challenges OT practitioners experience when using mental health interventions.

During the needs assessment, a resident who resides at the SNF reported inadequate meaningful social events or choices for activities for the past five years resulting in loss of autonomy and social isolation. Another resident who participated in meaningful occupations alone in his room also experienced social isolation. Social isolation was present in both situations because opportunities to promote recovery through the means of self direction and/or peer

support were not facilitated by facility practices or staff. The need to incorporate principles of self direction and peer support to address social isolation supported the inclusion of MI, COPM, Interest Checklist, GAS, and WRAP into the mental health toolkit.

The literature review and needs assessment reflected a lack of OT practitioner confidence and knowledge related to documenting mental health services in order to secure reimbursement. The OT practitioner at the facility initiated psychosocial approaches but struggled to document the interventions in skilled encounter notes for a SNF setting. This lack of confidence and knowledge limited the use of mental health assessments and intervention due to a fear that reimbursement for the services would be denied. Additionally, current changes within reimbursement models and regulations in a SNF context were taken into consideration. Therefore, the one-page summaries of the mental health tools were created as a medium to offer OT practitioners documentation examples of encounter notes and sample goals relevant to the SNF.

Translated mental health tools. The mental health tools that were selected are not typically utilized in a SNF setting, so translation was necessary. The Super Modified Interest List and Facilitated Sensory Plan were tools designed to be contextually relevant in a SNF. The creation of the two tools was needed for residents with SMI and cognitive impairments. The Super Modified Interest List and Facilitated Sensory Plan promotes occupational engagement by addressing a resident's leisure participation and sensory needs.

Super modified interest list. Through the use of 57 royalty-free images, the Super Modified Interest List was developed to address the lack of meaningful occupations in SNFs. The tool is comprised of a variety of activities the resident may have experienced prior to admission. OT practitioners and the resident with a SMI can use the Super Modified Interest List

to identify leisure interests (See Appendix D). The project developers adapted the Modified Interest Checklist to meet the needs of residents with cognitive impairments by enlarging the images and simplifying the list to include only one image per page. The resident interacts with each royalty-free image by putting the images in piles of "like, OK, do not like, and want to try." The OT practitioner presents the royalty-free images one at a time to assist residents who have difficulties with attention. Even though the Super Modified Interest List has activities that may not be relevant to a SNF, OT practitioners can facilitate a discussion with the resident about how to modify the activities to fit a SNF environment. The evidence supports engagement in leisure activities as a component to recovery, therefore the Super Modified Interest List gives residents an opportunity to explore leisure in a SNF setting.

Facilitated sensory plan. The Facilitated Sensory Plan was developed for residents with a SMI who may have difficulties modulating sensory experiences. A resident's ability to self-regulate is important for occupational engagement. A resident's environment and cognition level impact the resident's ability to access occupations and/or manage environmental stimuli. OT practitioners can train caregivers and encourage occupational engagement with the Facilitated Sensory Plan. A Facilitated Sensory Plan is needed because many interventions that address sensory modulation are primarily for self-directed use.

Sensory modulation interventions can be implemented through a Facilitated Sensory Plan. The Sensory Plan should have components that (1) build sensory, social, and emotional language, (2) identify patterns of response to different sensory stimulation, and (3) facilitate sensory opportunities within the environment.

The OT practitioner can complete the first step of the Facilitated Sensory Plan by building sensory, social, and emotional language. The OT practitioner facilitates a discussion

with the resident about their sensory, social, and emotional responses with a specific occupation such as bathing and showering. For example, a resident can identify that a warm shower may make them feel calm.

In the second step of the Facilitated Sensory Plan, the OT practitioner and the resident explore how the resident responds to a variety of sensory experiences within a SNF which include visual, olfactory, auditory, gustatory, tactile, and kinesthetic stimuli. The OT practitioner would then facilitate discussion of the resident's response to the sensory experiences using the language the resident learned from the first step in order to identify sensory preferences. For residents requiring greater facilitation, the OT practitioner may collaborate with the caregiver and utilize sensory defensiveness screening tools. The goal is for the OT practitioner and the resident to explore specific sensory inputs that lead to dysregulation and the sensory inputs that lead the resident back to self-regulation. For instance, the OT practitioner and resident identify that warm showers promote self-regulation, while warm blankets lead to dysregulation because of the resident’s tactile defensiveness to the blanket texture.

In the final step, the OT practitioner identifies sensory opportunities within the SNF. These opportunities would promote self-regulation for the resident throughout their day in the SNF environment. The OT practitioner may support residents in using their sensory, social, and emotional language to communicate their needs with caregivers such as a certified nursing assistant (CNA). An example would be the OT practitioner facilitating the resident to communicate to a CNA a need for a warmer shower. Ultimately, with caregiver support through the Facilitated Sensory Plan, the resident will have greater control of their environment, behaviors, and recovery.

Project Implementation

Two Ensign affiliated SNFs collaborated with this project to host the workshops for the evidence based mental health toolkit. The pilot workshops were advertised through the Ensign website (See Appendix C), social media, postcards (See Appendix B), and flyers (See Appendix A) to a variety of SNFs within a 50-mile radius of Santa Rosa. The project was implemented at two different Ensign affiliated facilities located in Sonoma and Cloverdale on March 28th and 29th of 2019. Participant attendees included OT practitioners, physical therapy assistants (PTA), certified OT assistants, and OT students. Participants had an option to refer to the materials in the booklet while the PowerPoint was presented.

Prior to the workshop, participants completed a survey on practice patterns powered by Google forms. Participants completed post-surveys which provided the project developers with an understanding of the relevance of the toolkit. (See Appendix F). Based on the post survey results, the content of the workshop was well received by the OT practitioners. However, challenges and unexpected outcomes were encountered in all phases of project implementation. Prior to project implementation, the project developers experienced challenges when preparing for the workshop.

Preparing for the workshop entailed (1) recruiting participants and (2) constructing the toolkit booklet. The recruitment process for participants was difficult due to promoting the workshop within a two-week time period. The recruitment process also entailed gaining the support of the directors of rehabilitation (DORs) to encourage rehabilitation team members of the SNF to attend the workshop during work time. The construction of the toolkit was challenging because of the need to obtain the appropriate copyright permissions when presenting copyrighted tools to the participants of the workshop (See Appendix D & E).

There were two unexpected outcomes during and after project implementation: (1) the professional background of the participants who participated in the workshop and (2) the invitation to present the toolkit at the Ensign Therapy Leadership Experience Conference and the OTAC Conference. The unexpected outcomes of the project implementation demonstrated the need for the mental health toolkit. The intention of the project was to educate OT practitioners with evidence-based mental health tools. However, the target population of the workshop reached a larger audience. The wider audience created an opportunity to educate PTAs on methods to engage residents in therapy. PTAs were also educated on the OT role in mental health practice, which can improve the collaborative process when addressing the needs of residents with a SMI. In addition, the OTA student attendee from the workshop is an example of how the mental toolkit can shape the next generation of OT practitioners.

Another unanticipated outcome was the continued demand for additional workshops of the mental health toolkit. The project was presented as a podium and poster at the Ensign Therapy Leadership Experience Conference at Newport Beach, California on June 11, 2019. The project was also accepted to be presented at the OTAC on October 17, 2019 in Pasadena, California as a Pre-Conference Institute. Based on prior feedback, a variety of changes were made to the toolkit and the workshop format. The changes included: (1) creating the Facilitated Sensory Plan, (2) highlighting the recovery model approach, (3) emphasizing documentation methods, (4) incorporating additional peer interaction and discussion.

In order to implement the project, funding was needed to reproduce the training materials and create a sample toolkit. Financial considerations were necessary when developing and implementing the project due to the needed resources. The funding sources of the project included the Ensign Seed Money Grant and the California Foundation of Occupational Therapy

(CFOT) Seed Money for Research Projects and Program Development Projects. This project was also supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $74,968 with 75% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S Government. The funding was used for the project design and implementation.

Project Evaluation

The project was evaluated by the pre- and post- surveys (See Appendix F). The questions on the surveys were designed to understand the confidence level, competency level, and relevance of OT practitioners using mental health tools prior to and after attending the workshop. The findings from the post surveys revealed MI, the Interest Checklist, and GAS were the most relevant tools for addressing the needs of residents with SMI in a SNF. OT practitioners reported the key takeaway lessons from the workshops were learning how to grade mental health assessments up or down and implement the tools more thoughtfully. The three OTR/Ls who attended the pilot workshops reported feeling a higher level of competency when applying the protocols from the toolkit & agreed they would like to implement the toolkit with the residents in a SNF.

The 18 OT practitioners who attended OTAC were given a post presentation survey. Based on the OTAC post-survey, participants reported the workshop learning activities within were engaging, interactive, and collaborative. The participants also provided feedback that the selected assessments and interventions were informative and relevant to practice, with the GAS being the most beneficial. According to the participants, they enjoyed the tangible toolkit booklet and how well the booklet was aligned with the recovery model approach.

Participants of the OTAC workshop traveled and paid separately for the Pre-Conference Institute to learn about the mental health toolkit specifically for SNFs. Participants were actively engaged throughout and very receptive of all the new information from the presentation. Participants requested access to the presentation, the toolkit booklet, and the Super Modified Interest List.

Discussion and Summary

The purpose of the project was to develop an evidence-based mental health toolkit and educate OT practitioners on how to implement the toolkit in SNFs for residents with a SMI. The process of developing the toolkit required reviewing the evidence from the literature and the needs assessment, which revealed OT practitioners did not adequately address mental health in SNFs. The mental health tools selected were translated for a SNF setting and provided OT practitioners with resources to address the barriers that residents with a SMI in a SNF face. The mental health toolkit was presented to OT practitioners in two separate workshops.

Three barriers emerged when developing the project. The first barrier was a reflection of the limited literature impacting the project development. The terminology in the literature created difficulties in defining the term SMI for the project. A clear definition of SMI was needed in order to select the appropriate best practice tools for this specific population. The literature varied in defining SMI with some research articles including posttraumatic stress disorder (PTSD) or anxiety. However, the common thread among the definitions of SMI included conditions of schizophrenia, bipolar, and depression. The project aligned the definition of SMI with the *OT Practice Guidelines for Adults Living with Serious Mental Illness* which highlights schizophrenia, bipolar, and depression in their definition of SMI (Noyes & Lannigan, 2019).

The second barrier was finding sufficient evidence describing the role of OT in SNFs. The literature was limited to two articles describing how OT practitioners are underutilizing their scope of practice by not providing mental health tools in a SNF setting. The literature review does not highlight how this is occurring in SNFs. Consequently, a needs assessment was coordinated to understand the OT practitioner’s role in providing LTC services in a SNF and

how they are addressing mental health. A limitation of the needs assessment was interviewing only one OT practitioner who work for multiple Ensign affiliated SNFs in Northern California.

The third barrier was choosing appropriate assessments and interventions within the OT field that addressed the needs of residents with a SMI. Even though the OT field has roots in mental health, the OT mental health tools had limited research demonstrating recovery for adults with a SMI. Thus, the project had to expand to the psychology field for research on best practice mental health tools. In addition, a frame of reference was needed to guide the selection process of the tools for the toolkit. According to Noyes & Lannigan (2019), the recovery model is the most effective approach for facilitating recovery for adults with a SMI. Each of the tools from the toolkit needed to align with at least one of the principles of the recovery model and OT values. After identifying the selected tools, a barrier that diverted the development process was obtaining the appropriate permissions for specific assessments and interventions. The tools with copyright barriers only permitted educational usage of the tools and prohibited modifications of the tool.

Once the mental health toolkit was completed, workshops were scheduled to present the material, as part of the project implementation. OT practitioners were the target population for the scheduled workshops. Two workshops were scheduled in the cities of Cloverdale and Sonoma, California. Three factors impacting project implementation included the length of the registration period, location of the workshop, duration of the workshop, and number of OT practitioners in attendance. The short registration period may have affected the workshop attendance numbers and the completion of the pre-surveys. The results from the pre-surveys would have informed the project of the OT practitioners' prior knowledge and training of mental health tools. A three-week registration period may not have been enough time for the OT

participants to plan on registering for a weekday workshop. In addition, the location of one of the workshops was 87 miles away from San Francisco, CA, a major metropolitan city. Limited options to public transportation may have impacted participant attendance. Furthermore, the one-and-a-half-hour workshop was not a sufficient amount of time to demonstrate all the materials from the mental health toolkit. Due to the time constraint, only five out of the seven tools were presented in the workshop. As mentioned before, the target population for project implementation was OT practitioners. However, invitations for the workshop extended to the entire rehabilitation team of the hosted SNFs, which included PTA and certified occupational therapy assistants. The presentation of the evidence-based mental health toolkit conveyed the OT's scope of practice within mental health to the rehabilitation team. Consequently, the rehabilitation team was informed of the OT's role when working with residents with a SMI. The information from the presentation expanded team members' knowledge of when to refer their client to OT services when relevant.

The participants completed a post-survey, which revealed that time, insurance reimbursement, and SNF policies were barriers to implementing mental health tools. The findings showed OT practitioners rated themselves with a high level or competence and confidence in utilizing the tools after attending the workshop. In addition, the surveys displayed that OT practitioners found the tools to be valuable and had potential to be used in practice. In the post-surveys, the OT practitioners also identified that MI, Modified Interest Checklists, and GAS were the most relevant mental health tools to utilize with residents in SNFs.

After the two workshops, the project was accepted as a three-hour session at the annual OTAC Conference 2019. In the prior workshops, participants vocalized a concern of how to document and bill for mental health services. Therefore, each tool presented at the OTAC had

significant training in documentation. The documentation portion of the workshop educated participants of how to document for skilled OT services when utilizing the tools from the toolkit.

The OT mental health toolkit for SNF practice promotes awareness and advocates for the use of current evidence-based mental health services for residents with an SMI who live in a SNF environment. Advocacy can be accomplished at the practitioner level and moves towards influencing national policies. Awareness is a key principle when advocating for OT mental health services. OT practitioners who are conscious of the lack of mental health tools in a SNF can advocate to provide mental health services for the residents. In order to justify the services for reimbursement, OT practitioners should be aware of how to articulate the needs and their skilled abilities when documenting. OT practitioners also facilitate self-advocacy skills for the resident through the use of the mental health toolkit. Therefore, advocacy may start with the resident in a SNF. Advocacy may be expanded to a national level by partnering with AOTA or other national organizations to transfer the mental health toolkit workshop content into online training modules for OT practitioners.

Recommendations

Recommendations for further development of this project include the collection of outcome data from OT practitioners who utilize the toolkit for residents with a SMI to demonstrate the effectiveness of the toolkit. The mental health toolkit can expand further by incorporating other evidence-based mental health tools most relevant to a specific SNF who may have other considerations. In addition, references such as the online video library and evidence tables can be expanded further in the future to provide OT practitioners more tools to implement into practice.

Recommendations for the OT field are to expand the limited quantitative and qualitative research on the mental health of adults with a SMI and advocate for the importance of mental health within the SNF. *The OT Practice Guidelines for Adults Living with SMI* is beneficial for OT practitioners when addressing the needs of residents with a SMI. However, additional research in the literature is needed for further justification of mental health support services. OT practitioners must advocate for evidence based mental health tools for residents with a SMI in order to view the resident as a whole rather than only focusing on physical disabilities during their stay in the LTC of a SNF.

Recommendations for future program developers implementing a similar project include (1) recruiting further in advance to increase participant attendance (2) facilitating increased discussions between participants and (3) creating interactive portions throughout the workshop.

Conclusion

The project addressed a gap in mental health service delivery for residents with a SMI who receive LTC services in SNFs because OT practitioners are not utilizing the full scope of their practice. The evidence-based mental health toolkit was created for OT practitioners to use in their OT process. The selected mental health tools were contextualized for a SNF environment to either preserve, maintain, or improve a residents' recovery. OT practitioners facilitate recovery by collaborating with the residents using the toolkit. The toolkit was presented to educate OT practitioners regarding implementation of the tools and documentation of the skilled services. Based on the participants' responses from the pilot workshops and OTAC, a need to address mental health in a SNF is evident and more mental health tools are needed for a SNF setting. Mental health assessments and interventions that are feasible, relevant, reimbursable and utilize evidence-based best practices can empower OT practitioners to implement mental health tools in the SNF setting to address the needs of residents with SMI.

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Appendix A: Recruitment Flyer

Psychosocial Toolkit Workshop

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Purpose:

Evidence-based mental health assessments and interventions will be presented to occupational therapy (OT) practitioners to better serve the needs of adults with a serious mental illness in a skilled nursing facility (SNF). OT students from Dominican University of California have consolidated the assessments and interventions into a toolkit. The toolkit will enhance the OT practitioners' skills and promote active engagement in the residents within the SNF.

Learn How To:

- Approach a resident using therapeutic use of self & motivational interviewing
- Access the toolkit & online video library, which will include two assessments, two interventions, & examples of documentation for mental health interventions
- Practice two assessments from toolkit to create a resident's occupational profile (i.e., Canadian Occupational Profile Measure & Modified Interest Checklist)
- Utilize two mental health interventions from toolkit
    - Wellness Recovery Action Plan & life skills group as group therapy sessions
- Document for reimbursement of mental health interventions
- Receive a certificate of completion for the training

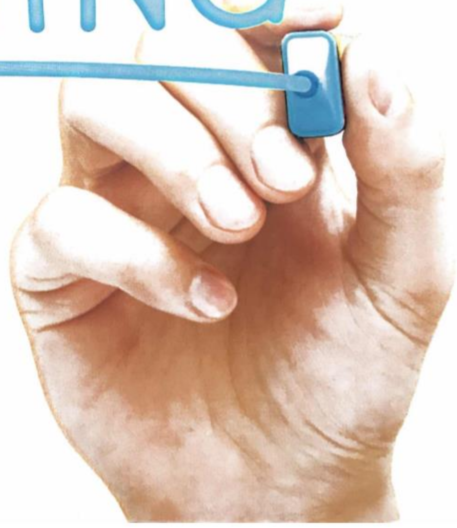
When? Where?

- Dates:
    - Thursday, 3/28/2019 at Cloverdale at 12:00-1:30pm
      RSVP at: https://ensigntherapy.com/event/psychosocial-toolkit-workshop-cloverdale
    - Friday, 3/29/2019 at Broadway Villa at 12:00-1:30pm
      RSVP at: https://ensigntherapy.com/event/psychosocial-toolkit-workshop-sonoma/
- One workshop day will be 1.5 hours

Lunch and refreshments will be provided.

Appendix B: Recruitment Postcard

TRAiNiNG



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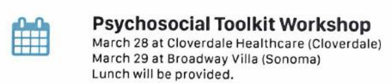
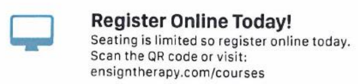
Clinical Pathway for Heart Failure Clients
April 12 at Park View Post Acute (Santa Rosa)
Lunch will be provided.

Please join us for a presentation of a clinical pathway for heart failure clients developed by Dominican MSOT graduate students.



Psychosocial Toolkit Workshop
March 28 at Cloverdale Healthcare (Cloverdale)
March 29 at Broadway Villa (Sonoma)
Lunch will be provided.

Evidence-based mental health assessments and interventions will be presented to occupational therapy practitioners to better serve the needs of adults with a serious mental illness in a skilled nursing facility.



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Appendix C: Website Registration

EnsignTherapy.com Careers Courses FlagPOST SPARC ENspire Posters Contact

Psychosocial Toolkit Workshop (Cloverdale)

March 28 @ 12:00 pm - 1:30 pm PDT

Evidence-based mental health assessments and interventions will be presented to occupational therapy (OT) practitioners to better serve the needs of adults with a serious mental illness in a skilled nursing facility (SNF). OT students from Dominican University of California have consolidated the assessments and interventions into a toolkit. The toolkit will enhance the OT practitioners' skills and promote active engagement in the residents within the SNF.

Lunch will be provided.

Learn how to:

- Approach a resident using therapeutic use of self & motivational interviewing
- Access the toolkit and online video library, which will include two assessments, two interventions, and examples of documentation for mental health interventions
- Practice two assessments from toolkit to create a resident's occupational profile (i.e., Canadian Occupational Profile Measure and Modified Interest Checklist)
- Utilize two mental health interventions from toolkit
  - Wellness Recovery Action Plan as concurrent therapy
  - Life skills group as group therapy sessions
- Document for reimbursement of mental health interventions

Interested in signing up for this course? Please take the survey (step 1) and then register online (step 2).

Instructions

Step 1 – Take the Survey

Please take the Psychosocial Workshop Pre-Survey. (Survey page will open in a new tab/window.) This survey will take approximately 15 minutes and will cover topics related to mental health and how OT practitioners in a SNF work with residents with a SMI.

Step 2 – Register for Course

Once you've completed the survey, return to this page and submit the course registration form below.

+ GOOGLE CALENDAR + ICAL EXPORT

EnsignTherapy.com Careers Courses FlagPOST SPARC ENspire Posters Contact

Psychosocial Toolkit Workshop (Sonoma)

March 29 @ 12:00 pm - 1:30 pm PDT

Evidence-based mental health assessments and interventions will be presented to occupational therapy (OT) practitioners to better serve the needs of adults with a serious mental illness in a skilled nursing facility (SNF). OT students from Dominican University of California have consolidated the assessments and interventions into a toolkit. The toolkit will enhance the OT practitioners' skills and promote active engagement in the residents within the SNF.

Lunch will be provided.

Learn how to:

- Approach a resident using therapeutic use of self & motivational interviewing
- Access the toolkit and online video library, which will include two assessments, two interventions, and examples of documentation for mental health interventions
- Practice two assessments from toolkit to create a resident's occupational profile (i.e., Canadian Occupational Profile Measure and Modified Interest Checklist)
- Utilize two mental health interventions from toolkit
  - Wellness Recovery Action Plan as concurrent therapy
  - Life skills group as group therapy sessions
- Document for reimbursement of mental health interventions

Interested in signing up for this course? Please take the survey (step 1) and then register online (step 2).

Instructions

Step 1 – Take the Survey

Please take the Psychosocial Workshop Pre-Survey. (Survey page will open in a new tab/window.) This survey will take approximately 15 minutes and will cover topics related to mental health and how OT practitioners in a SNF work with residents with a SMI.

Step 2 – Register for Course

Once you've completed the survey, return to this page and submit the course registration form below.

+ GOOGLE CALENDAR + ICAL EXPORT

Appendix D: Mental Health Assessments and Interventions Permissions

Motivational Interviewing Permission

Permission for Motivational Interviewing Inbox ×

Subject: Permission for Motivational Interviewing
To:

To Whom It May Concern,

I am a graduate student at Dominican University of California completing my master's thesis entitled Translated Evidence-Based Mental Health Toolkit for Skilled Nursing Facilities.

My thesis will be available in full text on the Internet for reference, study and/or copy. Except in situations where a thesis is under embargo or restriction the electronic version will be openly accessible through Dominican Scholar, the institutional repository of Dominican University of California, the Library's online catalog, and also through web search engines. These rights will in no way restrict re-publication of the material in any other form by you or by others authorized by you.

I would like permission to allow inclusion of the following material in my thesis: motivational interviewing (MI) strategies and how to implement MI. You can find a copy of how the MI information will be displayed in my thesis: The items included in my thesis will be referred to in future workshops for educational purposes. The material will be attributed through a citation. Please confirm in writing or by email that these arrangements meet with your approval. Thank you for your help.

Sincerely,
Cecelia Ly-Peh

wrote:

Hello Cecelia,

Thank you for your email and your interest in MINT. You have our permission to include the materials in your documents, using the proper citation as you stated.

Best wishes in your endeavors,

Operations Manager
MINT, Inc.

Cece Ly-Peh wrote:

Thank you for your permission. Would this permission include being able to use MI in future workshops for educational purposes? The material will be appropriately cited during the workshops as well.

Sincerely,
Cecelia

From: [redacted]

Subject: Re: Permission for Motivational Interviewing
To: Cece Ly-Peh <cecelia.ly-peh@students.dominican.edu>

Yes

Operations Manager
MINT, Inc.

Canadian Occupational Performance Measure Permission

Name: Cecelia Ly-Peh

Email:

Message: To Whom It May Concern:

My name is Cecelia. I am a second year student in the master of science occupational therapy (OT) program at Dominican University of California in San Rafael, California. My two colleagues and I are in the process of completing our capstone project. Our capstone topic is related to translating mental health interventions into a toolkit for OT practitioners. OT practitioners will use this toolkit specifically for residents with a serious mental illness living in the long term care unit of a skilled nursing facility. We plan to implement the information into a workshop by the end of March.

We are emailing you today, because we are interested seeking permission to use the Canadian Occupational Performance Measure (COPM) as one of our assessments in our toolkit. We believe the COPM would be a great addition to our toolkit because it aligns with the recovery approach which is best practice when serving individuals with a serious mental illness. Therefore we would like to know what the procedure is to obtain permission for the COPM.

Thank you in advance for your time. We look forward to hearing back from you.

Sincerely,
Cecelia

Re: TheCOPM.ca Contact Form

Hi Cecilia,

Thank you for your email. You will need to purchase enough COPM measures for your project and not include them in the toolkit if it is being copied or left with anyone. Measures can be purchased from out website at the following link: http://www.thecopm.ca/buy/. It would be best to refer to the COPM in the toolkit but have the measures separated. Good luck with your project.

Regards,

Administrative Manager
COPM Inc.
www.thecopm.ca

My capstone members and I would like clarification regarding the statement, "purchase enough COPM measures for your project and not include them in the toolkit if it is being copied or left with anyone." From our understanding, we can purchase COPM measures for our workshop but we are not allowed to leave the purchased COPM measures with the OT practitioners attending the in person workshop? Is that correct?

Thank you for your time!

Sincerely,
Cece

Hi Cece,

I have touched base with Mary Law regarding your follow up question. We want to ensure the COPM measure is not photocopied. You can give them the measure but please write "DO NOT COPY" on the measure before you give it to the therapists taking part in your project.

Let us know if you have any further questions.

Interest Checklist Permission

Cece Ly-Peh

I am a graduate student at Dominican University of California completing my master's thesis entitled Translated Evidence-Based Mental Health Toolkit for Skilled Nursing Facilities.

My thesis will be available in full text on the Internet for reference, study and/or copy. Except in situations where a thesis is under embargo or restriction the electronic version will be openly accessible through Dominican Scholar, the institutional repository of Dominican University of California, the Library's online catalog, and also through web search engines. These rights will in no way restrict re-publication of the material in any other form by you or by others authorized by you.

I would like permission to allow inclusion of the following material in my thesis: (1) use the interest checklist and modified interest checklist (2) redistribute the interest checklist and modified interest checklist (3) adapt/modify the modified interest checklist by utilizing the same activities, but with different images (here is the link to access it: You can find a copy of how the interest checklist and modified interest checklist information will be displayed in my thesis: The items included in my thesis will be presented in future workshops for educational purposes. The material will be attributed through a citation. Please confirm in writing or by email that these arrangements meet with your approval. Thank you for your help.

Sincerely,
Cecelia Ly-Peh

wrote:

Dear Cecelia,

You have permission under the condition that the items from the assessment are watermarked with the word SAMPLE in large letters, diagonally, across the page.

Thank you,

Professor and Associate Dean for Academic and Faculty Affairs
Director, Model of Human Occupation Clearinghouse

Dean's Office
College of Applied Health Sciences
University of Illinois at Chicago

808 S. Wood St., 167 CMET
Chicago, IL 60612
(312) 996-8217

From: Cece Ly-Peh

To:
Subject: Re: Permission for the Interest Checklist

Thank you for the clarification. Is the permission for also adapting/modifying the interest checklist? And being able to present on the interest checklist and modified interest checklist in future workshops?

Thank you for your time.

Sincerely,
Cecelia

wrote:

Cecilia
Yes, as long as you transparently report that modifications were made, and know that the psychometric data would change between versions.
Best Wishes,
Renee

From: Cece Ly-Peh

To:
Subject: Re: Permission for the Interest Checklist

Thank you! Could I also please clarify if the permission is granted for the interest checklist and modified interest checklist to be presented in future workshops?

Sincerely,
Cecelia

wrote:

Cecelia
Yes, as long as you do not distribute them for people to keep and use.
Best Wishes,

Goal Attainment Scale Template

Name: Jan Conducto

Email: janmartha.conducto@students.dominican.edu

Subject: RE: permission Goal Attainment Scale templates

Message: Good afternoon,

I recently emailed your address to obtain permission in gaining the GAS templates. However, I am concerned the email may not be the current email address. The email is copied and pasted below for your reference.

Thank you for your time and consideration.
Jan Conducto

Below is the said email:

"Dear

My name is Jan Conducto. I am a third year student in the master of science occupational therapy (OT) program at Dominican University of California in San Rafael, California. I am emailing you today to obtain the Goal Attainment Scale (GAS) templates per request as stated in the article: "Goal attainment scaling: Tracking goal achievement in consumers with serious mental illness."

My two colleagues and I are in the process of completing our capstone project. Our capstone topic is related to contextualizing mental health interventions into a toolkit for OT practitioners. OT practitioners will utilize this toolkit for residents with a serious mental illness living in the long term care unit of a skilled nursing facility. We would like to present the GAS, along with other evidence-based tools in a workshop for OT practitioners at the Occupational Therapy Association of California (OTAC) conference on October 17, 2019.

We believe GAS would be a great addition to our toolkit because the intervention aligns with the recovery approach, which is best practice when serving individuals with a serious mental illness. Our goal is to educate the OT field of this tool and consider the benefits/challenges of using GAS within a SNF setting. The conference session will serve as an educational medium.

We are interested in including the GAS templates mentioned in your article, because the tool is modified in a manner to best serve the needs of residents within a SNF. Therefore, we would like to know what the procedure is for gaining permission to obtain and share the templates.

We are happy to provide any additional information for clarification. Thank you in advance for your time. We look forward to hearing back from you.

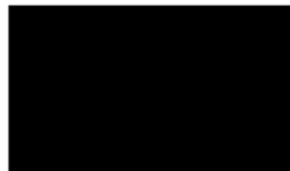
Re: Form Submission - New Form - RE: permission Goal Attainment Scale templates Inbox ×

to me

Dear Jan,

Please find the goal attainment templates attached. Best of luck in your research.

--



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Wellness Recovery Action Plan Permission

Seeking permission for capstone project Inbox ×

Thu, Sep 19, 10:54 AM

To Whom It May Concern:

My name is Natalie Barrales. I am a third-year student in the Master of Science Occupational Therapy (OT) program at Dominican University of California in San Rafael, California. I am emailing today to seek permission to use the Wellness Recovery Action Plan (WRAP) for a capstone project.

My two colleagues and I are in the process of completing our capstone project. Our capstone topic is related to researching best practice and evidence-based tools for residents with a serious mental illness living in a skilled nursing facility (SNF). The findings will be available to current OT practitioners working in SNFs.

Our initial research has shown a gap in practice in implementing mental health interventions in SNFs. The evidence illustrates residents in SNFs presenting difficulties with motivation, social participation, personal responsibility, and self-regulation (managing their own emotions). These areas of concerns can be addressed by utilizing the WRAP and other researched mental health tools.

We would like to present the WRAP, along with other evidence-based tools in a workshop for OT practitioners on October 17th at the Occupational Therapy Association of California (OTAC) conference. During this conference, we are not interested in obtaining profit or changing the essence of the WRAP. Our goal is to educate the OT field of this tool and consider the benefits/challenges of using the WRAP protocol within a SNF setting. The conference session will serve as an educational medium and not a training on the WRAP. If OT practitioners are interested in learning more about the WRAP, we will inform OT practitioners to refer to the WRAP website for further training and materials. Again, the goal of the capstone project is to introduce the OT practitioners to establish evidence-based tools and discuss how to apply the tools in a SNF.

We are happy to provide any additional information for clarification. Thank you in advance for your time and consideration. We look forward to hearing back from someone soon.

Sincerely,

[redacted] wrote:

Thanks for your email. We will grant permission to you based on your email below. Please note that you should share the copyright notice for WRAP and that it's used with permission for your project only. Please also share a slide or provide the web address where WRAP products can be ordered. Please let me know if you have any questions.

Business Manager, Publishing

O: 978-261-1444

F: 978-261-1467

Appendix F: Pre- and Post-Surveys

Pre-Survey:

Thank you for registering for the Psychosocial Workshop!

Hello! Our names are Natalie Barrales, Jan Martha Conducto, and Cecelia Ly-Peh. We are students from Dominican University of California. We are currently in the second semester of our capstone project. Our project aims to educate occupational therapy (OT) practitioners of evidence-based mental health interventions for residents with a serious mental illness (SMI) (i.e., depression, anxiety, bipolar, schizophrenia).

This survey will take approximately 15 minutes and will cover topics related to mental health and how OT practitioners in a SNF work with residents with a SMI. We thank you in advance for your time, and we look forward to reading your responses!

General Background Information:

Please choose the option that best describes you:

- ○ I currently work in an Ensign affiliated SNF
- ○ I currently work in another SNF setting
- ○ I have previously worked in a SNF setting
- ○ Other

How long have you been an occupational therapist working in a skilled nursing facility setting?
#___yrs

Does your facility have a long-term care?

Do you treat long term care residents?

In your caseload are any of the residents diagnosed or have symptoms consistent with a serious mental illness?

How would you rate your level of skill in treating residents with serious mental illness (SMI)?

No level of competence — High level of competence

1 2 3 4 5

How would you rate the interprofessional communication amongst staff members (Nurses, PT, OT, etc.) at your site in relation to residents with a serious mental (i.e., change in condition, daily schedule, precautions, barriers to discharge, changes in/effects of medication, etc.)?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very Good
- ○ Excellent
- ○ Other:

What could be done to improve interprofessional communication at your site?

Does your facility have specific protocols, procedures, or practice guidelines that you use to treat your residents with SMI (i.e., through the use of structured interventions, sequencing of interventions, requiring use of specific assessments or educational handouts, etc.)? If so, please describe the protocol used and your satisfaction with its use.

Evaluation Questions:
What is your evaluation process (include assessments, if any)?

Are you satisfied with your evaluation process?

Strongly disagree				Strongly agree
1	2	3	4	5

How often do you currently create occupational profiles with your residents with a SMI? An occupational profile that consists of all components: a client's occupational history and experiences, patterns of daily living, interests, values, and needs (AOTA, 2014).

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently
- ○ Always
- ○ Other:

If you answered "Never" why not?

Which of the following approaches do you use in your evaluation process (check all that apply):

- ❏ Therapeutic use of self (i.e., active listening)
- ❏ Motivational interviewing (MI)

Do you currently use the Canadian Occupational Performance Measure (COPM) assessment with your residents with SMI?

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently
- ○ Always
- ○ Other

If you answered "Never" why not? If you answered “Other,” please explain.

Do you currently use (or have previously used) the Interest Checklists with your residents with SMI?

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently

- Always
- Other

If you answered "Never" why not? If you answered “Other,” please explain.

What would support your implementation of additional/new mental health **assessments**? (i.e., access to online and in-person training, information booklet on assessments and treatments, documentation examples etc.)

What do you perceive as being the strongest barriers to the implementation of additional/new mental health **assessments**? (i.e., time constraint, absence of materials and supplies, SNF’s policy, insurance reimbursement, requiring additional education, etc)

Intervention Questions:

How would you rate your level of skill when integrating mental health interventions into your treatment plans?

No level of competence				High level of competence
1	2	3	4	5

Do you have experience in implementing mental health interventions in your facility?

If yes, what type of mental health interventions are you utilizing?

What percentage of your total treatment time targets psychosocial wellbeing for residents with SMI?

- Less than 10%
- 10-25%
- 25-50%
- 50-75%
- 75-100%
- Other:

What would support your implementation of additional/new mental health **interventions**? (i.e., access to online and in-person training, information booklet on assessments and treatments, documentation examples etc.)

What do you perceive as being the strongest barriers to the implementation of additional/new mental health **interventions**? (i.e., time constraint, absence of materials and supplies, SNF’s policy, insurance reimbursement, requiring additional education, etc)

Do you currently use the Goal Attainment Scale (GAS) with your residents with SMI?

- Never
- Rarely
- Occasionally
- Frequently
- Always
- Other

If you answered "Never" why not? If you answered “Other,” please explain.

Do you currently use the Wellness Recovery Action Plan (WRAP) with your residents with SMI?

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently
- ○ Always
- ○ Other

If you answered "Never" why not? If you answered “Other,” please explain.

Do you currently use the Life Skills Group with your residents with SMI?

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently
- ○ Always
- ○ Other

If you answered "Never" why not? If you answered “Other,” please explain.

Which of the following modes of therapy do you use in your intervention process (check all that apply):

- ❑ **Concurrent** (One OT practitioner administering TWO residents at the same time while performing DIFFERENT activities)
- ❑ **Group** (One OT practitioner administering TWO to FOUR residents at the same time while performing SAME or SIMILAR activities)
- ❑ **Individual**
- ❑ **Other**:

How often do you provide concurrent modes of therapy (As one OT practitioner administering two residents at the same time who are performing different activities)? If you do not utilize concurrent modes of therapy, please skip to question #.

- ○ Never
- ○ Rarely
- ○ Occasionally
- ○ Frequently
- ○ Always
- ○ Other:

How would you rate your level of skill for administering interventions that utilize concurrent modes of therapy with two residents with a SMI?

No level of competence High level of competence

1 2 3 4 5

How often do you provide group modes of therapy (As one OT practitioner administering two to four residents at the same time while performing the same or similar activities) to your residents with SMI? If you do not utilize group modes of therapy, please skip to question #.

- Never
- Rarely
- Occasionally
- Very Frequently
- Always
- Other:

How would you rate your level of skill for administering interventions that utilize group modes of therapy to residents with a SMI?

No level of competence High level of competence
1 2 3 4 5

Documentation Questions

How would you rate your level of skill for documenting assessments/interventions for residents with a SMI?

No level of competence High level of competence
1 2 3 4 5

What occupation based interventions are documented in alleviating the symptoms of residents with serious mental illness?

How are the interventions justified in documentation to address the symptoms of residents with serious mental illness?

Other:

If you are willing to be briefly interviewed over phone or email, please leave your name and email and/or phone number in the answer box below.

Post Survey:

Thank you for participating in our presentation today. This post survey will have similar questions as the Psychosocial Workshop Pre-Survey. Now that you have completed the workshop we would appreciate your feedback. Thank you in advance for your time.

General Background Information

How would you rate your level of skill in treating residents with a serious mental illness after attending the workshop?

No level of competence High level of competence

1 2 3 4 5

How confident do you feel about applying the protocols from the toolkit learned today in the SNF facility?

No level of confidence High level of confidence

1 2 3 4 5

Did the information presented feel relevant to a skilled nursing facility environment?

Yes No

Evaluation / Intervention / Documentation Questions:

How do you feel about your evaluation / intervention process after attending the workshop?

- ❑ I will implement the toolkit to residents
- ❑ I can see the benefits but the toolkit has some limitations
- ❑ I do not think that I will implement the toolkit
- ❑ Other

Which mental health assessments do you find most relevant to a skilled nursing facility environment?

- ❑ Canadian Occupational Performance Measure (COPM)
- ❑ Interest Checklists
- ❑ None of the above

Which approaches or assessments would you likely implement into getting the resident's occupational profile?

- ❑ Canadian Occupational Performance Measure (COPM)
- ❑ Interest Checklists
- ❑ Therapeutic Use of Self (i.e., active listening)
- ❑ Motivational interviewing (MI)
- ❑ None of the above

Which mental health interventions do you find most relevant to a skilled nursing facility environment?

- ❑ Goal Attainment Scale (GAS)
- ❑ Wellness Recovery Action Plan (WRAP)
- ❑ Life Skills Group
- ❑ None of the above

What resource(s) from the toolkit do you find supportive for your implementation process.

- ❑ Video library
- ❑ One page summaries of assessments and interventions
- ❑ Sensory toolkit
- ❑ Life Skills Group protocols
- ❑ PowerPoint presentation
- ❑ Evidence table
- ❑ Case study

- ❏ Documentation sample
- ❏ Supplies for Canadian Occupational Performance Measure (COPM)
- ❏ Supplies for Wellness Recovery Action Plan (WRAP)
- ❏ Supplies for grading up and down Interest Checklists
- ❏ None of the above

Do the resources from the toolkit remove barriers for you to the implementation of additional/new mental health **assessments**? (i.e., time constraint, absence of materials and supplies, SNF's policy, insurance reimbursement, requiring additional education, etc)

Yes No

How would you rate your level of skill for documenting assessments/interventions for residents with a SMI?

No level of competence High level of competence

1 2 3 4 5

<u>Workshop / Presentation Evaluation Questions:</u>

Are there components to the training workshop you recommend changing?

How likely are you to recommend this training session to a staff member working in a SNF?

How well did the content that was delivered match your expectations?

What did you learn in the workshop?

Rate the productivity of the workshop circuit.

How engaging was the presenters? What is needed to improve for quality presentation?

List any suggestions on how to improve this workshop