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Abstract

Mental health has been identified as a priority practice area for occupational therapy. However, recent research suggests that the number of occupational therapy practitioners working in mental health is declining. The purpose of this survey research study was to examine the extent to which occupational therapy (OT) and occupational therapy assistant (OTA) programs include mental health topics in their curricula. A link to an on-line survey was sent to program directors of OT and OTA programs in the United States. A total of 105 programs fully completed the survey (33% response rate). All of the respondents (n=105) reported that their curricula included content related to adult mental health conditions and interventions and 98.1% (n=103) included content related to 11 child and adolescent mental health conditions. Programs varied in how explicitly they focused on specific intervention strategies to support or improve mental health. Focused pre-service curricular content and intentional fieldwork experiences may help to ensure that OT practitioners are inducted into mental health settings and equipped to meet practice demands. Entry-level OT and OTA programs cover a broad range of mental health-related topics. More research is needed to understand why some topics are included in curricula at greater rates than others.

Keywords

Mental health, entry-level OT and OTA programs, curricula

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ABSTRACT

Mental health has been identified as a priority practice area for occupational therapy. However, recent research suggests that the number of occupational therapy practitioners working in mental health is declining. The purpose of this survey research study was to examine the extent to which occupational therapy (OT) and occupational therapy assistant (OTA) programs include mental health topics in their curricula. A link to an on-line survey was sent to program directors of OT and OTA programs in the United States. A total of 105 programs fully completed the survey (33% response rate). All of the respondents (n=105) reported that their curricula included content related to adult mental health conditions and interventions and 98.1% (n=103) included content related to 11 child and adolescent mental health conditions. Programs varied in how explicitly they focused on specific intervention strategies to support or improve mental health. Focused pre-service curricular content and intentional fieldwork experiences may help to ensure that OT practitioners are inducted into mental health settings and equipped to meet practice demands. Entry-level OT and OTA programs cover a broad range of mental health-related topics. More research is needed to understand why some topics are included in curricula at greater rates than others.

BACKGROUND

Early occupational therapy education focused on understanding the “curative effect of goal directed activity” (Levine, 1987, p. 249), the significance of habit formation (Slagle, 1922), and the inextricable relationship between the mind, the body, and the environment (Kielhofner, 2004). During the profession’s formative years, occupational therapy practitioners worked almost exclusively with psychiatrists in the treatment of individuals with psychiatric disabilities and used psychoanalytic and psychodynamic approaches to aid recovery (Scheinholtz, 2010). As the needs of society changed around the First World War, occupational therapy practitioners began to treat individuals with physical disabilities and by the mid-twentieth century had adopted a biomedical

perspective (Ikiugu, 2010; Kielhofner, 2004). Despite the adoption of this new perspective, mental health remained a critical component of entry-level occupational therapy education and facilitated practitioners' understanding of underlying disorders and their influence on functional performance deficits (Fidler & Fidler, 1963; Kielhofner, 2004).

Education related to mental health conditions, functional impairments, and interventions continues to be an important part of occupational therapy practitioners' preparation (Craik & Austin, 2000; Scanlan et al., 2015). However, current workforce trends suggest that many occupational therapists and occupational therapy assistants are choosing not to enter into this area of practice (AOTA, 2015b; LaGrossa, 2008) and those that do often experience burn out and ultimately leave these settings (Scanlan, Meredith, & Poulsen, 2013). The relative absence of occupational therapy practitioners in mental health settings has led to unintentional consequences (Weinstein, 2013). In many states, for example, occupational therapy practitioners are no longer recognized as qualified mental health providers (QMHP; LaGrossa, 2008) and many mental health jobs which were previously held by occupational therapy practitioners have been phased out or are now assumed by other practitioners (Gutman, 2011). Additional consequences, which are likely interrelated, include traditional mental health practitioners' limited understanding of occupational therapy's contribution to the team and the challenges occupational therapy practitioners may face when trying to reinsert themselves into traditional mental health settings after a prolonged absence (Cahill & Egan, 2017).

The AOTA has encouraged continued practice in mental health through many efforts, including the development of task forces and workgroups, as well as the dissemination of several official documents (LaGrossa, 2008; Weinstein, 2013). For example, *Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Interventions in Occupational Therapy Practice* (AOTA, 2010) was developed by the Mental Health Competencies Ad Hoc Committee to describe the specialized training and practice expectations for entry-level occupational therapy practitioners, and *Occupational Therapy Services in the Promotion of Mental Health and Well-being* was adopted by the AOTA Representative Assembly Coordinating Council in 2015 (Kannenberg, Amini, & Hartman, 2015). More recently, the unique contributions of occupational therapy in mental health were outlined in *Occupational Therapy's Distinct Value: Mental Health Promotion, Prevention, and Intervention across the Lifespan* (AOTA, 2016). The AOTA also considered how occupational therapy education programs could influence new graduates to enter into mental health practice settings. In 2013, AOTA's Accreditation Council for Occupational Therapy Education (ACOTE) began enforcing standard C.1.7 which mandates that students, in all levels of training, complete a fieldwork experience with a primary focus on psychological and social factors that influence engagement in occupation (ACOTE, 2011; Brown, 2012a; Weinstein, 2013).

Purpose

It has been suggested that adequate academic preparation is the key to encouraging

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new occupational therapy practitioners to enter into mental health practice (Scanlan et al., 2015; Whalens et al., 1998). However, a current review of the literature yielded no studies that directly explored the breadth of mental health topics that are included in occupational therapy (OT) and occupational therapy assistant (OTA) academic curricula in the United States. Program survey data specific to mental health education and training for occupational therapy practitioners could promote curricular changes that could encourage new practitioners to enter this diminished area of practice and possibly provide more support for making occupational therapy practitioners eligible for the QMHP status nationwide. Therefore, the purpose this study was to examine the extent to which OT and OTA programs included mental health topics in their curricula.

METHOD

Research Design

A survey design was selected for this study because it allowed for data collection from a large sample size in a relatively efficient manner (Fowler, 2013). This study was approved and conducted in accordance with the guidelines of the university's institutional review board. Participants demonstrated consent related to their participation in this study by completing and submitting the on-line survey.

Participants

An email including a cover letter and the survey's URL link was sent to the directors of 318 accredited entry-level OT and OTA programs in the United States (122 entry-level OT programs, 196 entry-level OTA programs) based on contact information available in the public domain (i.e., information available on AOTA's website, as well as each particular program's website).

Procedures and Data Collection

We used a survey questionnaire to elicit information from program directors of entry-level OT and OTA programs. Potential participants received a cover letter describing the purpose of the study and a URL link to SurveyMonkey, the on-line survey engine that housed the survey questionnaire. A single follow-up reminder email with the URL link to the survey questionnaire was sent to the directors one month after the original email was sent. Data were collected over a three month period.

Survey Instrument and Data Analysis

The current survey questionnaire was modeled after other studies that focused on curricular content within OT programs (see for example Deacy, Yuen, Barstow, Warren, & Vogtle, 2012; Yuen & Burik, 2011). Fourteen questions (i.e., 13 closed-ended items and 1 open-ended item) specifically addressed the nature and extent of mental health content offered in entry-level OT and OTA programs. The closed-ended items identified the academic level of the program, approximate class size, background information about the program, and the extent to which content and coursework specific to mental health were included in the curriculum. Questions included whether or not the curriculum offered specific course content related to geriatric, adult, and child and adolescent mental health; opportunities to learn from individuals with mental health

diagnoses or staff from organizations serving clients with mental health concerns; approaches to ACOTE standard C.1.7; and specific topics and populations covered in relation to mental health.

The content for the survey questionnaire was developed by the authors, who are experienced occupational therapy academicians and clinicians, after an extensive literature review. Both authors have experience in mental health; the first author has a background in community mental health and is also credentialed as an alcohol and drug counselor, and the second author has a background in school mental health. Face and content validity were addressed through a review of the questionnaire by two other occupational therapy practitioners with extensive backgrounds in mental health practice. Reviewers' feedback was used to revise questions and provide additional clarification.

Data were analyzed using descriptive statistical methods and IBM SPSS Version 20 (IBM Corporation, Armonk, NY). Characteristics of the curricula were compared between the OT and OTA entry-level programs using cross-tabulation and Fisher's exact test of association. $P < 0.05$ was considered statistically significant.

RESULTS

Out of the programs that responded, 11 surveys were incomplete and were not included in the analysis, resulting in a 33% response rate. Out of the 105 respondents, 64.8% (n=68) were OTA programs, 34.3% (n=36) were master's level OT programs, and <1% (n=1) were doctoral entry-level OT programs. All of the programs (100%; n=105) indicated that they included content related to psychiatric and psychosocial conditions and interventions for a variety of populations and ages. Programs varied, however, in terms of how explicitly they focused on intervention strategies to support or improve positive mental health. Approximately 11% (n=11; n_{OT}=3; n_{OTA}=8; p=0.559) of programs did not include content specific to mental health promotion for adults in their curricula and 18.45% (n=19; n_{OT}=5; n_{OTA}=14; p=0.368) did not include content specific to mental health promotion for children and adolescents.

Respondents were asked to indicate if their program included *dedicated* courses pertaining to mental health interventions during specific periods of the lifespan. Some respondents chose not to answer questions related to all of the different periods in the lifespan. One hundred and three respondents indicated whether or not they included an adult mental health intervention course and the majority of the programs (74.76%; n=77; n_{OT}=33; n_{OTA}=44; p=0.001) did. Out of 100 programs, 47% (n=47; n_{OT}=32; n_{OTA}=15; p<0.001) included geriatric intervention courses, and 46% (n=46; n_{OT}=33; n_{OTA}=13; p<0.001) included child and adolescent mental health intervention courses. In addition, more than half of all of the programs provided opportunities for their students to learn from adults with primary mental health conditions (87.61%; n=92; n_{OT}=30; n_{OTA}=62; p=0.134), children and adolescents with primary mental health conditions (57.14%; n=60; n_{OT}=29; n_{OTA}=31; p=0.001), and family members of people with mental health conditions (56.19%; n=59; n_{OT}=30; n_{OTA}=29; p<0.001). Opportunities to learn from other mental health providers were also frequently endorsed by participants (91.42%; n=96; n_{OT}=32; n_{OTA}=64; p=0.182).

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Respondents were asked to indicate whether or not their respective program included content related to 40 discrete topics. Table 1 (see Appendix) includes the 40 topics and is ordered based on frequency. The six most frequently indicated topics included: mood disorders (100%; n=105), the Diagnostic Statistical Manual (98.1%; n=103), psychotropic medications and their impact on occupational performance (96.2%; n=101), social skills interventions (95.2%; n=100), life skills interventions (93.3%; n=98), and the Model of Human Occupation (93.3%; n=98). The six least frequently indicated topics included: school-based mental health interventions (19%; n=20), children in foster care (28.6%; n=30), concerns of individuals who identify as lesbian, gay, bisexual or transgender (34.3%; n=36), bullying prevention and friendship promotion interventions (35.2%; n=37), Assertive Community Treatment (ACT) (35.2%; n=37), and the Transtheoretical Stages of Change Model (36.2%; n=38).

Specific mental health interventions and models of practice were covered at variable rates. The therapeutic use of crafts was reported by 85.7% (n=90) of respondents. Mindfulness interventions were covered by 69.5% (n=73) of respondents; the Recovery Model was covered by 58.1% (n=61) of respondents; the use of the Functional Group Model was covered by 55.2% (n=58) of respondents; and motivational interviewing was covered by 48.6% (n=51) of respondents.

Significant differences between OT and OTA programs existed with regard to 14 different topics: the Recovery Model (p=<0.001), motivational interviewing (p=<0.001), the Transtheoretical Stages of Change Model (p=<0.001), the Intentional Relationship Model (p=<0.001), children in foster care (p=0.001), concerns of individuals who identify as lesbian, gay, bisexual or transgender (p=0.003), eating disorders (p=0.003), Assertive Community Treatment (p=0.005), mental health policy (p=0.007), self-regulation interventions (p=0.007), dialectical behavioral strategies (p=0.022), case management (p=0.023), cognitive behavioral treatment strategies (p=0.025), and mental health screening (p=0.043).

Fieldwork education is an essential component of entry-level OT education. All programs (100%; n=105) indicated they included at least one fieldwork experience designed to meet standard C.1.7. Of the programs reporting, 94 (89.5%) indicated they provide fieldwork experiences in settings where clients have a primary mental health concern. Homeless shelters, alcohol and drug centers, adult day care centers, and behavioral health hospitals were identified as viable mental health fieldwork sites.

DISCUSSION

Mental health education is a critical component of OT and OTA programs (Craik & Austin, 2000; Scanlan et al., 2015). Mental health education ensures that occupational therapy practitioners entering the workforce are competent in both promoting positive mental health and addressing occupational performance issues related to mental illness (AOTA, 2016). All of the programs represented in this study identified the inclusion of mental health content and fieldwork experiences as outlined by the ACOTE standards in their educational curricula, specifically in content related to adult, geriatric, and child and adolescent mental health conditions and interventions. The majority of participants,

however, reported that their program did not have a dedicated mental health course. Few participants indicated the inclusion of dedicated courses related to adult mental health, and even fewer participants indicated that their academic programs included dedicated courses focusing on geriatric and child and adolescent mental health.

The lack of dedicated mental health courses could be due to faculty members' preference to integrate mental health content into other course work. Viewed one way, the integration of such content may be supportive of what Hooper (2010) refers to as "single-subject centered learning" (p. 101), where topics, such as mental health conditions, are no longer valued as discrete facets of a practitioner's knowledge basis, but rather a dimension that is essential to understanding occupational performance. This trend, however, may be reversing soon in part because of the AOTA Board of Directors' intentionally focused advocacy efforts related to promoting occupational therapy's distinct value in mental health (AOTA, 2016). Recent policy victories, as Stoffel (2015) noted, have successfully resulted in occupational therapy services being a required component of community mental health programming and explicitly incorporated into the language of key mental and behavior health policies which are currently pending. Perhaps, now more than ever, occupational therapy educators must remain cognizant of intentionally cultivating students' knowledge and skills so that they feel equipped to work in mental health practice and to assume these newly expected jobs. Additionally, an emphasis on "how to be" a mental health occupational therapy practitioner may help to promote provider self-care, which is considered to be a key factor in preventing burn out in mental health settings (Ashby, Ryan, Gray, & James, 2015; Scanlan et al., 2015).

The frequency that the inclusion of specific mental health topics were reported was highly variable. This finding may be suggestive of differences in the number of courses, as well as the amount of instructional times devoted to mental health in the different programs. The three most frequently covered mental health-related topics (i.e., mood disorders, the Diagnostic Statistical Manual, and psychotropic medications) provide a knowledge base that is beneficial to all mental health professionals, not just occupational therapy practitioners. While some other topics, such as life skills interventions, may be more unique to the field of occupational therapy, including both types of topics in a preparation program is critical to the facilitation of positive client outcomes and best practice (Scanlan et al., 2015).

The results from this study suggest that specific topics related to different phases of the lifespan, particularly those that impact the care of older adults and children and adolescents, are not always included in OT and OTA curricula. More emphasis in OT and OTA curricula needs to be placed on content related to geriatric and child and adolescent mental health issues as it is estimated that over 20% of older adults (i.e., individuals aged 65 and older) meet the criteria for some form of a mental health disorder (Karel, Gatz, & Smyer, 2012) and 1 in 5 children will experience a significant mental health concern before they reach adulthood (Merikangas et al., 2010). The role of occupational therapy in adequately addressing the mental health needs of all members of society is becoming increasingly more important as the discrepancy

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between the number of clients in need of services and the number of qualified mental health providers continues to grow (Bruckner et al., 2011; Kakuma et al., 2011).

There were significant differences between OT and OTA programs on 14 different topics. Six of the topics (i.e., cognitive behavioral strategies, self-regulation interventions, Transtheoretical Stages of Change Model, Assertive Community Treatment, motivational interviewing, and dialectical behavioral strategies) focused on different aspects of behavior change. Three of the topics (i.e., policy, screening, and case management) were related to evaluation and supervisory roles. Two of the topics included models of practice (i.e., Recovery Model and Intentional Relationship Model) and three of the topics were related to individuals at-risk for occupational dysfunction (i.e., children in foster care, individuals who identify as lesbian, gay, bisexual or transgender, and individuals with eating disorders). Research is needed to more fully understand why such differences exist between OT and OTA programs and whether or not they can be attributed to the interpretation of ACOTE standards, the functional role differences between occupational therapists and occupational therapy assistants, or other factors. One possible explanation is that OTA programs are preparing graduates to carry out intervention plans and work more directly with clients on occupational performance issues, thereby allowing occupational therapists to focus on evaluation, intervention planning, and managerial roles (AOTA, 2014; Foster & Smith, 2010).

Fieldwork experiences are thought to be a good indicator of students' future work settings (Crowe & Mackenzie, 2002). The declining number of occupational therapy practitioners entering mental health may also reduce the number of potential mental health fieldwork placements, requiring program directors and academic fieldwork coordinators to seek non-traditional, community-based placements. This decline may also impact the number of new graduates taking their first jobs in mental health practice settings. This finding is consistent with the literature, as meeting the ACOTE Standard C.1.7 in many cases requires creative problem solving among program directors and academic fieldwork coordinators to identify alternative mental health fieldwork sites (Brown, 2012b). Strengthening the mental health focus in entry-level curricula serves not only as a strategy for increasing the number of occupational therapy practitioners working in mental health settings but additionally increases the potential number of mental health fieldwork sites and clinical preceptors.

Limitations

This study is not without limitations. Care should be taken in generalizing the results of this study since many OT and OTA programs did not return a completed survey. Additionally, it is important to note that the survey only asked respondents to indicate if certain content was taught. The study's results do not allow determination of the depth to which topics are covered or the quality of instructional methods. Another limitation of the study is that program directors were asked to complete the study. It is possible that different findings may have resulted if faculty responsible for teaching mental health content had been surveyed instead. Recommendations for future research include surveying the extent to which mental health topics are covered in post-professional occupational therapy programs.

Conclusion

Mental health occupational therapy practice is on the decline (AOTA 2015b). However, many occupational therapy leaders and scholars are encouraging occupational therapy practitioners to remain active in mental health practice and to advocate for the profession's continued role in such settings (Ashby, Gray, Ryan, & James, 2015; Ikiugu, 2010). Occupational therapy and OTA programs include a range of mental health curricular content. Focused pre-service curricular content and intentional fieldwork experiences in mental health settings may help to ensure that graduates from OT and OTA programs understand the profession's distinct value in mental health, seek (or develop) employment opportunities in traditional mental health settings, and feel equipped to meet practice demands.

Implications for Education and Research

- Occupational therapy education programs should address mental health promotion, prevention, and interventions for individuals across the lifespan.
- Research is needed to understand why certain mental health topics are included in OT and OTA curricula at varying rates.
- Research is needed to understand which strategies are most useful in securing adequate mental health fieldwork sites.

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Appendix

Table 1

Mental Health Topics Covered by OT and OTA Programs

	Number of Programs Including Topic, n (%)			
Mental health topics	All Programs (N=105)	OT Programs (n=37)	OTA Programs (n=68)	p-value
Mood disorders	105 (100%)	37 (100%)	68 (100%)	1.000
Diagnostic Statistical Manual-5	103 (98.1%)	36 (97.3%)	67 (98.5%)	1.000
Psychotropic medications and impact on occupational performance	101 (96.2%)	35 (94.6%)	66 (97.1%)	0.612
Social skills interventions	100 (95.2%)	34 (91.9%)	66 (97.1%)	0.342
Life skills interventions	98 (93.3%)	35 (94.6%)	63 (92.6%)	1.000
Model of Human Occupation	98 (93.3%)	34 (91.9%)	64 (94.1%)	0.695
Cognitive behavioral strategies	96 (91.4%)	37 (100%)	59 (86.8%)	0.025
Thought disorders	95 (90.5%)	34 (91.9%)	61 (89.7%)	1.000
Community re-entry interventions	95 (90.5%)	34 (91.9%)	61 (89.7%)	1.000

Self-regulation interventions	94 (89.5%)	37 (100%)	57 (83.8%)	0.007
Personality disorders	94 (89.5%)	31 (83.8%)	63 (92.6%)	0.189
Coping strategies interventions	91 (86.7%)	34 (91.9%)	57 (83.8%)	0.369
Therapeutic use of crafts	90 (85.7%)	29 (78.4%)	61 (89.7%)	0.146
Sensory processing interventions	88 (83.8%)	34 (91.9%)	54 (79.4%)	0.164
Impact of major traumatic life events	88 (83.8%)	34 (91.9%)	54 (79.4%)	0.164
Self-management of chronic mental health conditions	86 (81.9%)	33 (89.2%)	53 (77.9%)	0.191
Substance use disorders	86 (81.9%)	29 (78.4%)	57 (83.8%)	0.597
Cognitive disabilities model	86 (81.9%)	33 (89.2%)	53 (77.9%)	0.191
Suicide prevention	78 (74.3%)	25 (67.6%)	53 (77.9)	0.254
Eating disorders	77 (73.3%)	36 (97.3%)	51 (75.0%)	0.003
Mental health screening	74 (70.5%)	31 (83.8%)	43 (63.2%)	0.043

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Health policy directly impacting the provision of mental health services	73 (69.5%)	32 (86.5%)	41 (60.3%)	0.007
Mindfulness interventions	73 (69.5%)	29 (78.4%)	44 (64.7%)	0.185
De-escalation strategies and crisis management	70 (66.7%)	23 (62.2%)	47 (69.1%)	0.056
Veteran's concerns	70 (66.7%)	27 (73%)	43 (63.2%)	0.388
Homelessness	66 (62.9%)	24 (64.9%)	42 (61.8%)	0.834
Recovery Model	61 (58.1%)	32 (86.5%)	29 (42.6%)	<0.001
Functional Group Model	58 (55.2%)	22 (59.5%)	36 (52.9%)	0.544
Dialectical behavioral strategies	53 (50.5%)	22 (59.2%)	31 (45.5%)	0.022
Motivational interviewing	51 (48.6%)	27 (73.0%)	24 (35.3%)	<0.001
Intentional Relationship Model	44 (41.9%)	24 (64.9%)	20 (29.4%)	<0.001
Mental Health First Aid	41 (39.0%)	14 (37.8%)	27 (39.7%)	1.000

Case management	41 (39.0%)	20 (54.1%)	21 (30.8%)	0.023
Transtheoretical Stages of Change Model	38 (36.2%)	25 (67.6%)	13 (19.1%)	<0.001
Assertive Community Treatment (ACT) programs	37 (35.2%)	20 (54.1%)	17 (25.0%)	0.005
Bullying prevention and friendship promotion intervention	37 (35.2%)	13 (35.1%)	24 (35.3%)	1.000
Concerns of lesbian, gay, bisexual, & transgender individuals	36 (34.3%)	20 (54.1%)	24 (35.3%)	0.003
Children in foster care	30 (28.6%)	18 (48.6%)	12 (17.6%)	0.001
School-based mental health interventions	20 (19.0%)	8 (21.6%)	12 (17.6%)	0.614

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