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## Utilizing Student Consultation to Promote Incorporation of Occupational Therapy in a Pediatric Behavioral Health Unit

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### Abstract

This advanced graduate elective was designed for second year Master of Occupational Therapy students to provide opportunities for students to act as consultants of the profession and collaborators within the community utilizing community engaged learning methods. This elective helped to detail components of evidence-based practice, primary needs of integration, and future opportunities within an urban pediatric behavioral health unit. The practice area of mental health was chosen specifically as the collaborating site due to the decline of occupational therapist recognition as qualified mental and behavioral health providers. This lack of recognition may limit reimbursement and funding, and decrease employment opportunities, both detriments to practice. However, within the last decade there has been a resurgence in establishing the profession's roots within mental and behavioral health practice. Several key pieces of federal legislation have recognized occupational therapists' expertise and have cited the profession in several mental and behavioral health initiatives. Many states are seeking recognition of occupational therapists as qualified behavioral health providers (QBHP) or qualified mental health providers (QMHP) and this elective provided the opportunity for didactic instruction to intersect with advocacy and education while producing a rich learning experiences for all involved.

### Keywords

Community engaged learning, consultation, behavioral health

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## **Utilizing Student Consultation to Promote Incorporation of Occupational Therapy in a Pediatric Behavioral Health Unit**

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### **ABSTRACT**

This advanced graduate elective was designed for second year Master of Occupational Therapy students to provide opportunities for students to act as consultants of the profession and collaborators within the community utilizing community engaged learning methods. This elective helped to detail components of evidence-based practice, primary needs of integration, and future opportunities within an urban pediatric behavioral health unit. The practice area of mental health was chosen specifically as the collaborating site due to the decline of occupational therapist recognition as qualified mental and behavioral health providers. This lack of recognition may limit reimbursement and funding, and decrease employment opportunities, both detriments to practice. However, within the last decade there has been a resurgence in establishing the profession's roots within mental and behavioral health practice. Several key pieces of federal legislation have recognized occupational therapists' expertise and have cited the profession in several mental and behavioral health initiatives. Many states are seeking recognition of occupational therapists as qualified behavioral health providers (QBHP) or qualified mental health providers (QMHP) and this elective provided the opportunity for didactic instruction to intersect with advocacy and education while producing a rich learning experiences for all involved.

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### **INTRODUCTION**

The changing healthcare landscape of the 1990's prompted many healthcare institutions to eliminate services that offered little to no reimbursement for certain patient populations (Howard, 1991). One profession heavily affected by the push for increased healthcare revenue was occupational therapy (OT). While OT services are successfully applied to highly reimbursable patient populations, like orthopedics, there is less

emphasis of OT incorporation in pediatric mental and behavioral health (American Occupational Therapy Association, 2015). The under-utilization of services is unfortunate: research has demonstrated the impact of clinical applications of OT in child psychiatry and psychology (American Occupational Therapy Association, 2015). Specifically, the services rendered by an OT have the ability to augment evidenced-based psychiatric care by increasing self-confidence through successful completion and mastery of age appropriate activities of daily living, improving routine flexibility, and addressing sensorimotor skills (Sholle-Martin & Alessi, 1990).

Recent events such as federal funding to incentivize states to establish certified community behavioral health centers (Substance Abuse and Mental Health Services Administration, 2017) and the opioid crisis have resulted in an increased societal awareness and acceptance of accessing mental and behavioral health services. As more individuals seek to improve their emotional well-being, insurance companies are beginning to reimburse services that are complimentary to and improve the outcomes of traditional psychiatric care (Klowden, 2018). The widening of services covered under insurance premiums has directly assisted the OT profession in reestablishing itself as a qualified provider who possess a unique and vital skill set to assist with improving emotional well-being (Jackson & Arbesman, 2005). Unfortunately, due to the gap of time where the profession was absent in mental and behavioral healthcare, an intentional reintegration of OT services is needed to create stable and long-lasting partnerships moving forward.

Increases in collaborative problem solving among service providers, the inclusion of trauma-informed and family-centered care, and reductions in both complex medication regimens and utilization of restraints and seclusions, have all been noted to occur when OT has been embedded within pre-existing services on inpatient pediatric behavioral health units (Scholle-Martin & Alessi, 1990). Further, behavioral health services which adequately treat presenting psychiatric symptoms and address other factors known to influence one's overall emotional health (e.g. comorbid medical conditions, psychosocial factors, adaptive/physical abilities, etc.), are more likely to have improved and long-lasting positive outcomes (Gathright, Holmes, Morris, & Gatlin, 2015). Current research supports the use of collaborative and innovative models of interdisciplinary psychiatric healthcare teams as a means to improve patient outcomes, thus the push for team science and interprofessional practice collaborations (Lee, Martin, Hembry, & Lewis, 2018; Sams, Garrison, & Bartlett, 2016). The addition or re-addition of OT as a part of the interprofessional practice team and as part of integrated care models is a vital component as the profession of OT adequately acknowledges the social, economic, physical environment, and health behaviors that influence health (Cooke, 2018). These collaborations thus should begin well before one enters a healthcare profession, and start during one's time as a student.

Integrating collaborative community engaged experiences for students, academic partners, and community leaders has many documented benefits to include increased knowledge and skills regarding scope of practice of the profession by community partners, increased student competency regarding the role of their professional

contributions, and faculty perceiving community engaged work to be highly beneficial for not only teaching but service and research as well (Bloomgarden & O'Meara, 2007; George-Paschal & Saviers, 2016; Van Rensburg, Van der Merwe, & Erasmus, 2019). Therefore, the aim of this educational innovation was to promote student engagement in the specific setting of inpatient behavioral health in order to highlight the services OT could provide, assess the organizational flow of the unit, and provide foundational evidence for the reintegration of OT in this setting.

## **DESCRIPTION**

The collaborating partner site was an inpatient pediatric behavioral health unit which is multidisciplinary in nature and provided short-term care through inpatient and partial hospitalization programs to youth ages 8 to 17 years old experiencing acute, chronic, or worsening psychiatric or behavioral symptoms. The unit, located within an urban academic affiliated pediatric hospital, was not presently serviced by OT. Eighteen students enrolled in advanced graduate OT elective courses (advanced pediatrics and community based practice) at an urban research-intensive institution offered consultative services to the pediatric unit in order to demonstrate OT's potential contributions to client care and the interprofessional team. The number of students enrolled in the pediatrics course was ten and the number of students enrolled in the community course was eight. One clinical assistant professor and one assistant professor within the department of OT at the academic institution and one director of the inpatient pediatric behavioral health unit led the collaborative elective.

## **Model of Community Engagement**

The many contextual overlays of this consultative project extended beyond a traditional service learning opportunity. Thus, the collaboration between two academic instructors and one clinical director and the subsequent clinical team of the pediatric unit utilized the Community Engagement (CE) Components Practical Model (Ahmed, Young, DeFino, Franco, & Nelson, 2017). This model (see Figure 1) acknowledges five components of community engagement when working in and with academic settings. These include community outreach and service, education, clinical care, research, and policy and advocacy. This model recognizes the intricate and necessary overlap between and among the five defined areas in order to prevent silos both within the greater community and within the community of academia. Additionally, this model helps to explain that not all areas may or will be integrated simultaneously and encourages awareness of the natural interplay between areas like training, communication and dissemination, and diversity and inclusion.

Utilizing the CE Components Practical Model allowed for a shift in perspective for both the academics and the clinical director beyond providing traditional services in OT delivery, such as focusing solely on clinical care, by taking into consideration barriers to service delivery, the referral, evaluation and intervention process, insurance implications, and hospital policy, among others. This provided a basis for student focus, encouraging students to look beyond "service to the community" as intervention. Having this tangible model aligned shared interests between the academics and clinical director more seamlessly. Further, utilizing the CE Components Practical Model identified three

areas for developing the elective. First, it led to further understanding the knowledge regarding OT among the staff of the inpatient pediatric unit. Next, it helped to create a unique student learning experience integrating areas of policy and research. Lastly, the CE Components Practical Model helped to identify the true translational research potential this project possessed.

Translational research, as defined by the National Institutes of Health, provides two areas of defined translation, commonly referred to as T1 and T2. T1 applies to basic research transferring knowledge to clinical research and T2 translational research focuses on “enhancing the adoption of best practices in the community” (Rubio et al., 2010). The CE Components Practical Model provided structure to how this specific collaboration could be organized in a way that could begin the trajectory of adopting OTs as a core part of the inpatient pediatric behavioral health unit team, with hopes of eventually leading to a standard of care and best practice in the community. Without utilizing the CE Components Practical Model, the thought process of this designed elective and collaboration would have not reached its full potential.

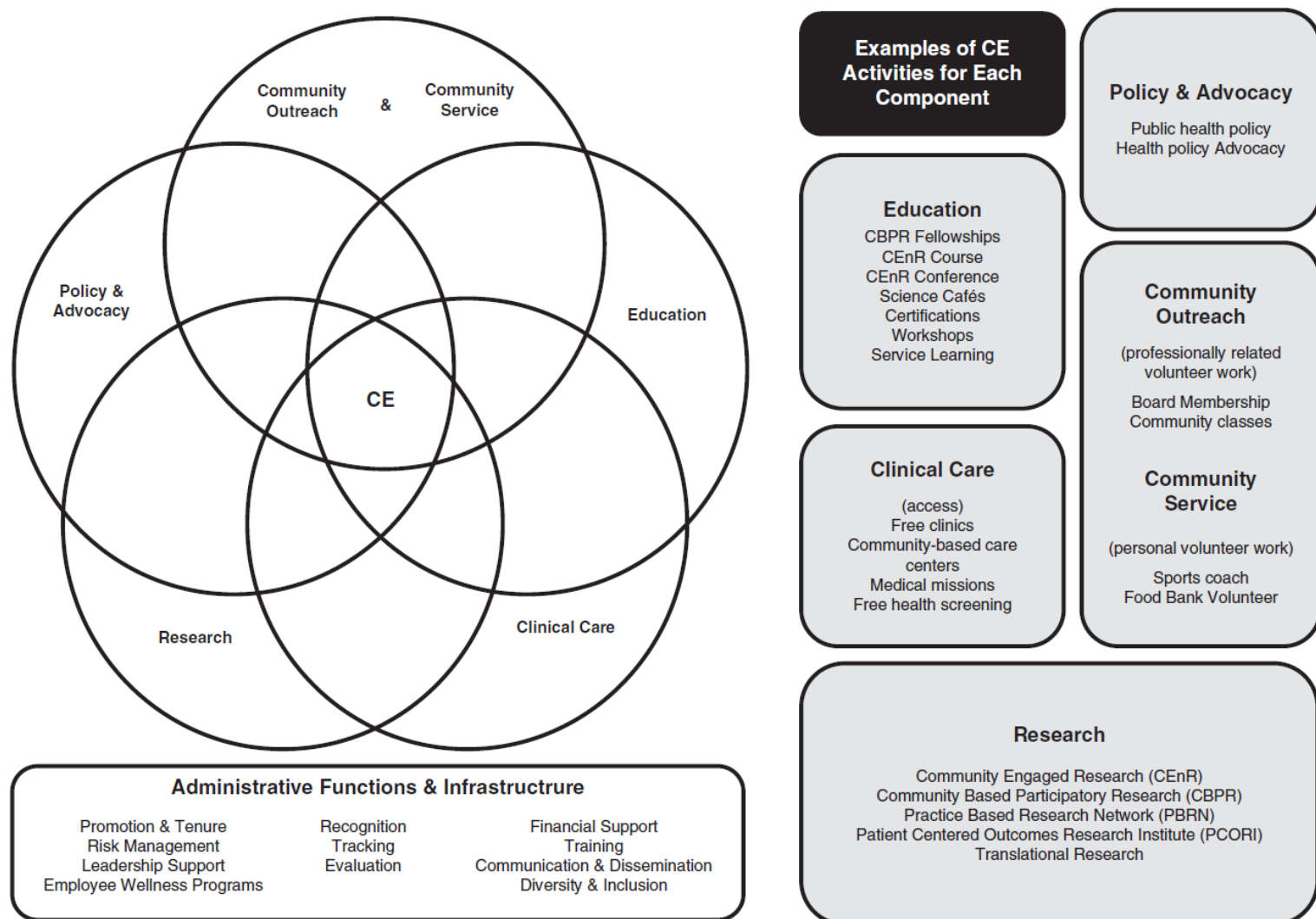


Figure 1. The community engagement (CE) Components Practical Model (Ahmed, Young, DeFino, Franco, & Nelson, 2017; used with permission).  
<https://encompass.eku.edu/jote/vol4/iss2/art12>  
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## ASSESSMENT

### Pre-Knowledge Survey

From the moment graduate students begin their academic journey in OT school, instructors urge them to formulate an “elevator speech” of what OT is and does so that students can readily explain OT’s contributions to consumers and providers alike. However, before the academics in this partnership could investigate what OTs could potentially provide to an inpatient pediatric behavioral health unit, the academics found it valuable to first understand the unit staff perceptions of OT. Cohn (2019) during her 2019 Eleanor Clarke Slagle Lecture urged OT practitioners to “assert our competence” in regard to the breadth and depth of OT practice. Lamb (2018) similarly noted practitioners must abandon the belief that “no one knows what occupational therapy is” (p.3.) However, recent literature suggests that other professions continue to have limited knowledge regarding the scope of practice in OT. In a survey among primary care team members Dahl-Popolizo, Davis, Voysey, Wade and Muir (2017) noted the majority of those surveyed had limited knowledge regarding the roles and responsibilities of an OT in a primary care setting. Smith and Mackenzie (2011) noted that among seven nurses working with OTs in an inpatient mental health setting role confusion continued to exist regarding what exactly OTs did on this particular unit. Thus, with permission, an adapted version of an existing survey first developed by Staniforth, Fouche, and Beddoe (2014) to better understand public perceptions of social work was constructed to obtain inpatient pediatric behavioral health staff perceptions of OT (see Table 1). The survey was sent to day shift unit staff (n=12) which included disciplines from nursing, social work, and psychology. Four staff members responded to the survey. The survey was sent, data was collected, and data was managed utilizing Research Electronic Data Capture (REDCap) hosted at Indiana University (Harris et al., 2009). REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources (Harris et al., 2019).

Although this small sample size (n=4) cannot be generalizable, results from this survey provided a basic working knowledge surrounding key staff perceptions. The most critical finding from this survey surrounded the question regarding trust. To the statement *in general, Riley personnel trust occupational therapists*, the mean response was 4.33 out of 5.00. To the statement *in general, occupational therapists at Riley are hard working*, the mean response was 4.67 out of 5.00. Without trust the richness of the student consultative project would be limited.

Table 1

*Survey to Staff*

1) When you hear the words 'occupational therapist' what is the first phrase that comes to mind? _____
2) Please rate your agreement with the following statements: strongly disagree, disagree, neutral, agree, strongly agree 1) In general, Riley personnel trust occupational therapists. 2) In general, occupational therapists at Riley are hard working. 3) In general, occupational therapists have a stressful job at Riley
3) Please answer yes or no to the following statement: I believe that occupational therapists are mental health professionals and should be recognized as a QBHP (Qualified Behavioral Health Provider).
4) What is the basic level of education that OTs are required to have in Indiana? None School leaving (high school) Diploma Bachelor's degree Higher degree (e.g. Masters or PhD) Don't know
5) What is the basic level of education that you believe OTs in Indiana should have? None School leaving (high school) Diploma Bachelor's degree Higher degree (e.g. Masters or PhD) Don't know
6) Select all that apply. Do you think that OTs work in the areas of: Child development and delay Mental illness and addictions Health- adapting to illness Trauma Informed Care Return to work/vocational training Access to community resources Adolescent development Services for older adults
7) What could OTs do to improve the public image of their profession? _____
8) Would you encourage your children or a close family member to become an OT? Yes          No



As an aim of the community-based practice course, students (n=8) were similarly given a pre-elective survey regarding their perceived knowledge of community-based practice. This survey was a requirement of the course, although not associated with points or a grade, and was administered electronically via an electronic learning management system and adapted from the Carnegie Mellon University Prior Knowledge Self-Assessments (n.d.; see Table 2). This survey was approved by the Institutional Review Board of Indiana University (Protocol 20011837548).

Table 2

*Pre/Post Test Knowledge Survey for Students*

1) How familiar are you with "Community Based Practice"? Please include your rating in your answer and a 1-2 sentence explanation. I have never heard of it or I have heard of it but don't know what it is. I have some idea what it is, but don't know how to engage in this practice. I have a clear idea what it is, but haven't ever experienced it first-hand. I can explain what it is and what OT practitioners do in this setting, and I have experienced it first-hand.
2) Have you designed (your own idea) or developed (someone else's idea that you grew) a community program before? Please include your rating in your answer and a 1-2 sentence explanation. I have neither designed nor developed one. I have designed one, but not developed one. I have developed one, but not designed one. I have both designed and developed one.
3) How familiar are you with child and adolescent inpatient psychiatric units? Please include your rating in your answer and a 1-2 sentence explanation. I have never heard of it. I have heard of it, but don't know what it is. I have some idea of what it is, but it's not very clear. I know what it is and but can't it explain to someone else. I know what it is and can explain it to someone else.

Seven students responded that they had some idea of what community-based practice was, but did not know how to engage in this practice, with one student answering that they had a clear understanding of what community-based practice was but had never experienced it first-hand. Five students reported they had neither designed nor developed a community program, two students reported having developed a community program but not designed one, and one student reported both designed and developing a community program prior to this elective. Lastly, three students had heard of a child and adolescent inpatient psychiatric unit but did not know what it was, two students had

some idea but not very clear, one student knew what it was but could not explain it to someone else, and two students reported knowing what it was and could explain it to someone else.

Both of these surveys provided excellent insight to perceived knowledge of both staff and students in order to inform the academics regarding levels of learning and capacity of learning during the sixteen weeks. Distribution of the surveys was approved by the Institutional Review Board of Indiana University (Protocol 1808743957).

### Consultative Project

Students completed their consultative service projects over five weeks in a three-hour working lab format. Students were assigned to eight small groups of 2-3 students supervised by an OT faculty member, one with expertise in community engaged research, the other with clinical expertise in pediatrics. Each student group focused their consultative services on a specific area of need as identified by faculty in collaboration with the clinical director of the pediatric behavioral health unit. A full description of the consultative assignment and topical outline can be found in Table 3.

Table 3

#### *Topical Outline and Consultative Assignment Details*

<b>Topical Outline:</b> Week 1-4: Community Engaged Practice Week 5-8: Community Engaged Experiential Application Week 9-12: Professional Dissemination Week 13-16: Sustainability
<b>Evaluative Methods:</b> Your group will need to construct at least 5 guiding questions for your <b>needs assessments</b> . This is your opportunity to find out exactly what information you might need to help you develop your project or proposed programming. Who will you need to schedule to meet with? Do you need to consult other outside resources like the library or other inpatient child psychiatric units that already have OT included? Remember the basis of an occupational profile can be broader than at the individual level, it can be at the community, population, or organization level. Think about everything you might need to know about your client. Examples from Fazio (2017) include: <ul style="list-style-type: none"> <li>• How would you describe your purpose (mission, philosophy) of your organization?</li> <li>• What group of individuals (target population) do you serve?</li> <li>• What are some of the characteristics (ages, abilities, and so on) of this population?</li> <li>• What kinds of programming are already in place that you offer? (treatment, prevention, group, individuals, etc.)</li> <li>• What are your funding sources? For-profit/Not for profit?</li> <li>• Do our ideas for programming seem realistic to you? Would they add value to your existing services?</li> </ul>

- Are there other unmet programming needs that you as an occupation centered practitioner, might be able to consider?

Fazio, L.S. (2017). *Developing occupation-centered programs with the community* (3<sup>rd</sup> ed.). Thorofare, NJ: Slack Incorporated.

#### **Individual Contributions:**

Documentation of your work sessions utilizing DAP (Data, Assessment, Plan) format. Four notes in total. All elements of a note are required in order to receive full credit.

#### **Paired Outcomes:**

As partners, please write a four-page paper (1 inch margins, Arial 11-inch font) to include your summary regarding the **process** and experience in constructing your evidence based ideas and summary of findings. You should have at least 3-5 peer reviewed journal references that support your critical thinking and analysis. Essentially, this should include both positive and perhaps any obstacles you experienced in developing your ideas. Was it easy to navigate a system that doesn't yet include OT? What barriers to incorporating OT still exist, if any? What additional opportunities to including OT did you uncover? Any barriers to finding evidence to support OT's role? To name a few. This summary should be unique to your paired experience.

#### **Oral Presentation:**

Prepare a 30 min professional presentation regarding your idea/project/plan over your 5-week experience. Presentation must include outcomes of your needs assessment, a summary of your evidence, implications for potential incorporation—how do you incorporate your OT idea into the program?, suggestions for future collaboration and of course, your references. Please dress professionally as community site members may be in attendance. Also in addition to your 30 min presentation, you will have 10 min for Q&A.

#### **Final Poster Presentation:**

Utilizing the provided template please create a professional poster on your experience (essentially put your oral presentation on paper!). You must attend the State Conference to receive full credit. This does not require registration to the conference, however we always encourage you to engage in professional networking and development.

#### **Community Resources:**

On your learning management system, your group will be responsible for uploading into your assigned folder the peer-reviewed journal articles you referenced on your project, any proposed materials or assessments that you have identified, including costs and where to buy them, and a brief explanation of how/why item/product is used. A minimum of 7-10 resources/ideas/tools are required.

To examine how OT services could be incorporated into the behavioral health unit, students completed a needs assessment by interviewing staff. The focus of the assessment was to gather adequate data to develop an organizational occupational profile to identify the unit's needs, target population, and mission/vision of the unit; sources of funding; and existing programming within the unit. Findings from the needs assessment included addressing barriers within occupational performance, such as

activities of daily living, instrumental activities of daily living, social participation, education, and leisure, as well as addressing patient routines and roles in the absence of OT expertise. Staff also reported needing to identify unique and appropriate ways to address sensory processing, self-regulation, and emotional regulation needs of patients.

Students used many strategies to develop their proposal once the needs assessment was complete. Tactics utilized to foster a well-developed and thoughtful plan included continuing to collaborate with unit staff, seeking and reviewing current evidence regarding OT practice in acute psychiatric settings or similar settings; interviewing currently practicing experts from other organizations, and examining resources available to the unit. Students completed an outcome report to summarize findings, including obstacles or opportunities to incorporating OT, evidence to support OT's role or barriers to finding evidence, and recommendations and future implications.

Finally, students presented their findings from their consultancy project and provided the clinical director with digital copies of their project findings, current literature, and recommended resources for the unit.

### Consultative Findings

The results of the student consultation project identified many avenues for improvement, growth, and incorporation of OT practices. Student findings (see Table 4) identified three major areas where OTs could become a vital member of the unit's multidisciplinary team: assessments, sensory processing, and OT-specific interventions.

Table 4

#### *Student Findings*

Measurement	Student findings	Collaboration outcome
<b>ASSESSMENT OF LIFE HABITS (LIFE-H) FOR CHILDREN</b>	Assesses the client's perceived performance in 6 domains (Noreau et al., 2007). OTs are equipped to reduce barriers to participation in these domains and increase client engagement in meaningful activities.	Future education and training for OT on unit to incorporate into practice.
<b>CHILDREN'S ASSESSMENT OF PARTICIPATION AND ENJOYMENT (CAPE)/PREFERENCES FOR ACTIVITIES OF CHILDREN (PAC)</b>	Assesses preferences and enjoyment of play and leisure activities including participation patterns (King et al., 2006). Preferences can be used by OT to incorporate into daily routine with parent involvement on the unit.	Future education and training for OT on unit to incorporate into practice. Promotes occupation-based inventions.

<b>OCCUPATIONAL CIRCUMSTANCES ASSESSMENT INTERVIEW RATING SCALE (OCAIRS)</b>	Semi-structured interview allows clients to rate their ability to adapt in 12 areas of function (Deshpande, Kielhofner et al., 2002). Gives clients a voice to collaborate on goal setting, plan of care, and occupation-based interventions.	Future education and training for OT on unit to incorporate into practice. Promotes occupation-based interventions.
<b>PEDIATRIC QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE (PQLES-Q)</b>	Measures quality of life through assessing enjoyment and satisfaction in daily activities (Endicott, Nee, Yang, & Wohlberg, 2006). OTs can further assess physical, mental, and sensory implications of daily activities and adapt activities to increase health promoting effects.	Utilized this measure as a screening indicator for patient referral for OT evaluation and treatment. Promotes occupation-based interventions.
<b>CHILD SENSORY PROFILE 2, SHORT SENSORY PROFILE 2, SCHOOL COMPANION SENSORY PROFILE 2, AND THE ADOLESCENT/ADULT SENSORY PROFILE</b>	Sensory-based measurements (Pearson Education, Inc., 2008, 2014). Evidence-based design for sensory room on unit and sensory diets. Modify use of existing fidgets unit staff was distributing.	Proper evaluative methods for use of sensory equipment and interventions.

Lastly, the post survey (n=8) regarding student knowledge of community-based practice, adapted from the Carnegie Mellon University Prior Knowledge Self-Assessments (n.d.; see Table 2) was redistributed after the completion of the elective and provided evidence of greater perceived learned knowledge. Half of the students rated a four, defined as being able to explain what community based practice is and what OT practitioners do in this (community-based) setting, and experienced it first-hand. The other half of respondents included a rating between having a clear idea of community-based practice but haven't ever experienced it first-hand and having experienced it first-hand. One student comment provided additional insight, *"I am still a little unsure of the full parameters of community-based practice in all of its facets, but I have a greater understanding of programming."* Six students reported having both designed and developed community-based programming as well as being able to articulate what an inpatient psychiatric unit is and could describe it to someone else. For

this particular student cohort, their “elevator speech” as described previously, grew in confidence for the area of community-based practice. One student noted, *“I have a clear understanding of what community-based practice is and have experienced the collaboration and consulting aspect of community programming.”*

## DISCUSSION

Utilizing student consultation to grow the awareness of OT and produce tangible outputs for both the academic instructors and the director of the inpatient pediatric behavioral health unit was a productive experience. Creating community partnership within course offerings has many benefits. Breen et al. (2018) identified common themes during a community based course offering to include improved flexibility and adaptability among students, viewing the instructor as mentor and supervisor, and learning through interaction. Similarly, Dinour, Szaro Blumberg, and Bose (2018) noted that community partners reported greater engagement with graduate students when working towards a “real life” community issue. Hou (2014), in her work of blending problem based learning with a community engaged approach, deepened understanding of theory to practice. Hou (2014) also noted that her course offering resulted in increased use of theory and evidence based interventions as central components to identified community health needs. Orchestrating this experience at the intersection of an integrated collaborative approach and placing the student to work alongside the community apart from a traditional fieldwork, has preliminary merit due to the many opportunities for turning scholarship into community engaged research.

As demonstrated by the results of the student post knowledge-survey, students rated themselves as having greater understanding of their contributions both as a student consultant and as a future practitioner within the community. Lastly, needs of the facility were met as future collaborative experiences with the Department of OT within the academic institution became a priority, as demonstrated by the collaborative grant.

With the necessary components of a proof of concept established by both the brief survey utilized with the inpatient behavioral health team, and the extensive literature and logic provided by the students, the academic leads and community partner were well situated to justify the need for obtaining a grant focused on clinical and translational research. Follow up meetings with the collaborators ensured model development was well understood by all. The proposed model derived from this collaboration suggests utilizing the OT as an essential team member and part of the core team of providers on an inpatient behavioral health unit rather than using OT on a consultancy basis. A model of referral and assessments completed upon evaluation, emphasis on providing occupation-based interventions, and attendance by the OT in care coordination meetings, daily rounds, and weekly huddles were recommended. The proposed collaborative grant submitted during the time of this publication is still under review.

## Limitations

Limitations of these collaborative advanced electives included a poor response rate for the staff survey. Due to this small sample size it was difficult for the academics and director of the unit to gather all opinions and investment levels. Additionally, this elective

for community-based practice was limited to an enrollment of eight student participants. The pediatric elective however did not have an enrollment limitation, and thus allowed for an enrollment of ten. It could be inferred that these students had a greater desire to understand community-based practice than those who did not select this elective. Students enrolled in the pediatric elective were also not given the student pre/post knowledge assessment survey, initially due to the specific questions regarding community based practice, however distributing this survey to students in both advanced electives would have provided a larger sample.

### **Implications for Occupational Therapy Education**

Based on the findings of this project, OT's contributions in a pediatric behavioral health unit are vast. Areas of expertise including incorporation of assessments and measures providing evaluative information critical to care coordination, incorporation of occupation based interventions to include leisure pursuit, sensory self-regulation, and social participation with emphasis of increasing performance in activities of daily living. Preliminary education that address the unique aspects of the community program obtained through needs assessment allowed for the graduate students to create tailored recommendations in the areas of assessments and measures and possible individual and group interventions helped to lay the foundation for future students and practitioners alike. Academic-community partnerships are critical and are a necessary component to educate the public regarding the benefits of OT. Collaborations with this specific pediatric hospital are ongoing and the desired form of sustainability for both the academic institution and the pediatric hospital is the full time employment of an OT on the pediatric behavioral health unit. Of note, the success of this elective is now a core course offering for the academic intuitions entry-level doctor of OT program, titled; "Community Based and Population Focused Occupational Therapy." The trajectory of our profession, the relevancy of community based participatory research should be considered within curriculums. Given the Accreditation Council of Occupational Therapy Education's standards concerning community and population focused health, new course offerings, specifically geared towards community engagement has merit and could be the basis for many doctoral capstone projects' future research will include student perceptions of the core course offering and community partners' perceptions of working with entry level occupational therapy doctoral students.

### **CONCLUSION**

As the profession of OT continues to attempt to reclaim inclusion in behavioral and mental health settings the need for thoughtful and intentional integration of utilizing innovative partnerships, specifically in community-based settings is needed. Incorporating students as consultants for community partners and collaborators with academic instructors provides them a unique opportunity to grow their confidence in underserved settings and as future practitioners. Designing and evaluating the effectiveness of such course offerings, although time consuming, is necessary to continue to demonstrate the relevancy of the profession.

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