OCCUPATIONAL THERAPY PRACTICE IN MENTAL HEALTH:

MODELS, CONDITIONS, INTERVENTIONS AND RECOVERY

Editor:
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Occupational Therapy Practice in Mental Health: Models, Conditions, Interventions, and Recovery

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FOREWORD

The Foreword is by World Federation of OT President Elect. Tecla Mlambo. PhD, MSc OT, MSc Clin Epidemiology, BSc HOT.

The purpose of this book is to enhance the understanding of occupational therapy practice in mental health for all people around the globe, including consumers, families, students, occupational therapists, and other health professionals. This book presents a diverse range of views from authors around the world and is informed by all forms of knowledge, not just Western ways of knowing. Many of the authors of the chapters of this book are themselves from ethnic minority groups. Some of them are consumers of occupational therapy and mental health services. The authors reside in different parts of the world, including Africa, Oceania, and Europe. This was a deliberate effort to ensure that those diverse voices are heard, and that a diverse range of worldviews is included.

This book intentionally uses simple English, pictures, tables, and illustrations to aid the reader, student, or occupational therapy practitioner to clearly understand the concepts. The case examples used are from different contexts around the world to give relevance to the reader. This is the goal of this book, to increase understanding of occupational and practice in mental health practice for everyone not just native English speakers or those from the dominant western cultures.

Chapters are organised in sections, with each section having been carefully crafted and coordinated by one author. Coordinating authors and specific chapter authors are identified. While the text is substantially the work of the contributing authors, a small number of additional authors were invited to contribute to specific areas. Each chapter starts with a brief synopsis of key theoretical and empirical issues to guide the reader who wishes to investigate the broader literature. Most chapters include resources, tools, and instruments that support effective practice. To ensure continuity of style and a coherent, integrated body of material, the coordinating author for each section will assume editorial responsibility for the chapters that constituted that section, and the editor reviewed the entire text for continuity and styling for the book.

Section one summarises theoretical models commonly used by mental health occupational therapists so that the reader is able to choose an appropriate model to use for their clients in their contexts. Section two builds on the theoretical models and provides practitioners with an understanding of the person's components through an introductory understanding of common mental health conditions encountered in practice. Section three delves into interdisciplinary team interventions with a focus on occupational therapy-specific interventions such as psychoeducation, cognitive behavioural therapy, dialectical behavioural therapy, solution-focused therapy, and many others. Lastly, section four discusses and critiques the concept of recovery.

Despite the sequential nature of the organisation of the book, each chapter is a standalone chapter that can be read and understood on its own. Readers can assume a smorgasbord approach and read what they need when they need it and are not bound by the order of the sections or chapters.

This is one of the most comprehensive and transformative books on mental health and occupational therapy, written by academics, clinicians and consumers of occupational therapy and mental health services from various parts of the world. The book is the beginning of an

important journey of indigenisation and true globalisation of occupational therapy curricula and knowledge. An excellent resource that has been long overdue on the market, and a critical tool in the hands of an educator, student and consumer of occupational therapy and mental health services.

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PREFACE

Growing up, I have always wanted to write a book. In my mind, writing a book was the epitome of academic excellence. That was before the advent of the internet. Now, with the internet being accessible to most of the world's population, anyone can write a book and publish it themselves, so why write a book? There are many reasons **why not** to write a book, including 'it is time-consuming for very little benefit'. A colleague of mine advised me to just write an article and publish it! "It takes way less time, and you get better metrics from journal articles," they said. By the way, these so-called metrics are tied to one's promotion and career advancement opportunities. I had to write this book in my own time and in secret, without sharing what I was doing with my colleagues for fear of ridicule. So why did I write this book?

First, there were some encouraging people along the way. Notably, a colleague at Waikato Hospital in New Zealand, Dr Basil Bunting, a psychiatrist from South Africa and author of Psychiatry in Easy Steps, wrote a message in a copy of his book that he gave to me in 2002, which was as follows: *"Hi Tawanda, It is very nice working with you. It's a pleasure to have a colleague from Africa. Hope this book inspires you to write your book. Basil*". Twenty-two years later, I have now written my book in response to this call to action.

Secondly, I am an occupational therapist working and living in Australia. The first thing you should know about me is that I identify as and am biologically male. At the time of writing this preface, there were only 9% registered male occupational therapists in Australia. Now, that is a familiar story worldwide, but the point is that I belong to the minority in this profession. The second thing you should know about me is that I am a black African of African origin born and bred in Zimbabwe. Now, without doing the maths, you get the picture that I truly belong to the minority (probably less than 1%) in this wonderful profession of occupational therapy.

'My people', meaning the group of people I am similar to or belong to, are, however, not the minority as the current population of Africa is close to 1.5 billion people or 18.2% of the world's population. Culturally, I also belong to the non-western or collectivist cultures, which constitute about 85% of the world's population. It is baffling to note that occupational therapy practice is meant to serve the world, and yet people who make up 85% of occupational therapy clients are probably less than 10% of the world's occupational therapists. This figure is far less when one looks at people who then go on to produce the knowledge that informs what occupational therapists know and do. So, the reason for writing this book is to contribute towards making the occupational therapy profession a truly global profession that is applicable to all people and representative of the views of all people, not just those who are 'privileged'. Okay, this needs a bit of explanation- I have been an occupational therapist for almost 3 decades, have a growing publication record, and my highest qualification is a PhD, but at the time of writing this book, I had never been invited to write a book chapter! My story is not dissimilar to many other people of a similar background to mine in the profession of occupational therapy. I think you would have quickly discerned that I wrote this book out of frustration and also purpose. The frustration was that I realised that I did not belong to the group of usual book contributors who often get invited to write popular occupational therapy texts. The purpose was that I felt we were being fed information from one worldview and, more specifically, from the views of academics only, most of whom had not seen or treated a single patient in two decades. By the way, this is not a criticism of academics; I am one of them. They know stuff, and they do important research. Rather, this is a call to action for academics to also value the contributions from clinicians and other minority groups, which

include not only culturally and linguistically diverse people but also people with a lived experience.

Decolonising OT: Historically, occupational therapy has been referred to as 'a white middle-class female profession'. This is still the case today. Many authors of a similar background to mine are calling for the 'decolonisation' of occupational therapy. This call emanates from the 2015 'Rhodes Must Fall' campaign at UCT, which quickly spread to other universities in South Africa and sparked a worldwide debate on decolonising curricula. Some argue that this is a sensationalist or cheap way of gaining political mileage, and others argue it is a much-needed transformation in academia and, indeed, in occupational therapy. It must be noted that the concept of decolonising a curriculum was first discussed in Ngũgĩ wa Thiong'o's book, Decolonising the Mind, which argued that the annihilating 'cultural' and 'psychological' consequences of colonialism had to be taken as seriously as, though not separately from, its economic, political and military ones.

As I understand it, 'decolonisation', as used in occupational therapy literature, describes a process of critically examining the current curricula, which is Western culture dominated with the intention of removing the cultural and psychological impacts of colonialism on the axiology, ontology, and epistemology of occupational therapy. It is argued by many in the profession of occupational therapy that occupational therapy is based on Western culture because of the existing structures, processes, and systems in the profession that continue to perpetuate the status quo. There are no deliberate efforts by occupational therapy professional bodies to seriously change the status quo, and in fact, some are becoming an occupational therapy out of reach for most minorities by constantly raising the bar and increasing the level of qualification and years of training needed to become an occupational therapist. Such practices are precipitants for some to call for 'decolonisation' of the profession.

Let me be very clear here, I totally agree with the intent of 'decolonisation'. Whilst I agree with the intent of 'decolonisation', I tend to disagree with the use of the term 'decolonisation' to describe this noble intent. Let me explain a bit more about myself, *i.e*., my positionality. I was born in Zimbabwe, then Southern Rhodesia, a British colony at the time. I grew up during the time of the liberation struggle in Zimbabwe. I experienced colonisation as a brutal matter of life and death, and I am living with the after-effects of the war and the colonisation practices of the time today. Colonisation should never be minimised, and using the term 'decolonisation' when referring to curricula is minimising the real evil nature of colonisation. For lack of better words, 'globalisation' and 'indigenisation' to me seem more appropriate terms to spark the transformation that is needed in the profession. To me, these words are more in line with the principles of 'allyship', and that is what we need rather than the revolutionary message that is latent in 'decolonisation'.

Occupational therapy is a relatively new profession, new to the world and new to non-Western cultures, so yes, there is a lack of non-white voices, and we certainly need to be heard. To me, this is about inclusivity and making the profession more applicable and relevant to all people. I think, as people, we should refrain from divisive and sensationalism and instead focus on progressive and inclusive talk whilst acknowledging our history. As occupational therapists, we want our beloved profession to be more relevant to all people, more encompassing of diverse views of people around the world, and to be informed by all forms of knowledge, not just Western ways of knowing. Here is a fun fact: not all black people or people from minority groups think the same; it is racist to assume they do. So, my views are my views, and I am not representing any other person or group's views here.

Many of the authors of the chapters of this book are themselves from ethnic minority groups. Most authors of this book are practising clinicians, and some of them are consumers of occupational therapy and mental health services. The authors reside in different parts of the world, including Africa, Australia, India, North America, and Europe. This was a deliberate effort to ensure that those diverse voices are heard, and their diverse worldviews included.

Occupational therapy theory and practice is complex. For many people from around the world, the concepts do not have meaning in their own cultures and contexts. This book deliberately uses simple English, pictures, tables, and illustrations to aid the student or occupational therapy practitioner to clearly understand the concepts. The case examples used are from different contexts around the world to give relevance to the reader. This is the goal of this book, to increase understanding of occupational theory and practice in mental health practice for everyone not just native English speakers or those from the dominant western cultures. Although this book can be read sequentially, this is not a necessity. In fact, I anticipate that this book will be read like a smorgasbord where each person will pick what they wish to devour first according to their taste.

To conclude, I hope that every reader will reflect on their values, their way of thinking, knowing, and practice and, to some extent, motivate them to question, adapt, change, confirm, or re-affirm it and consequently move them towards a new understanding. To me, through critical thinking and reflection, being truly person-centred and value-driven and deliberately being inclusive in our ways of knowing and doing, we can actively eliminate the remnants of colonialism and globalise occupational therapy.

Yes, to responsible transformation as we march together in this journey towards doing, being, and/ or becoming evidence-based, value-driven global occupational therapists. Let this book be a vehicle for transformation and the first to many more editions to come.

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DEDICATION

This book is dedicated to all my clients, whose insights and experiences have profoundly shaped my understanding of mental health practice. Without their trust and collaboration, I would not have been able to share the knowledge that informs my teaching and writing today.

I also dedicate this work to future occupational therapy clients and therapists across the globe, as it is for them that this journey of exploration and learning is truly intended.

To all therapists and clients, may we always remember that our greatest strength lies in collaboration, where collective efforts illuminate the path to healing and growth.

ACKNOWLEDGEMENTS

Firstly, I would like to acknowledge the encouragement from my mentor and PhD supervisor, who encouraged me to get into research many years ago. I would also like to acknowledge the belief in me by Jenni Tregoweth (Manager in Mental Health Rehab at Waitemata District Health in New Zealand), who, as my master's lecturer at Auckland University of Technology, predicted that I was going to write a book and gave me the belief and encouragement to do so. I have now done so. I would also like to acknowledge my fellow section editor, Professor Pamela Meredith (University of Sunshine Coast, Australia), who reviewed most of my own work and was my sounding board through and through. I would also like to acknowledge all the authors who contributed to this book and those who will contribute to future editions of this book. Thank you so much. I would like to specifically acknowledge those with a lived experience who shared their expertise and stories and co-authored chapters in this book, as without their input, the whole ethos of this book would have been lost. Thank you. Lastly, I would like to thank my wife, children, and the entire extended family for their unwavering and ongoing support.

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Part 1
Occupational Therapy Models in Mental Health Practice

• Summary of the common occupational therapy models used in mental health practice.

• Summary of theoretical constructs and historical evolution of each model.

• Case and practice examples of how occupational therapists can use models in various practice contexts.

Models provide a structure to guide practice. Models help to delineate our key values and beliefs as occupational therapists and help articulate our understanding of occupational performance as a transaction between the person, the environment, and the occupation. However, many experienced occupational therapists have traditionally not seen themselves as using any model but rather relying on their professional reasoning.

The issue at hand is that the profession is ever-changing and exists in an ever-changing environment requiring occupational therapy practitioners to continuously adapt and respond to current and future client needs. Theoretical models help occupational therapists to be able to respond to current and future needs.

The purpose of this section is not to recommend any specific model but to summarise theoretical models commonly used by mental health occupational therapists so that the reader is able to choose an appropriate model to use for their clients in their contexts. When it comes to theoretical models, there is no one-siz--fits-all. This section will summarise the Model of Human Occupation (MoHO), the Person, Occupation, and Environment (PEO) model, the Canadian Model of Occupational Performance and Engagement (CMOP-E), and the Kawa model.

CHAPTER 1

The Model of Human Occupation (MOHO)

Tawanda Machingura[1,*], **Edwin Mavindidze**[2] and **Clement Nhunzvi**[3]

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Abstract: In this chapter, the Model of Human Occupation (MOHO) and its concepts are introduced to the reader. More specifically, each of the four components of the MOHO is defined and described, and examples from everyday practise are provided.

Keywords: Assessment , Model , Mental health , Occupational therapy , Occupation , Occupational behaviour , Occupational performance , Occupational therapy , Participation .

INTRODUCTION

Occupational therapists rely on occupation-based models of practice when working with their clients to enable them to do the things they want to, need to, or are expected to do. Occupation-based models are premised on the ontological stance in the philosophy of occupational therapy that "ever-changing humans, interconnected with everchanging environments, occupy time with ever-changing occupations and thereby transform – and are transformed by- their actions, environments and states of health" (Hooper & Wood, 2014, p.38). As such, occupation-based models focus on three interconnected elements that make up the occupational experience: person, environment, and occupation. Occupation-based models are built on the foundations laid by earlier frames of reference in occupational therapy, refocusing beyond just dysfunction and providing a more holistic outlook on occupation, even in those without impairments. A frame of reference or practice model is "a set of interrelated, internally consistent concepts, definitions, and postulates derived from or compatible with empirical data, providing a systematic description of or prescription for particular designs of the

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Tawanda Machingura (Ed.)

environment for the purpose of facilitating evaluation an effecting change*"*(Mosey, 1986, p.5). It is a body of knowledge generated through research and practice used to develop a theory that is used by occupational therapists to inform them in a particular area of practice (Kielhofner, 2009a). Therefore, each model presents a unique perspective on the person, environment, and occupation illuminating the characteristics of each element that contributes to occupational being and ultimately supporting well-being. The occupational therapist uses occupation-based models as a magnifying glass, focusing on specific aspects of the occupational experience, gaining a deeper understanding, and targeting them. Mosey (1986), however, warns that practice models are "not a formula for action; but rather only a guide" (p.5).

This chapter focuses on one of the most popular occupation-based models of practice used in mental health practice, the Model of Human Occupation (MOHO) (Kielhofner, 2008). The MOHO was first published in 1980 as a series of four articles in the American Journal of Occupational Therapy (Kielhofner & Burke, 1980; Kielhofner, 1980a, 1980b; Kielhofner *et al*., 1980). Since then, it has been the most extensively evidenced and most used occupation-based model, with about 80-92.1% of occupational therapists around the world now using this model (Cheung & Fung, 2020; J. Lee, 2010; S. W. Lee *et al*., 2008, 2012). The MOHO is presented here, starting with a brief history of its foundations followed by an extensive discussion following the seven elements of an occupational therapy practice model: *the theoretical base, function-dysfunction continuum, the behaviours indicative of function and dysfunction, postulates regarding change, the primary assumptions, goals for intervention, and occupational therapy assessment and intervention techniques* (Creek, 2014; Hagedorn, 1992; Hinojosa & Kramer, 1993; Mosey, 1986).

The functions of MOHO as a conceptual model can be classified into four domains: Descriptive, Delimiting, Generative, and Integrative.

Descriptive – The MOHO can be used to describe the occupational phenomenon and provide operational definitions to aid the application of occupation to practice. Relevant variables are described, and the variations between them are also explained.

Delimiting – Just as lenses work, MOHO can be used to identify and filter in and out certain information about phenomena, helping to focus and organise data into meaningful units. This function is expanded on in assessments and evaluations supported by the model.

Integrative – True to its theoretical influences, the MOHO facilitates the systematic bringing together of other theoretical constructs and data into a consistent, meaningful, and unified whole.

Generative – The model continues to be a utility in research, innovation, and development. MOHO can be used as a conceptual framework in testing hypotheses and generation of new ideas.

A BRIEF HISTORY

MOHO evolved from the work of Mary Reilly during the 1960s and 1970s, who, at the time, was working on the Model of Occupational Behaviour (Fig. **1**). Like many in occupational therapy, Reilly believed that humans transform their health and well-being through the use of their hands and minds. In the 1961 Eleanor Clarke Slagle Lecture, she famously said, 'Man, through the use of his hands as they are energised by mind and will, can influence the state of his own health' (Reilly, 1962, p.6, 1963). Mary Reilly opposed the medical model and felt that occupational therapists did not simply aim to reduce their clients' illness but their incapacity. Reilly defined occupational behaviour as activities that occupy time, involve achievement, and address the economic realities of life (Reilly, 1962). In her model, the goal of occupational behaviour is to reduce the disruptions and incapacities in occupational behaviour. Some of the basic assumptions at the time were that humans have an intrinsic need to master, occupation is intrinsically motivated, humans need occupation, and health is a balance of rest, work, and leisure. Reilly's work became the basis for MOHO, occupational science, and a new paradigm in occupational therapy where, once again, occupation was regarded as front and centre in occupational therapy practice.

Gary Kielhofner, Mary Reilly's student, was the architect of MOHO. In 1975, Kielhofner wrote an unpublished master's thesis on the model that formed the basis of the MOHO first published in 1980 (Kielhofner & Burke, 1980). Kielhofner believed that routines, habits, and motivation are part of a dynamic system influenced by the social and physical environment (Kielhofner & Burke, 1980). The diagrammatic representation of the original model is shown in Fig. (**1**) below.

When using MOHO, the routine and habits of the person are key to adaptation, and so are the motivation and meaning of the activity to the person. The MOHO underwent progressive development over the years to incorporate new knowledge and progressive changes in the profession's philosophy and domain of practice. After Gary Kielhofner's untimely death in 2010 (Braveman *et al*., 2010), colleagues across the world have continued to develop the MOHO and research its applications across the occupational therapy domain and in various contexts

CHAPTER 2

Canadian Model of Occupational Performance and Engagement

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Abstract: This chapter describes the key aspects of the CMOP-E model and how occupational performance and engagement are understood through the lens of the CMOP-E model. The chapter ends with a case study illustrating the application of the model in practice.

Keywords: Case study, Client-centred practice, Canadian Model of Occupational Performance and Engagement, Engagement, Occupation, Occupational performance, Person-environment-occupation transactions.

INTRODUCTION

The Canadian Model of Occupational Performance and Engagement (CMOP-E) is a key model that helps practitioners understand how individuals engage in occupations within their unique social, physical, cultural, personal, political, and economic contexts. The model particularly emphasises the importance of spirituality, which is at the core of the person, and the fact that occupation is the bridge that connects the person and their environment. CMOP-E is a comprehensive and commonly used model of practice in occupational therapy mental health practice.

In this chapter, we will explore the origins of the model, the core components of the model, including the person, occupation, and environment components, and how these transact to enhance or hinder occupational performance. The chapter will end by utilising a case study to illustrate how this model can be used in practice.

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The CMOP-E theory

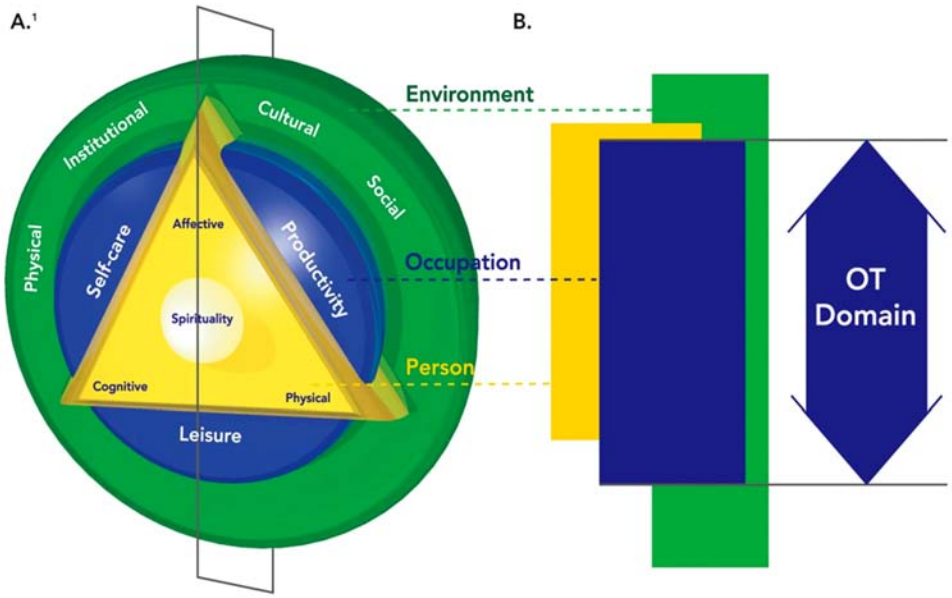
CAOT has been working together with members to provide a vision for the conceptual grounding, processes, and outcomes of occupational therapy in Canada for many years. This vision was first articulated in the Guidelines for Client-Centred Practice published in 1983, 1986, and1987 and consolidated in 1991, followed by the OT guidelines for client-centred mental health practice in 1993.

Enabling Occupation: An Occupational Therapy Perspective was re-printed with an updated preface in 2002. These publications have been integral to guide Canadian occupational therapy practice and are now used in many countries around the world. The 2007 publication entitled Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, and Justice through Occupation was launched in July 2007 in St John's, Newfoundland.

Here are some key historical facts:

- The Canadian Model of Occupational Performance (CMOP)- Townsend *et al*. (1997; 2002)
- 1980s-early 1990s: Canadian occupational therapists and medical representatives developed guidelines to facilitate an occupationally focused, client-centred practice of occupational therapy (Townsend *et al*. 1997, 2002).
- A key driver for the work was to demonstrate the effectiveness of interventions, justify actions, and promote the profession of occupational therapy.
- Emphasis was placed upon ensuring that occupation was recognised as a core concept of occupational therapy practice.
- The original model was based upon the work of Reed and Sanderson (1999) and called the Occupational Performance Model (OPM) (1982, 1983, and 1991), with occupation divided into self-care, productivity, and leisure.

As the name suggests, the Canadian Model of 'Occupational Performance and Engagement' is the result of this vision of CAOT. The change from CMOP to CMOPE was made because the authors felt that occupational performance alone was limiting and did not capture the full scope of OT practice. OTs are involved in not just enabling people to 'do' occupations but to be engaged in 'doing'. Polatajko *et al*. defined occupational performance as the dynamic interaction of a person, occupation, and environment. It does not have a specific depiction of the model but is encompassed within the whole model. A pictorial representation of the model is in Fig. (**1**) below.



A.¹ Referred to as the CMOP in *Enabling Occupation* (1997a, 2002) and CMOP-E as of this edition
B. Trans-sectional view

Polatajko, H. J., Townsend, E. A., Craik, J. (2007). *Canadian Model of Occupational Performance and Engagement* (CMOP-E). In E. A. Townsend and H. J. Polatajko, *Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation*. p.23 Ottawa, ON: CAOT Publications ACE.

Fig. (1). The Canadian Model of Occupational Performance and Engagement (Polatajko *et al*., 2007)

Occupational enablement means enabling people to choose, organize, and perform those occupations they find useful and meaningful in their environment. The CMOP-E can be used with individuals, families, groups, communities, organisations, and populations.

Person

Spirituality: Spirituality can be described as a life force that gives a sense of a higher self, acts as a source of will and self-determination, and gives a sense of meaning, purpose, and connectedness (Duncan, 2020).

Cognitive (thinking): Memory, orientation, concentration, intellect, insight, judgement, general knowledge.

Affective (feeling): Emotions, mood, affect, volition, self-esteem, coping skills, and ability to adapt to changing circumstances.

CHAPTER 3

Kawa Model

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Abstract: This chapter overviews the Kawa Model as developed by Michael Iwama and colleagues. It starts off with some insights into a conversation with Dr Iwama following a chance meeting with the author in 2006. This chapter then explores model concepts and ends with an exploration of how the Kawa Model may be utilized in practice.

Keywords: Collectivist cultures, Life flow, Occupational therapy, Kawa model.

INTRODUCTION

The Kawa model was developed by Michael Iwama. I had the pleasure of having a conversation with Dr. Michael Iwama in 2006 in New Zealand when he came to the National Occupational Therapy Conference to present the Kawa Model. I will share what he said and what I got out of our conversation.

According to Dr. Iwama, the word Kawa means 'River' in Japanese (Iwama, 2006). Dr. Iwama told me that he was originally from Japan; however, he was educated in the USA and Canada and worked in Canada at the time. He stated that he regarded himself as a Japanese Canadian occupational therapist and social scientist. He stated that the humble beginnings of the Kawa model were the time he travelled back to Japan and realised that Japanese Occupational Therapists and, indeed, the Japanese people, in general, had a different view of what occupation was. Occupation, as perceived and described in the West, meant something completely different to Japanese people. In Japanese, he advised that occupation meant 'boring, laborious work'. This did not sit well with him, so he collaborated with a group of Japanese occupational therapists to design a model of occupational therapy practice that would resonate with the Japanese people, people from the East, and indeed many people around the world. The model was

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subsequently published in 2006 and is one of the newest models in occupational therapy practice even today.

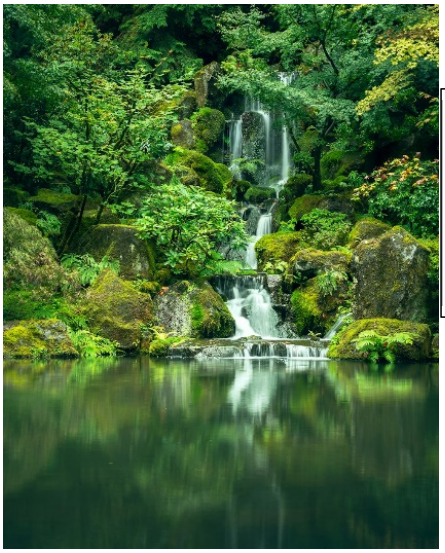
To understand this model, it is important to place it in the sociocultural and geopolitical context in which it was developed. The model was originally developed in response to a perceived need for an occupational therapy model that was relevant to non-western contexts, initially, which was the Japanese occupational therapy practice context. The authors sought a way to challenge the Western dominance in the field of occupational therapy that did not seem to value the collectivist view of many people from non-Western backgrounds. OT as a profession originated in Western culture in the USA. Dr Iwama and many occupational therapists from non-western backgrounds, myself included, are of the view that many of the assumptions that the profession was founded on differ from our own experiences of occupation and understanding of life and the nature of humans. Collectivist cultures such as Japanese/Asian or African or indigenous people in many countries, including New Zealand, Australia, Canada, and the USA, view the individual or the 'self' differently. In fact, in many non-western cultures, the concept of a self is not completely separate from the other people, plants, animals, and inanimate structures that surround them.

The question might be so how is the Kawa Model different? Dr. Iwama and the group he was working with found out that what resonates with Japanese people are metaphors. The Kawa model was built on the foundation of a metaphor of a river flowing from the mountains where it originates, probably from the melting of ice and flowing all the way to the sea where it ends and empties all its contents, *i.e.*, the water. The river may also start due to rainwater. Depending on the environment, water will start to flow and form a river (Fig. **1**). Sometimes, they flow into lakes or the sea. The twists and turns in life will always be unique. The breadth, depth, and flow of the river will vary and change throughout the journey. The river is taken to be all its elements, which include the riverbed and the river walls that shape the river, the water that flows in the river, the rocks that impede the water flow, and the driftwood that either impedes the water flow when it gets logged between the rocks or enhances water flow when it knocks off some rocks to increase water flow.

Concepts and Components of the Model

The model is a metaphor for a river that symbolises 'life flow' or 'life energy'. The elements of the model include the water, rocks, driftwood, and river floor and walls. Rivers start due to rain and flow from up high in the mountains towards a low point in the land. In the application of the model to humans, the river is a metaphor for life as a journey beginning when one is born (origins of the river),

and as one goes through life, there are ups and downs and twists and turns just like a river (Fig. (**2**); as we know, life will end at some point when one dies just as a river ends when it flows into a dam, sea, or ocean.

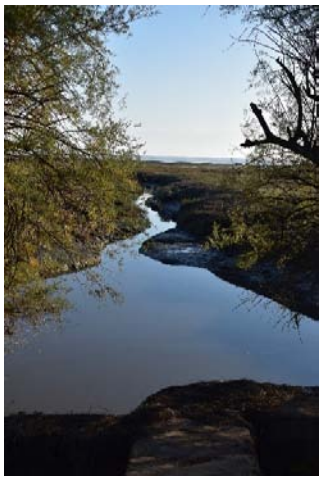


Beginning of the river in the mountains.

Symbolises beginning of life's journey.

Fig. (1). The beginning of river or life.

Photo by Anders Ipsen on Unsplash



Twists and turns symbolize the ups and downs in life

Fig. (2). Twists and turns in a river.

Photo by Pauline on Unsplash.

CHAPTER 4

Person-Environment-Occupation Model and its Derivatives

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Abstract: This chapter will provide an overview of the Person-Environmen--Occupation (PEO) and the Person-Environment Occupation Performance (PEOP) Models. The PEO model emphasises the importance of congruence between person, environment, and occupation (PEO fit) and the subsequent occupational performance within an event. Another ecological model, PEOP, focuses on the client and relevant intrinsic (person) and extrinsic (environment) influences on the performance of everyday occupations. The chapter discusses how these models can be applied to individuals, groups (or organizations), and populations.

Keywords: Environment, Models, Occupation, Person.

INTRODUCTION

One way that can help us to understand complex ideas is to represent them as a model. When we talk about a model, we are simply referring to a visual representation of a concept or system. These visual images can help us to better understand complex concepts as they aim to convey large amounts of information in a simple and clear way.

OT theory has moved from a biomedical model, which was more popular pre 1990s, to a transactive model, which is based on the systems theory. In a transactive model of occupational performance (OP), the word 'transactive' is used to denote the product of a dynamic interwoven relationship between the person (P), the environment (E), and the occupation (O) and where behaviour cannot be separated from contextual influences.

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The PEO Model

The PEO model was founded by Law *et al*. (1996) in response to an identified need articulated through occupational therapy literature. This model was based on knowledge from person-environment models and client-centred practice, which was an emerging framework in Canada at the time (Strong *et al*., 2010). The purpose of this model was to supplement existing models and provide occupational therapists with a framework to assess clients, provide interventions, and articulate their practice to others, including clients, other professionals, and funders (Strong *et al*., 2010). The key concept of this model is the interconnectedness between the person, the environment, and the occupation (Fig. **1**). The PEO model (Law et, 1996) is a framework that guides clinical reasoning through the analysis of interdependent transactions. It is used by many occupational therapists as a framework that they apply when working with their clients and guides their practice. The transactional approach in this model emphasises the interdependence between the environment and the person and enables users to explain occupational performance. It is a very simple model to explain a very complex phenomenon. Indeed, the very simplicity of the model is deceptive, given how complex occupational performance is.

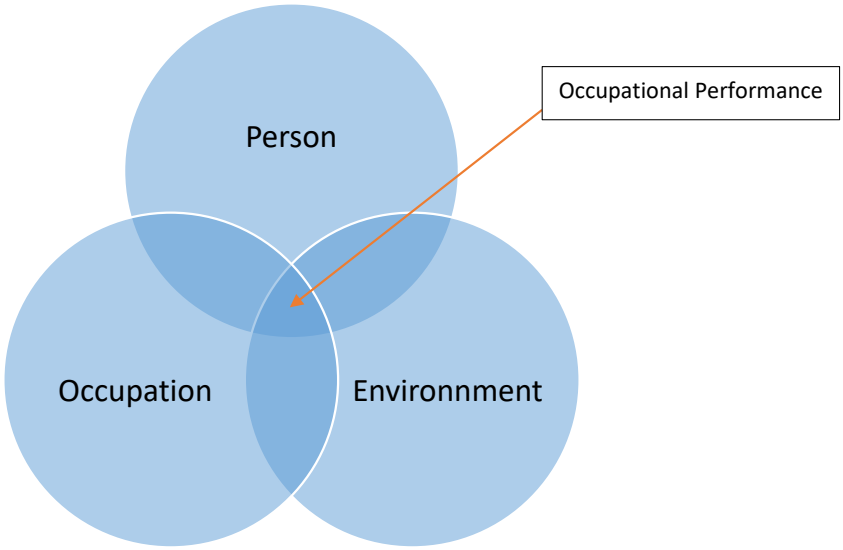

Fig. (1). PEO.

Visually, the model consists of three overlapping circles with an occupational performance at the centre where all three circles overlap. Each circle represents one aspect: the person, the environment, and the occupation. It must be emphasised that the relationship between the P, E, and O is dynamic and changes

over time (Law *et al*., 1996). The following is a description of the components of the model.

Person

The person is a unique being who assumes multiple roles and cannot be separated from contextual influences. The person should be considered from a biopsychosocial perspective, and they bring to the context a set of attributes, skills, knowledge, and experience. The person will have an influence on the environment around them, just as their environment will influence them.

Environment

The environment is defined as the context within which occupational performance takes place, and it is categorised into cultural, socioeconomic, institutional, physical, and social (Turpin *et al*., 2024). All the environmental categories are equally important to consider according to the model. We consider the environment from the unique perspective of the person, household, neighbourhood, and/or community. It is clear here that ecological systems theory forms a foundation for this model. The person's cultural environment is typically made up of the shared values, beliefs, and attitudes of the relevant community. Whether a person connects with their cultural environment or not will influence their occupational performance (MacRae & Boggis, 2019). The socioeconomic aspect of the environment considers a person's social and economic position in society and how it influences their behaviour. At an institutional level, we consider concepts such as governance, regulations, laws, and policies that influence society. The physical aspects of the environment have tended to be more recognisable, and historically, a central consideration for occupational therapists. Over time, as we moved away from the medical model and towards the social model of disability, the other aspects of the environment have become equally important. The social model of disability suggests that it is not a person's impairments that disable them; instead, it is due to the barriers that exist in their broader environment (Oliver, 2013). Finally, when considering the social aspects of the environment, we can consider a person's intimate social environment, their community, and broader society. To enable us to unpack the social environment even further, using other relevant models, such as Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1974) can be valuable. Bronfenbrenner considers five different systems: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem, which can all influence a child's behaviour and growth. They highlight the complex dynamic systems that exist whereby a person is influenced by their environment, and, in turn, they influence the world around them (Bronfenbrenner, 1979).

Part 2
Conditions in Mental Health Practice

• Summary of the common occupational therapy models used in mental health practice.

• Summary of theoretical constructs and historical evolution of each model.

• Case and practice examples of how occupational therapists can use models in various practice contexts.

This section builds on the understanding of theoretical models in occupational therapy practice. The models provide occupational therapists with an explanation and understanding of human behaviour, function, and dysfunction. Leading on from models, key considerations in occupational therapy theory and practice are the person components as these transact with the environment and the occupation and either facilitate or inhibit occupational performance.

The purpose of this section is to provide practitioners with an understanding of the person components through an introductory understanding of common mental health conditions encountered in practice. This section contains chapters on conditions such as eating disorders, personality disorders, mood disorders, and psychotic disorders. The intention was never to cover all conditions but to introduce occupational therapists to some common mental health conditions and explain how occupational therapists can provide evidence-based interventions when working with people experiencing those particular conditions.

CHAPTER 5

Psychotic Disorders

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Abstract: Psychosis is a debilitating group of symptoms that affects an individual at the same time and occurs over a period of time. These symptoms often include disturbances in behaviour, the thinking process, thought content, perception, affect, and mood. This chapter with briefly explore what psychosis is and then focus on one of the most debilitating psychotic disorders known to mankind, schizophrenia.

Note

This chapter is meant to be introductory, and the reader is encouraged to seek further information from comprehensive psychiatric texts. This chapter can also be used as a quick revision chapter for students and clinicians.

Keywords: Bipolar, Delusional disorder, Psychotic disorders, Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, Substance-induced psychotic disorder.

INTRODUCTION

It is important to first acknowledge that there is debate in the field of psychiatry around what is a mental disorder, with some pointing out past turnarounds and failures; for example, homosexuality used to be regarded as a mental disorder (Stein *et al*., 2021). Recently, the DSM-5 definition has refered to dysfunction in 'psychological, biological, or developmental processes' (American Psychiatric Association, 2013). In writing this chapter on psychosis, the DSM-5 definition of mental disorder is assumed.

The term 'psychosis' was derived from the Greek word 'psyche', meaning 'mind', and the Latin word 'osis', meaning abnormal condition. The literal translation of the word psychosis is, therefore, 'abnormal condition of the mind'. A key feature of psychosis is that the person is affected by a collection of symptoms that occur

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at the same time and do so over a period of time ranging from one week to several months or even years. The most commonly described symptoms of psychosis include a deterioration in social and occupational functioning (behaviour), a loss of mental functioning (thinking processes), a loss of ability to distinguish fantasy from reality (perception), and changes in mood and affect [emotions or feelings; Howes *et al*., 2012]. Psychosis affects the way a person thinks, feels, and behaves. Psychosis tends to occur in a spectrum ranging from subclinical symptoms to severe psychosis, such as in schizophrenia (Mennigen & Bearden, 2020). Fig. (**1**) below shows the spectrum of common psychotic disorders.

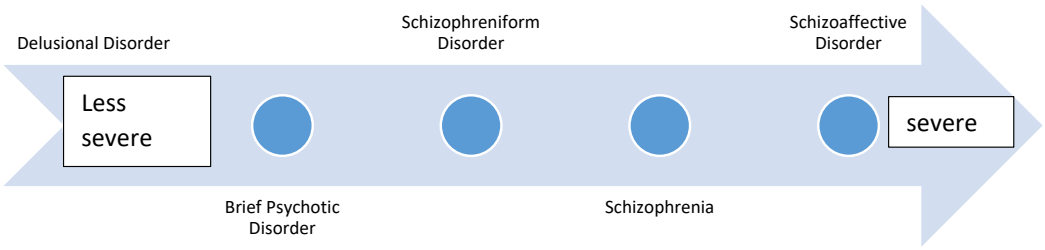

Fig. (1). Spectrum of psychotic disorders.

A large part of the population with subclinical symptoms does not seek help (Mennigen & Bearden, 2020).

Onset

The first onset of psychotic disorders is usually in adolescence or young adulthood. Recent research, however, indicates that nearly a quarter of first onsets occur after the age of 40 when looking at population data obtained from the World Health Organization (McGrath *et al*., 2015; McGrath *et al*., 2016). This implies that psychotic symptoms in childhood and adolescence do not always predict the onset of a major mental illness later on in life (Mennigen & Bearden, 2020).

Types

The different types of psychotic disorders are determined by the spectrum of symptoms that one presents with and also how long those symptoms last. The symptoms can be for short periods of time, lasting a few days or weeks, and others can take much longer, lasting a month or more (Bhati, 2013). Table **1** provides more details on specific types.

Table 1. Types of Psychotic Disorders[1]

Type	Brief description / Duration
Brief Psychotic Disorder	Duration of an episode of the disturbance is at least 1 day to 1 month with eventual full return to premorbid level of functioning.
Schizophreniform Disorder	Two of the following symptomsmust be present for a significant portion of time during a 1-month period (or less if successfully treated): delusions, hallucinations, disorganized speech, disorganized behaviour, and negative symptoms. At least one of the following must be present: delusions, hallucinations, or disorganized speech.
Substance-Induced Psychotic Disorder	Prominent hallucinations or delusions developed within a month of substance intoxication or withdrawal that cannot be better accounted for by a psychotic disorder that is not substance induced.
Schizoaffective disorder	2 weeks of delusions and hallucinations alone, periods where hallucinations and delusions are accompanied by major depression or mania, and the mood symptoms are present for a significant period of the total duration of the illness.
Schizophrenia	Two of the following must be present for a significant portion of time during a 1-month period (or less if successfully treated): delusions, hallucinations, disorganized speech, disorganized behaviour, and negative symptoms. At least one of the following must be present: delusions, hallucinations, or disorganized speech. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (*i.e.*, active-phase symptoms) and may include periods of prodromal or residual symptoms.
Delusional Disorder	Duration is 1 month or longer. Functioning is not markedly impaired, and behaviour is not obviously odd or bizarre. If mood episodes are present, their total duration is brief relative to the duration of the delusional periods.

Etiology

The causes of psychosis are not fully understood. What is known is that psychosis is often associated with early life adversities, and these manifest as childhood emotional and behavioural problems (Menningen & Bearden, 2020). There are other known risk factors for developing overt psychotic symptoms later on in life, and these include:

- Genetic risk- such as a family history of psychosis,
- Early exposure to drugs -such as cannabis,
- Early neurodevelopmental problems- such as autism spectrum symptoms, lower IQ, and delayed early motor development,
- Early life stress and childhood trauma -such as complications in eutero or during birth, *e.g.*, birth asphyxia, and socioeconomic difficulties (Menningen & Bearden, 2020).

CHAPTER 6

Anxiety and Mood Disorders

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Abstract: This chapter gives an overview of anxiety and mood disorders. Anxiety and mood disorders are arguably the most common mental illness worldwide. The purpose of this chapter is to introduce the reader to the pathophysiology, aetiology, and epidemiology of these conditions so the reader can develop an in-depth understanding of how to work with people with anxiety and mood disorders. The occupational therapy perspective is woven in throughout this chapter.

Keywords: Anxiety, Bipolar disorder, Depression, Generalized anxiety disorder, Manic episode, Mood disorders, Obsessive-compulsive disorder, Occupational therapy, Occupational therapy, Panic disorder, Phobia, Post-traumatic stress disorder.

INTRODUCTION

Anxiety and depression are arguably the most common mental health conditions known to affect people worldwide. This chapter introduces anxiety disorders first and then delves into mood disorders, including depression. These conditions are presented in one chapter as they often co-exist and complicate one another. In general, anxiety disorders are characterised by excessive worry or fear of something that might happen, whereas mood disorders often affect how one perceives themselves and their environment. People with depression, for example, may also excessively worry about something that has already happened.

In this chapter, we will explore these disorders in detail, including their signs and symptoms, as well as medical and occupational therapy management. This chapter aims to equip the readers with an introductory yet comprehensive understanding of anxiety and mood disorders so that they are well-positioned to recognize and manage these conditions within the bounds of their professions.

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Tawanda Machingura (Ed.)

Anxiety

Anxiety is a distressing, unpleasant emotional state of nervousness and uneasiness (Akinsulore, Owojuyigbe, Faponle, & Fatoye, 2015). It can be anticipatory before a threat, persist after a threat has passed, or occur without an identifiable threat (Craske & Stein, 2016). Anxiety is often accompanied by physical changes and behaviours similar to those caused by fear and occurs in a wide range of physical and mental disorders (Kandola *et al*., 2018; Perusini & Fanselow, 2015).

Causes of Anxiety

Causes are not fully known and are often a combination of factors, including: —

- Environmental. This includes a response to stressful life events *e.g*., job loss/ pregnancy/ abuse and/or significant exposure to life-threatening disasters (Porter, 2011). Trauma is thought to be a significant factor in the development of anxiety disorders (Bridley & Daffin, 2018).
- Humanistic, existential, and sociocultural theories. This emanates from a loss of sense of self and/ or concerns about the meaningfulness of life and the need for self-actualisation.
- Psychodynamic theory. Anxiety is linked to unresolved, unconscious psychological conflict that originates in the ego as it tries to moderate intense challenges from the id and superego (Duncan, 2005).
- Culture bound. Ancestral communication, curses, or omens (Duncan, 2005)
- Physical health problems. Examples include diabetes, asthma, and heart disease (Niles *et al*., 2015)
- Biological factors (Martin, Ressler, Binder, & Nemeroff, 2009)
- Family history (genetic transmission) (van Sprang *et al*., 2022)
- Sodium lactate and caffeine stimulate anxiety (Hermann, Lay, Wahl, Roth, & Petrowski, 2019; Lara, 2010)
- Substance use, especially heavy or prolonged (Vorspan, Mehtelli, Dupuy, Bloch, & Lépine, 2015)
- Cognitive, learning, and behavioural theories (Chorpita & Barlow, 2018; Hallion & Ruscio, 2011; Rector, Bourdeau, Kitchen, Joseph-Massiah, & Laposa, 2016)
- Learned responses, contributing to a highly strung personality style (Kotov, Gamez, Schmidt, & Watson, 2010).

Panic Disorder

Panic disorder is characterised by short, sudden attacks of fear, fear of losing control, or terror (Bouton, Mineka, & Barlow, 2018). The onset is often late adolescence or early adulthood (Olaya, Moneta, Miret, Ayuso-Mateos, & Haro,

2018). Signs and symptoms include heart pounding, feeling short of breath, feeling as if choking will occur, chest tightness, pain, dizziness, and other physical symptoms that appear quickly and peak within 10 minutes (Meuret *et al*., 2011). It can happen unexpectedly and can be situationally bound or situationally predisposed (Copeland, 2003)

Phobia

A phobia is defined as having an irrational fear that leads to avoidance of certain objects and specific situations (Garcia, 2017). Its onset is in childhood or early adolescence (American Psychiatric Association, 2022). Phobias are classified by specific fears, such as a fear of places or situations that might cause panic (agoraphobia) or a fear of blood (Hemophobia) (Eaton, Bienvenu, & Miloyan, 2018). Phobias present with associated physical symptoms, as is the case with panic disorder (Samra & Abdijadid, 2018).

Obsessive Compulsive Disorder (OCD)

In OCD, obsessions are repetitive thoughts, and compulsions are ritualistic behaviours. A person may present with obsessions, compulsions, or both that one realises are unreasonable, unnecessary, intrusive, and irresistible. The average age of onset is late adolescence (Brakoulias *et al*., 2017). Common compulsive behaviours include hand washing, cleanliness of the skin, checking appliances, locking doors, and counting, hoarding, and arranging items in a specific order (Abramowitz & Jacoby, 2015).

Generalised Anxiety Disorder (GAD)

GAD is characterised by excessive worry or anxiety about a variety of life events or activities, such as school, work, or family concerns, that are difficult to control (Groves, Binasis, Wootton, & Moses, 2023). These worries happen most days for a period of at least 6 months (Stein & Sareen, 2015). The Australian lifetime prevalence for GAD has been found to be 8% (Ruscio *et al*., 2017).

Post Traumatic Stress Disorder (PTSD)

PTSD is a psychological stress disorder from exposure to traumatic events such as natural disasters, violent crime, torture, accidents, or war (Benjet *et al*., 2016). It is characterised by chronic anxiety, exaggerated startle response, difficulties with concentrating, nightmares, and insomnia (Bryant, 2019). PTSD can present with comorbid depression and or substance misuse (Angelakis & Nixon, 2015; Flanagan, Korte, Killeen, & Back, 2016).

CHAPTER 7

Eating Disorders Diagnosis, Assessment, and Psychosocial Interventions

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Abstract: Currently, one in five Australian children suffer from an eating disorder (ED). Eating Disorder (ED) is a severe mental health condition characterised by severe disturbances in eating behaviours, related thoughts, and emotions (American Psychiatric Association [APA], (2013)). Occupational therapists have a unique skill set to assist with the recovery of an ED. As occupational therapists, we analyse the person, occupation, and environment to provide a variety of interventions to reduce/minimize occupational performance issues (OPI). This chapter will review the diagnostic criteria for the different EDs, the occupational therapy process using the Canadian Model of Occupational Performance and Engagement (CMOP-E) and the Canadian Practice Process Framework (CPPF), and apply the learnings to a case study.

Keywords: Anorexia nervosa, Avoidant-restrictive food intake disorder, Binge eating disorder, Bulimia nervosa, Canadian model of occupational performance and engagement, Case study, Eating disorders – unspecified, Eating disorders, Mental health, Other specified feeding or eating disorder.

INTRODUCTION

Eating disorders are serious and complex mental health conditions that affect individuals of all ages, cultures, races, and economic status across the globe. Many people with eating disorders are desperately attempting to cope with life problems, emotional pain, personal challenges, or societal pressures through an unhealthy relationship with food. The learning objectives for this chapter are:

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1. Understand the different types of eating disorders and the diagnostic criteria.
2. Understand the Occupational Therapy scope of practice within the sector of eating disorders.
3. Understand the Occupational Therapy interventions within the sector of eating disorders.
4. Understand how to use and apply the CPPF and CMOP-E within a case study.

Diagnostic Criteria

According to the International Classification Disease 11th Edition (ICD-11), there are eight different types of feeding and EDs, including anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant-restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), and feeding or EDs – unspecified (UFED) (World Health Organisation [WHO], 2019). It is important to note that previously, OSFED and UFED were previously known as EDNOS (ED not otherwise specified) as a catch-all category for individuals who did not meet the criteria for AN or BN. Therefore, some individuals may still be diagnosed with EDNOS, now known as OSFED.

ICD-11 describes AN as an ED that presents with a significantly low body weight for an individual's height, age, and developmental stage (WHO, 2019). AN is commonly classified as a body mass index (BMI) under the 5th percentile for children (approximately 18.5 kg/m^2) (WHO, 2019). Low body weight is due to self-induced behaviours, including restricted eating, purging behaviours, and/or increased energy expenditure (*e.g.*, exercise or medication abuse) (WHO, 2019). Individuals present with an intense fear of gaining weight or becoming fat even though they are presenting already at dangerously low weight (APA, 2013). Individuals may also present with body dysmorphia, where they may think their body appears larger than it is (APA, 2013). ICD-11 describes BN as an ED, which presents with frequent and recurrent episodes of binge eating followed by behaviour to prevent weight gain (WHO, 2019). This may include self-induced vomiting, excessive exercise, laxatives, and/or enemas. Individuals with BN are often obsessed with their body shape, weight, and size (WHO, 2019). ARFID is a feeding disorder where an individual avoids and/or restricts the intake of food. This results in energy and/or nutritional deficits, which can impact the physical health of the individual (WHO, 2019). However, ARFID is not related to body weight or shape (WHO, 2019). ARFID usually stems from fear of consequences (*i.e.*, vomiting or choking), sensory sensitivity, and/or lack of interest in food (Thomas & Eddy, 2019). Individuals with OSFED have an ED that does not meet the exact requirements of AN, BN, or BED (APA, 2013). OSFED includes atypical AN, BN, BED, purging disorder, and night eating syndrome (APA,

2013). Presentations now categorised under OSFED and UFED in DSM-V were summarised under the term EDNOS in ICD-11. Individuals with BED experience incidents of binge eating with a lack of control; however, no compensatory behaviours are used to offset the binging episode (APA, 2013).

In the Australian context, one in five children in Australia suffers from an ED (Mitchison *et al*., 2019). Burt and colleagues (2020) completed a study to investigate the prevalence of ED in children who were Aboriginals compared to non-Aboriginals. A study by Burt *et al*. (2020) identified that the prevalence was similar; however, night-eating syndrome occurred at a higher rate within the Aboriginal population. Hay and Carriage (2012) found Aboriginals were at a higher risk of binge eating episodes compared to non-Aboriginals. Hay and Carriage (2012) discovered Aboriginals are more at risk of disordered eating in relation to body weight concerns associated with obesity. Interestingly, Burt and colleagues (2020) found that individuals who were not presenting as underweight were often overlooked, leading to a delayed diagnosis and treatment. Therefore, it is crucial to assess the whole individual rather than just their weight (Burt *et al*., 2020).

MODES OF THERAPY

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) has the foundation that one's behaviour, thoughts, and feelings are interconnected, influencing one's reaction and response to a situation (Wilding & Milne, 2010). Enhanced Cognitive Behavioural Therapy (CBT-E) is an evidence-based practice to assist with treating EDs (Grave *et al*., 2019). CBT-E focuses on the individual and their ED rather than external factors (*i.e*., family dynamics) (Grave *et al*., 2019). CBT-E is designed for the individual to take control over their recovery rather than being dependent on others to do the work (Grave *et al*., 2019). CBT-E is an individual-based practice where there is honesty and agreement about the treatment the individual is participating in. CBT-E addresses the individual's beliefs about shape and weight regarding their body. CBT-E also addresses one's eating behaviours and their relation to their ED. CBT-E utilises cognitive and behavioural strategies to provide the individual with education to address the ED thoughts and behaviours (Grave *et al*., 2019).

Cognitive Behavioural Therapy for Avoidant/Restrictive Food Intake Disorder (CBT-AR) is a specific form of CBT designed for individuals diagnosed and struggling with ARFID. There are four stages to CBT-AR:

CHAPTER 8

Assessment and Treatment of Personality Disorders in Occupational Therapy Practice

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Abstract: This chapter focuses on the unique role of occupational therapy in the assessment and treatment of personality disorders. Integrating occupational therapy assessments and interventions within existing assessment and treatment approaches can improve functional outcomes for people with personality disorders. Occupational therapy plays a pivotal role in multidisciplinary areas and across generic therapeutic approaches, for example, Dialectical Behaviour Therapy (DBT). Occupational therapists are experts in assessing the performance of daily activities and functioning across the lifespan. Therefore, occupational therapist makes a valuable contribution to the recovery journey of people with personality disorders. This review introduces the role of occupational therapy in the management of personality disorders as defined by the Alternative Model of Personality Disorders (AMPD) in the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5). Assessment and treatment options unique to the profession are also described.

Keywords: AMPD, Multidisciplinary treatment approach, Mental health services, Pccupational therapist, Personality disorders.

INTRODUCTION

People with a Personality Disorder (PD) often remain undiagnosed, or a diagnosis is delayed due to stigma in the community and within health services (Stiles, 2023). Personality disorders have their onset in adolescence, which provides an opportunity to start treatment as soon as possible, according to Sharp (2018). However, diagnosing adolescents with personality disorders does not tend to be the norm. More often, diagnoses of personality disorders are made once a person has developed ineffective coping strategies to manage their distress, such as frequent presentations to emergency departments, self-harming, and suicide attempts (Lewis, 2019: Meuldijk, 2017). Delays in diagnoses and treatment

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increase the risk of impaired psychosocial functioning, with reduced participation in meaningful activities such as work and relationships. The person with personality disorder then feels increasingly disconnected from their social environment, which can contribute to the worsening of their symptoms.

Definition

The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) defines a personality disorder as a person's way of thinking and feeling about themselves and others that significantly and adversely affects how they function in many aspects of daily life. The DSM-5 retained the same categorical approach that was included in the DSM-IV and differentiated 10 distinct types of personality disorders: paranoid, schizoid, schizotypal antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive.

The ICD-11 Classification of Personality Disorder also includes impairments to self, interpersonal functioning (with different levels of dysfunction), and domain qualifiers: negative affectivity, detachment, disinhibition, and anankastia. The Personality Trait domains are similar in the ICD-11 and the DSM-5 despite being developed independently. The main difference is the inclusion of anankastia in the ICD-11 and the psychotic domain in the DSM-5. Both the ICD-11 and the DSM AMPD are veering away from categories towards a dimensional model with greater emphasis on psychosocial functioning.

The DSM-5 Personality and Personality Disorder working group recommended an Alternative Model of Personality Disorders (AMPD). The AMPD was published in Section III of the DSM-5's 'Emerging Measures and Models' (Skodol, 2015). The inclusion of the AMPD in the DSM-5 has assisted clinicians in utilising descriptions of a person's personality, thus facilitating enhanced treatment planning (Widiger, 2013; Widiger, 2007.). Thus, the AMPD model of personality disorders will be described.

The AMPD is designed to be flexible and aligns with occupational therapy's core philosophy that daily functioning within your environment is a priority. The AMPD defines personality disorder as a combination of clinically significant problems in daily functioning and psychopathology. The AMPD considers the person more holistically, which also aligns with occupational therapy's philosophy and includes the consideration of comorbidities such as substance use, the person's developmental stage, and their sociocultural environment (Krueger, 2020).

The AMPD includes criteria A to G. Criterion A defines the level of personality functioning, where functioning is described as impairments in their sense of self and interpersonal functioning. Criterion B includes pathological personality traits. Criterion C and D refer to the pervasiveness and stability of impairments of functioning and psychopathology - personality traits are severe yet remain relatively stable. Criteria E, F, and G discuss alternative explanations of personality pathology, which includes differential diagnoses and other medical conditions. Other explanations considered are their developmental stage, for example, adolescence.

Aetiology

The aetiology or cause of personality disorder is complex. Childhood trauma is often a major theme for people living with personality disorders. However, not all children who have lived through traumatic experiences develop a personality disorder (Beatson, 2010). Dialectical behaviour therapy uses the biosocial model to explain the aetiology of borderline personality disorder (BPD) (Linehan, 1993). The biosocial model provides people with a great sense of relief when they hear the explanation. This model is a no-blame model, transactional, and provides threads of hope that can benefit a person in their recovery journey. The 'bio' in biosocial refers to the biological attributes of someone with BPD and sensitivity to emotional cues, experiencing stronger emotions longer and more often, as well as impulsivity. The "social" refers to the person's social and living environment. Within this environment, the person experiences invalidation and lack of role-modeling of effective expression of emotion. These interactions become 'transactional' and reinforce emotional expression and intensity. The primary function of emotions is to communicate. When the emotional message is not received or the message is invalidated, the communicator escalates the intensity of their communication style (Linehan, 2015). The biosocial model is one method of explaining the aetiology of BPD. Other models include the development of maladaptive schemas from adverse childhood experiences and impaired mentalising (seeing multiple perspectives) due to attachment trauma (Sharp, 2022).

Prevalence

People with a diagnosis of personality disorder account for a high economic cost to society through frequent presentations to emergency departments and accessing a significant proportion of specialist psychiatric services (Bender, 2001; Meuldijk, 2017; Soeteman, 2008). An Australian study by Lewis *et al*. (2018) confirmed that over 20% of people presenting to the emergency department and 25% of mental health inpatient admissions had a diagnosis of personality disorder. Lewis

Part 3
Occupational Therapy Interventions in Mental Health Practice

• Summary of the various occupational therapy interventions used in mental health practice

• Discussion of how occupational therapists can select and use the most appropriate intervention for each client and situation

• Explanation of the importance of evidence-based practice in occupational therapy interventions in mental health practice.

I worked with a psychiatrist once who asked me, “What do occupational therapists do in mental health anyway?” On the spot, it was difficult for me to come up with a 3-minute elevator pitch for him, and I am afraid I fumbled more than I would have liked.

In mental health settings, occupational therapists are a fundamental part of the interdisciplinary team in delivering a range of interventions, like psychoeducation, cognitive behavioural therapy, dialectical behavioural therapy, solution-focused therapy, family therapy, group therapy, stress management, social skills training, health and fitness interventions, and even medication. While many of these interventions are considered in this text, we particularly focussed on interventions commonly led by occupational therapists. These include occupation analysis and related therapeutic media, supported employment, leisure and recreational therapy, and sensory modulation.

CHAPTER 9

Foundations of Occupational Therapy Practice in Mental Health

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Abstract: This chapter provides an overview of occupational therapy practice in mental health. Occupational therapists often find themselves working in a multidisciplinary team. The occupational therapist (OT) enables and promotes consumers to obtain the skills needed to enhance their ability to participate in or modify the environment to support their participation in everyday occupations. This chapter introduces the occupational therapy process and discusses some common interventions used in mental health, such as supported employment. The chapter concludes by discussing emerging and future mental health occupational therapy practice opportunities.

Keywords: Biopsychosocial approach, Health promotion, Occupation, Occupational therapy, Supported employment.

INTRODUCTION

In 1914, George Barton introduced the term ‘occupational therapy’, with the discipline being officially founded in 1917 at Clifton Springs, New York, in the USA. Considering that it has been just over 100 years since the profession was founded, it is still considered in the infancy stage of development (Paterson, 2008). Despite this, the occupational therapy profession has flourished internationally, with over 110 member organisations across the Global North and South representing 633,000 occupational therapists (World Federation of Occupational Therapists, 2024). The underpinnings of the therapeutic use of occupation, the profession’s therapeutic medium, have their origins in mental health (Paterson, 2008).

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Historically, mental health care has, to a large extent, been dependent on social, medical, political, and economic factors. The founders of the profession of occupational therapy were influenced by many key public personalities in the 1700s, including the French psychiatrist Phillipe Pinel and the British philanthropist William Tuke, who in the late 1700s advocated for the 'unshackling of patients' and instead providing them with activities to occupy their minds, which included arts and crafts. Pinel and Tuke are widely recognised for spearheading the moral treatment movement (Paterson, 2008). In the early 1900s, Dr. Adolf Meyer, a Swiss-born American Psychiatrist, viewed mental illness as a person's maladaptive interaction with the environment, and this became the basis of what we now know as the biopsychosocial model adopted by many in the field of psychiatry in the 20th century (Paterson, 2008). The other founders of the occupational therapy profession independent of Meyer were Americans William Rush Dunton (psychiatrist), Susan Tracy (nurse), Eleanor Clarke Slagle (social worker), Thomas Kidner (Architect), and George Barton (Architect and lived Experience Expert). The pioneers of the profession of occupational therapy had a background in a variety of disciplines, and today, occupational therapy remains a unique blend of the various health and technical professions, with occupational therapy being described as embracing the art and science of practice (Dirette, 2016). It appears as if the pioneers realised a gap in what they were all collectively providing to their patients at the time.

Currently, occupational therapy is a profession that aims to promote health and well-being through the therapeutic use of occupation. Occupations are the activities that people do in life across various contexts and environments that are meaningful, purposeful, personal, or collective in nature and that shape an identity over time (Pereira & Whiteford, 2022). The primary objective of occupational therapy is to support people to perform and engage in activities of everyday life, and occupational therapists assist people to enhance their ability to participate or modify the environment to better support their participation in these occupations (WFOT, 2007).

To work effectively in mental health, the occupational therapist requires some core skills, knowledge, and attitudes, including:

- An understanding of the biopsychosocial approach.
- Knowledge and understanding of common mental health conditions, including signs, symptoms, and interventions.
- Knowledge and understanding of the Mental Health Act, relevant laws, and other legislative instruments that commonly apply to mental health clients.
- An understanding of occupational therapy theories, frameworks, and processes.

These are discussed in detail in other chapters of this book.

- An ability to conduct a comprehensive initial assessment (this includes mental state and risk assessment, personal and family history, history of presenting illness, and an intervention/crisis management plan).
- Skills and abilities to work in partnership with the consumer (mental health client) and this includes therapeutic use of self and other interpersonal skills.
- Skills in evidence-based occupational therapy and other psychosocial interventions.
- Skills and knowledge of promoting occupational justice.
- Skills and knowledge of recovery-oriented and community development approaches.
- Knowledge of community services and resources.

The focus of OT services is to improve one's ability to engage in meaningful activities (including, but not limited to, play, leisure, work, education, social interaction, activities of daily living [ADLs], instrumental ADLs, sleep, and rest) in a range of settings, including homes, workplaces, communities, schools, residential facilities, and healthcare facilities.

The first pertinent question to ask is, “What do OTs do in mental health?”. Here are a few considerations to start to answer this question, which are explored further in this chapter:

- Evaluate the client’s condition and needs by reviewing their medical, personal, social, and family history, asking questions, and observing them doing tasks, activities, and/or occupations.
- Assess the client’s physical environment, for *e.g*., home or workplace, based on their health needs, *e.g*., labelling kitchen cabinets for a person with poor memory.
- Develop a treatment plan with the client, identifying specific goals and the relevant occupations that will be used to support them in working towards or reaching those goals.
- Teach alternative ways to perform tasks or new skills, for *e.g*., teaching a person with poor social skills how to communicate with others.
- Modify routines and habits, and sometimes, introducing and promoting new ones.
- Recommend special equipment, such as sensory equipment or electronic reminders, and instruct clients on how to use such equipment.
- Advocate for clients or supporting self-advocacy.

Occupational therapists assist individuals in resuming past roles or learning new ones.The actual “doing” of occupations enables continuous personal development

CHAPTER 10

Psychosocial Interventions

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Abstract: This chapter offers a thorough examination of psychosocial therapies used in occupational therapy, with an emphasis on cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), and family therapy. Giving readers a thorough grasp of these strategies and how to use them in occupational therapy practice is the main goal. This chapter explores the theoretical underpinnings, guiding principles, and practical applications of each intervention through the lens of evidence-based practice, emphasising the intervention's applicability in resolving a range of psychosocial issues that people encounter in their lives. The chapter emphasizes the holistic approach to client care by clarifying the integration of psychosocial therapies with the scope of occupational therapy, drawing on recent research and clinical experiences.

Drawing on current research and clinical insights, the chapter elucidates the integration of psychosocial interventions within the scope of occupational therapy, emphasizing the holistic approach to client care. Special attention is given to the role of occupational therapists in facilitating meaningful engagement and participation in daily activities through the implementation of tailored interventions.

Practical case examples and vignettes are employed throughout the chapter to illustrate the application of psychosocial interventions in real-world occupational therapy contexts. By the conclusion of this chapter, readers will not only gain a nuanced understanding of key psychosocial interventions but also develop the necessary skills to critically evaluate and select evidence-based approaches in their clinical practice.

Keywords: Acceptance and commitment therapy (ACT), Cognitive behaviour therapy (CBT), Family therapy, Occupational therapy, Psychosocial interventions.

INTRODUCTION TO COGNITIVE BEHAVIOUR THERAPY

CBT is a form of "talk therapy" that helps patients manage problems by changing their relationships with their thoughts and opening the way for behavioural alter-

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natives. A variety of issues, such as depression, anxiety disorders, issues with alcohol and drugs, marital issues, eating disorders, and other serious mental illnesses, have been shown to respond well to cognitive behavioral therapy (CBT), a type of psychological treatment (Gajecki *et al*., 2014).

CBT is aligned with occupational therapy practice in many ways. Firstly, it is a short-term, goal-oriented treatment that takes a hands-on, practical approach to problem-solving as the tenet of most occupation-based interventions. Secondly, CBT is present-focused and acknowledges the role of learned patterns of thought and behaviour. This is similar to occupational therapy practice, where the OT would explore the past, present, and future occupations and occupational patterns to assist the client with present and future occupational engagement.

Origins

CBT emerged in the 1950s and 1960s. CBT was developed by Aaron T Beck and Albert Allis. It has its roots in psycho-analytic psychotherapy and behaviour therapy. It is a highly effective strategy for dealing with many psychological problems. CBT offers a theoretical framework to comprehend how people's perceptions of their experiences might contribute to the emergence and perpetuation of psychological disorders like depression and anxiety.

Key Features

The main tenet of CBT is that thoughts, feelings (physical sensations and emotions), and behaviours are interrelated. What we THINK affects how we act and feel (THOUGHTS). What we DO affects how we think and feel (BEHAVIOUR). How we FEEL affects what we think and do (EMOTIONS). This is often referred to as the Cognitive Triad, which is shown in Fig. (**1**) below.

Thoughts include:

- Thoughts about self
- About others
- About our partners/family/friends
- About our colleagues
- About our work
- About our clients

Thoughts are important contributors to our lens on the world. CBT provides techniques to interrupt the automatic patterns that keep patients in destructive and often self-defeating cycles.

The therapist uses this approach by identifying and modifying cognitive distortions as important goals of treatment. The therapist helps a patient to critically examine whether their response to a situation is justified. CBT is not about replacing negative thinking with positive thinking. Rather, CBT is a problem-solving process. The focus of treatment is on how problems are being maintained in the present and how different symptoms interact with each other. CBT allows clients to break patterns and substitute them with helpful alternatives. This cognitive triad is shown in Fig. (**1**) below.

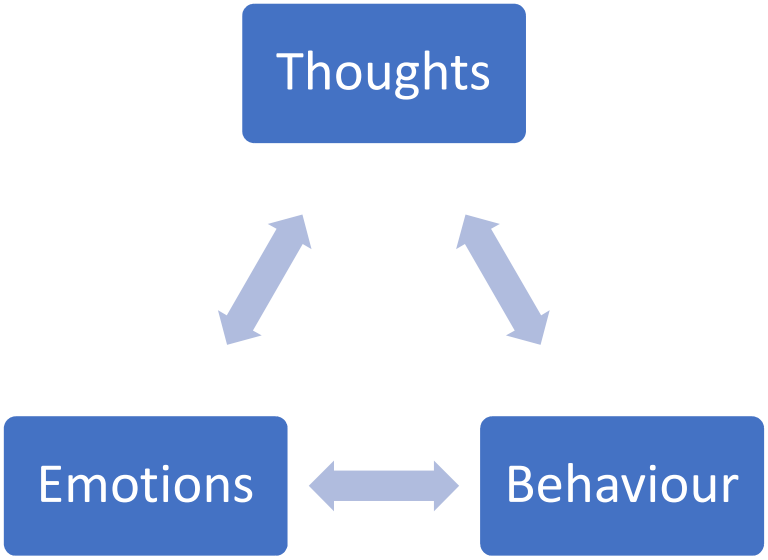

Fig. (1). Cognitive Triad.

CBT is defined precisely and has a structure that is followed by practitioners:

- Time-limited (set number of sessions)
- Operational manual
- Set agenda at the beginning of each session
- Clients are given homework
- Use of standardised measures

CBT requires high levels of collaboration between practitioner and client.

General Process

The CBT process generally involves establishing rapport and then working sequentially with the client to identify, challenge, and substitute unhelpful thoughts, as shown in Fig. (**2**) below.

CHAPTER 11

Leisure

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Abstract: Leisure is a powerful therapeutic modality that can build meaning and purpose for consumers, particularly those who have mental health issues. When acutely unwell, it can be challenging to engage in productive activities or understand cognitive-based interventions; therefore, leisure is an opportunity to build graded engagement. This chapter explores leisure as an evidence-based therapeutic modality in occupational therapy.

A brief history of leisure and how this has been incorporated in leisure or recreation settings is explored to provide context for Australia's current mental health system. A number of leisure theories are explored and applied to a mental health context, including the flourishing model, salutogenesis, serious leisure, and resilience. Furthermore, prominent leisure theory is then applied to occupational therapy theory to provide an occupational therapy focussed lens to the broader scope of leisure that could be utilised by multiple disciplines.

With the consideration of theory and occupational therapy, a number of informal and formal assessment strategies are explored with a specific spotlight on participation, satisfaction, and boredom in leisure. Utilisation of leisure as a therapeutic intervention is explored based on mental health contexts such as inpatient, rehabilitation, and community settings.

Finally, evidence-based recommendations are suggested to implement leisure in therapeutic services, such as inpatient and community settings. Occupational therapists can improve occupational engagement and performance by using occupation as an opportunity to explore, assess, and build meaningful engagement.

Keywords: Activity, Assessment, Community, Diversional therapy, Inpatient, Intervention, Hope, Leisure, Meaningful occupation, Multidisciplinary team, Occupational enrichment, Recovery, Recreation therapy, Salutogenesis, Therapeutic recreation, Volition.

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INTRODUCTION

Leisure is one of the four key domains of occupation (including rest, self-care, and productivity) (American Occupational Therapy Association, 2020). Leisure is an important part of a person's occupational profile, which can provide meaning and purpose to life. In mental health, leisure can be harnessed as a powerful therapeutic modality that facilitates meaningful engagement in an occupation that is conducive to recovery from severe and complex mental health issues. At times, engagement in occupation can be challenging for those with mental health conditions such as schizophrenia. There are a number of complexities that impact someone's ability to participate in an occupation, such as medication side effects (sedation and metabolic issues), volition, and reduced occupational opportunity. In occupational therapy, the core focus of therapy is to enhance occupational performance.

Leisure engagement should be carefully considered an important aspect of an individual's occupational profile (Townsend & Stanton, 2002). As part of the occupational therapy process, a person's daily activities, including leisure, should be considered (Townsend & Stanton, 2002). This starts with understanding their occupational profile, assessing their current skills or abilities through task analysis, and exploring their occupational performance issues (Townsend & Stanton, 2002). Each domain of occupation can then be considered when planning interventions, providing an intervention, and exploring outcome measures to effectively understand improvement in occupational performance. By identifying meaningful occupations, interventions can be tailored to the individual making the approach to therapy truly person-centred (Townsend & Stanton, 2002).

Understanding the link between participation, engagement, and interests is more predictive of subjective well-being compared to purely considering the number of leisure activities people choose to engage in (Schulz *et al*., 2018). This consideration is reminiscent of core occupational therapy practice and particular models such as the Canadian Model of Occupational Performance and Engagement (CMOP-E) and the Model of Human Occupation (MOHO) (Craik, 2009; Forsyth & Kielhofner, 2003). There are several reasons that people choose to participate in leisure activities, which include support for mental health, balance between occupations, improved physical health (such as strength and fitness), increased social connections, and support for self-esteem and confidence (Caldwell, 2005).

In mental health settings, leisure can be used as a powerful therapeutic modality to support meaningful engagement and build a sense of purpose. Leisure can also support the facilitation of treatment goals, assessment of function and cognition,

and building a therapeutic alliance. Particularly in mental health settings, consumers are often found to be bored and sedentary. In public health settings, there are limited leisure activities offered, and often, consumers have limited occupational opportunities to engage in activities that form part of their occupational profile.

This chapter will explore the use of leisure and recreation as an evidence-based therapeutic modality. Furthermore, this chapter will explore shared ideas about the use of leisure and recreation in mental health settings by an occupational therapist and recreation therapist.

This chapter will define leisure and provide context to the application of leisure in mental health settings and a brief overview of the history of occupational therapy and mental health. It will discuss the key stakeholders involved in leisure participation, evidence-informed ways to assess leisure participation, and the contexts leisure can be used in.

History of Leisure

Leisure activity has always been a key domain of occupational therapy practice (Craik & Pieris, 2006; Iwasaki *et al*., 2014; Shaw, 1985; Suto, 1998). Humans innately participate in activities and find opportunities to bring meaning or purpose to their engagement (Wilcock, 1995). Over time, occupations have been classed into categories, which provides a dearth of understanding of how individuals participate in activity (Wilcock, 1995). As society evolves and changes, our engagement in occupations does as well.

Over the past 100 years, there has been a paradigm shift in the way leisure is viewed by the general population and how people engage in leisure activities. In modern society, there is a higher emphasis on the importance of participating in leisure activities for 'self-care' or well-being, making activity prioritised as part of regular routine and self-identity (Christiansen, 1999). Leisure can also be considered salutogenic, a concept where participation in an activity is health-creating and health-promoting (Caldwell, 2005). Previously, leisure was defined as any activity that was not productivity (work) or rest (sleeping), grouping **instrumental activities of daily living (IADL)** such as laundry or meal preparation and leisure (or play) together. In the 1850s, during the gold rush in Australia, the average workday shifted from 12 hours per day, 6 days per week, with a strong emphasis on productivity, IDAL, and self-care to the '8-8-8' campaign, which introduced unionism and the importance of **occupational balance** (Christiansen & Matuska, 2006; Whiteford, 2000).

CHAPTER 12

Group Theory and Group Interventions in Occupational Therapy Practice

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Abstract: This chapter provides an in-depth exploration of the concepts and characteristics of group therapy and theories that highlight the need for using group therapy in practice. It equips occupational therapists with the tools to substantiate the incorporation of group therapy into their interventions. It also brings into foreground the various stages of conducting development and how it is used in the realm of occupational therapy. Different types of groups that are used in occupational therapy are discussed, supplemented with evidence-based examples. This aids occupational therapists in making informed decisions regarding the selection and timing of group interventions. The advantages of utilizing group therapy in occupational therapy, in contrast to individual therapy, are discussed. The chapter also addresses pertinent challenges and issues faced by therapists when employing group therapy. Lastly, steps in developing group protocols are explained using examples. This comprehensive content aims to assist practitioners in effectively conducting group sessions.

Keywords: Group types, Group therapy, Group concepts, Group theories, Group dynamics, Group protocols, Group characteristics, Occupational therapy.

INTRODUCTION

The importance of groups in occupational therapy practice

This chapter provides a structured approach to understanding the theory, practice, and ethical considerations of group interventions in occupational therapy. Group interventions are defined as planned interventions that use group dynamics provided to a group of three or more individuals together with a common purpose (American Occupational Therapy Association, 2020).

Human behavior is profoundly influenced by the interactions occurring within their social environment. These interactions, taking place within social groups involving two or more individuals, contribute to the development of one's social

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identity (McLeish & Oxoby, 2010). Being a part of a group offers essential support for fulfilling occupational roles, fostering confidence, and enhancing self-esteem. In the realm of occupational therapy, groups serve as a crucial treatment modality, leveraging inherent therapeutic factors like universality, altruism, and cohesiveness to help therapists achieve their clients' goals. These therapeutic factors, in conjunction with group features such as cohesiveness, norms, goals, boundaries, roles, and context, work synergistically to enhance clients' knowledge, attitudes, and skills within these group settings (Sousa *et al*., 2020). Group therapy is a widely employed method by occupational therapists due to its cost-effectiveness and the ability to address multiple goals simultaneously (Bertelsen, 2022).

Moreover, therapeutic groups are applicable not only to children but also to adolescents, adults, and the elderly. Groups can be open or closed and vary in homogeneity or heterogeneity, with group sizes ranging from 3 to 12 participants. These variables can influence the defined goals, the group dynamic, and the approaches employed by the leader during the therapy process.

Group therapy is not exclusively for clients; it can be extended to caregivers as well (Aboulafia-Brakha, 2014; Lapid *et al*., 2021; Karimi, 2019). Caregiver groups serve as a valuable platform to address specific issues through psychoeducation and foster a sense of closeness among caregivers who share similar experiences. For instance, the Multiple Family Groups (MFG) program, facilitated by a therapist, encompasses the individual (typically a youth, in this case, a juvenile offender), parents/caregivers, and other youth, along with their family members. This group serves to strengthen familial bonds through interaction, the cultivation of empathy, and the instigation of positive changes within family dynamics. Within this setting, families acquire skills to enhance community safety, provide better supervision for the youth, nurture empathy in the youth, and instill hopeful values. As they exchange stories, families engage in the process of sharing and expressing emotions, fostering empathy for one another, and receiving practical feedback. Activities within these groups may encompass didactic instruction, video presentations, open discussions, and role modeling (Karam *et al*., 2017).

Theories that explain the application of group therapy for individuals with mental illness include i) Group-as-a-whole theory, ii) Interpersonal theory, iii) Intrapsychic theory, and iv) General systems theory. According to the Group-as-a-whole theory (Bion, 1961), a group functions as a whole wherein each individual member in the group responds on behalf of and for all the members in the group. Group dynamics, a tacit characteristic of a group, plays an important role in the initiation of these responses. Interpersonal theory (Yalom, 1995)

focuses on individuals in the group understanding themselves and others, leading to supportive interpersonal relationships. These supportive interpersonal relationships help in dealing with suppressed emotions.

According to Intrapsychic theory (Slavson, 1950), the group offers an opportunity for patients to regress to a state of internal conflict or developmental arrest, with a focus on unconscious processes. This theory uses the dyadic theory in groups. In General systems theory (Durkin, 1981), individuals are considered separate from their environment and the group itself. The subgroups formed during group therapy form the focus wherein members of subgroups are more equipped to deal with intrapsychic resistances and defenses because they are more aware of the similarities and distinctions among themselves.

CHARACTERISTICS OF GROUPS

Group Content and Process: In occupational therapy, groups comprise two key elements: content (what is done during group therapy) and process (how things are done in group therapy). Content pertains to what is shared and produced during group therapy, while process relates to the manner in which interactions unfold among group members, with the leader or therapist, the formation of subgroups, and the overall environment cultivated during the session. This includes emotional expressions, communication dynamics among members, and the therapeutic relationship established between the therapist and group participants. While both content and process are important and necessary components of group therapy, the emphasis may vary depending on the type of therapeutic group. Content may take precedence in groups focused on activities and tasks, while process gains prominence in functional and social groups.

Group dynamics: Group dynamics, as defined by Finlay in 2002, encompasses the various forces, social structures, behaviors, relationships, and processes that unfold within a group context. It has emerged as a significant facilitator, offering participants vital support in the pursuit of personal growth and goal attainment. Key factors contributing to this include the establishment of a strong sense of belonging and connection within the closed group structure, as well as the presence of peer support, both of which play pivotal roles in this dynamic.

Group cohesiveness: Group cohesion refers to the collective feeling of unity and mutual understanding among members within a group setting. This cohesion serves as a powerful motivator, encouraging clients to actively participate in group therapy sessions. It provides a supportive environment for group members to experiment with new skills, knowledge, and attitudes in a safer environment. The feedback received during these sessions facilitates valuable learning opportunities from one another. Consistent sessions centered around shared

CHAPTER 13

Sensory Approaches, Attachment Theory, and Self-Regulation

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Abstract: Everyone experiences the world in unique ways based on their individual neurological systems, which have developed over time in an intricate and complex interplay between our genetic endowment, our sensory systems, and our past experiences of the world and the people in it. Convincing evidence has shown that people with mental illness and trauma histories have differences in their sensory processing patterns and also that they are more likely to be insecurely attached. In recognition of this, occupational therapists have shown a rapid increase in interest in the implementation of sensory approaches in mental health over the last 20 years. The relevance of attachment theory and the interrelationship between sensory and attachment systems have more recently been recognised in occupational therapy, with the recognition that these two systems develop at the same time within the same environmental conditions. In this chapter, an overview is provided of our sensory system, our attachment system, the interplay between these two systems, and the relevance of these systems in the fields of mental illness, trauma, and substance use. Understanding the sensory and attachment systems and the interrelationships between these can inform person-centred and trauma-informed occupational therapy for people with mental illness, ultimately improving occupational performance for clients with mental health conditions.

Keywords: Anxiety, Attachment theory, Co-regulation, Dysregulation, Individual, Intentional relationship, Mental health, Schizophrenia, Self-regulation, Sensory approaches, Sensory patterns, Stress, Substance use, Therapeutic relationship, Trauma.

INTRODUCTION

We each experience the world in unique ways based on our individual neurological systems, which have been developed over time in an intricate and complex interplay between our genetic endowment, our sensory systems, and our

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past experiences of the world and the people in it. In this chapter, an overview is provided of our sensory system, our attachment system, and the relevance of these systems in the fields of mental illness, trauma, and substance use. Understanding the sensory and attachment systems and the interrelationships between environmental and historical factors can inform person-centred and trauma-informed occupational therapy practice for people with mental illness. To begin, we need to understand the concepts of self-regulation and its related concepts.

Self-regulation, Co-regulation, and Dysregulation

Occupational therapy literature highlights the need for a person to be in the "just right state" to successfully achieve their functional goals. To learn at university, for example, we need to be both calm and alert at the same time. We can all relate to not being in quite the right frame of mind to engage in the activity in front of us. If I stay up too late studying last minute for a big exam at 8.00 am the next day, I may feel sluggish upon waking in the morning and look for something stimulating, like a quick run or a strong cup of coffee, to help me face the day. If, on the other hand, I have been celebrating with a friend after having aced the exam and come home happy and excited, I may find a warm shower or a warm glass of milk will calm me enough to sleep. Throughout our lives, we learn various behaviours to elevate our moods (alert us) and others' that can be more relaxing (or calming). We also learn when to use each of these strategies appropriately. This skill is known as our ability to self-regulate.

Self-regulationis the ability to maintain our level of arousal on a dimension from deep sleep through calmness to alertness, which permits us to engage in the occupations and activities we desire within the constraints of our environment. If I need to attend a lecture but I am agitated and not able to sit still, or if I am tired and dozing off, then I am not adequately regulated for that activity. Many people can recognise when they are insufficiently regulated and adeptly modify their behaviour to better support satisfactory functioning. There are several reasons, however, that people may not be able to do so. Infants and very young children will not yet have developed the skills to self-regulate, requiring the support of the caring adults in their lives to do so using co-regulation (*e.g.*, swaddling, feeding, rocking). We continue to need co-regulation throughout life as we draw on the support of others. For various reasons, some people may not have learned the skills to adequately self-regulate even though they are older, or the distress experienced may exceed their capacity to cope (*e.g.*, loss of a loved one or experience of a mental illness). Without the capacity to self- or co-regulate at any moment, we have the experience of being dysregulated (*i.e.*, an ongoing state of distress). In this chapter, sensory processing and attachment theories are considered, separately and together, to explain this challenge, with consideration

to how this insight can inform occupational therapy and support more adaptive responses.

Our Senses

As human beings, we experience the world through our senses. Most people are aware of the five main senses: sight (vision), smell (olfactory), taste (gustatory), touch, and hearing (auditory). These senses are sometimes collectively referred to as "exteroception" because the stimuli for the sensations originate outside the body (*i.e.*, externally). Less commonly known senses are deep pressure and joint position (proprioception), motion (vestibular), pain (nociception), and other inner body sensory systems (interoception), such as when our bladder or bowel signals that we need to use the bathroom, when our stomach indicates we are hungry or full, and even our emotional experiences. We need these sensory stimuli to function adaptively and safely in our world. While we might presume everyday sensory experiences to be non-noxious, even non-noxious stimuli can become problematic, either by their presence or their absence. For example, consider the impact of a ticking clock or dripping tap when you are trying to get to sleep. Also, consider the experience of a lack of sensory stimuli (sensory deprivation), like being in a secure white hospital room.

It is important to distinguish between a stimulus itself (*e.g.*, a sharp pin), the signal arriving at our specialised peripheral nervous system receptors (a pinprick), the message that is received in the brain (a pin has pricked me, and it hurts), and the interpretation our brain makes of that message to instruct our body regarding how to respond. The brain's ultimate interpretation is nuanced for each person based on our unique past experiences and neurological systems. In the case of the pinprick, the interpretation and related body responses will vary for individuals who work in the clothing industry (who regularly encounter the sharp end of pins) compared to someone who was recently stuck by a discarded heroin needle left in the sand. The brain's ultimate interpretation might also be affected by the individual's neurological state. For example, a person with a trauma history or diagnosed with anxiety is more likely to have an activated neurological state and may experience a more extreme physical withdrawal reaction and/or emotional response to the pinprick.

In her seminal work, Winnie Dunn (Dunn, 1997; Dunn & Brown, 1997) recognised that one's sensory pattern is comprised of two dimensions. First, the neurological threshold (*i.e.*, the level of the sensation needed to trigger recognition by the body), which can be described as high or low. Second, our response to the stimuli, which might be more active (to avoid, minimise, or maximise the stimuli; also known as "counteract") or passive (little or no

CHAPTER 14

Child and Youth Mental Health

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Abstract: Mental health affects a large number of children and young people worldwide. The role of child and youth mental health services is to provide timely assessment and interventions to improve the well-being and standard of life of children and youth with mental health conditions, foster child development, and ultimately save lives. This chapter explores the role of occupational therapists when providing services to children, families, and carers. The chapter summarises common models of practice used by occupational therapists and provides a synopsis of common conditions seen in child and youth mental health settings. The chapter then introduces common recovery-oriented interventions used when working with children and young people experiencing mental health problems and their carers and families.

Keywords: Occupational therapy, Models, Sensory, Multidisciplinary, Child and youth mental health, Multidisciplinary team, Mental health disorders, Anxiety, Depression, Bipolar, Sensory integration, Sensory modulation, Parents and family interventions.

INTRODUCTION

Worldwide, one in seven 10- to 19-year-olds experience a mental illness of some sort, and this accounts for 13% of the burden of disease for this age group (WHO, 2021). Globally, suicide is the fourth leading cause of death among 15–29-yea--olds (WHO, 2021). Mental health conditions in early life years can extend into adulthood and increase the risk of substance misuse, poverty, reduced life satisfaction, poor job satisfaction, and impaired relationships (Reardon *et al*., 2017). Whilst early intervention is paramount to limiting the development of these issues, having the knowledge and awareness of finding the most effective services for the child can be difficult to navigate (MacDonald *et al*., 2018). Given this responsibility largely falls on the parent or guardian, it is important that their

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experiences within the health system are considered. Parental involvement in Child and Youth Mental Health Services (CYMHS) is essential (Brown, 2020). The parent`s role is also to facilitate appointments and help implement treatments recommended by treating clinicians during sessions (Haine-Schlagel & Walsh, 2015).

Occupational therapists play a very important role in mental healthcare for children and youth. By working in a multidisciplinary team, they support the development of life skills and promote engagement in meaningful activities (American Occupational Therapy Association [AOTA], 2020). Recently, the impact of the COVID-19 pandemic on children and youth has further impacted this group. With the introduction of lockdowns, school closures, and social distancing, daily lives and daily routines were disturbed and limited (Loades *et al*., 2020). It is also important to acknowledge the impact of traumatic events such as natural disasters, like fires, and domestic abuse on children and youth (Leed *et al*., 2020).

Child Youth Mental Health Services (CYMHS) are usually public mental health services, although private child and youth mental health services also exist, particularly in Western countries. The importance of CYMHS is to provide timely assessment and interventions to improve the well-being and quality of life of children with mental health conditions, foster child development, and ultimately save lives (Reardon *et al*., 2017). Occupational therapists are often employed and work within child and youth mental health services. Occupational Therapy (OT) is a key component of mental health service delivery and provides support to consumers who have difficulties completing daily occupations (Nardella *et al*., 2018).

Role of Occupational Therapy in CYMHS

Occupational Therapy (OT) is a key component of mental health service delivery and provides support to consumers who have difficulties completing daily occupations (Nardella *et al*., 2018). Occupational therapists utilise client-centred approaches to make improvements to health and well-being by using targeted interventions that increase functionality. Transition to adulthood is an important role for OTs in CYMHS, as they aim to equip the youth with the necessary skills to attain independent living and successfully integrate into adult life (Bazyk, 2017). Emotional regulation is another focus area addressed by OTs, who use different therapeutic techniques, including sensory integration, to improve coping mechanisms and promote self-regulation among young individuals (Schaaf & Mailloux, 2015). OT strategies may include providing enabling environments and

other environmental modifications, behavioral interventions, and psychoeducation focusing on addressing the functional impairments associated with the psychiatric disorders (AOTA, 2014).

Other OT roles and interventions in CYMHS include:

- Clinic Interventions,
- Home interventions,
- School-based interventions, and
- Community-based programs.

Models of Practice

In occupational therapy, models and frames of reference are used to guide practice. This helps the occupational therapist to be theory-informed when identifying challenges and difficulties and formulating the interventions and strategies. In occupational therapy, there are a variety of well-established models and frames of reference that are commonly used when working with children and youth with mental health problems. In this chapter, we briefly overview the common models as another specific section of this book is dedicated to discussing models in more detail.

Model of Human Occupation (MOHO)

This is one of the most utilised models in mental health occupational therapy. In this model, the focus is on how human occupation is chosen and how and when it is done (patterned and performed) in context (Kielhofner, 2008). When used with children, the occupational therapist is interested in the individual's motivation to do, their habits, roles, routines, and performance abilities within their environment (Kiefhofner, 2008). The occupational therapist focuses on how the child's condition and difficulties impact their motivation, routines, and performance.

Person Environment Occupation Model (PEO)

This model's focus is on the fit between the person, environment, and occupation (Law *et al*., 1996). The occupational therapist will assess the transactions and fit between the child's abilities and capacities (person), their occupations *e.g*., play, and their environment. The occupational therapist would then work with the child and their significant others, including caregivers, to increase the fit. This includes considering environmental factors such as family dynamics and fiscal environment and how they impact performance and function.

CHAPTER 15

COVID-19, Mental Health, and Occupational Therapy

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Abstract: The COVID-19 pandemic has significantly impacted global health, prompting widespread public health measures that inadvertently disrupted occupational engagement and mental health. This chapter highlights the specific challenges presented by COVID-19 with a focus on mental health. This chapter focuses on mental health, a key strategy in responding to the pandemic, as identified by the World Health Organisation (WHO). Key mental health-related impacts of the COVID-19 pandemic on the world's population included occupational disruption, increased mental health issues, and a marked impact on vulnerable populations such as children and those with pre-existing mental conditions. Telehealth emerged as a crucial adaptation in occupational therapy, facilitating continuity of care. However, disparities in access to these services persist, necessitating further attention to health equity. Lessons learned are ongoing and point to the use of virtual/ teletherapy technologies, the need for integrated health services, and ongoing support for mental health care in future pandemics.

Keywords: COVID-19, Health service delivery, Mental health, Occupational engagement, Occupational therapy, Pandemic preparedness, Psychological distress, Social isolation, Telehealth, Vulnerable populations.

INTRODUCTION

Many pandemics and epidemics have been known to have occurred throughout human history. In the last century, the world has seen the Spanish flu (1918-1920), the Asiatic flu (1956-1957), the severe acute respiratory syndrome (SARS, 2002-2003), the "Swine" flu (2009), the Ebola (2013-2014) and many others. Psychological distress in the population has been reported in all previous pandemics and epidemics (Talevi *et al*., 2020). Despite this historical context, the world was seemingly surprised and unprepared when the COVID-19 pandemic

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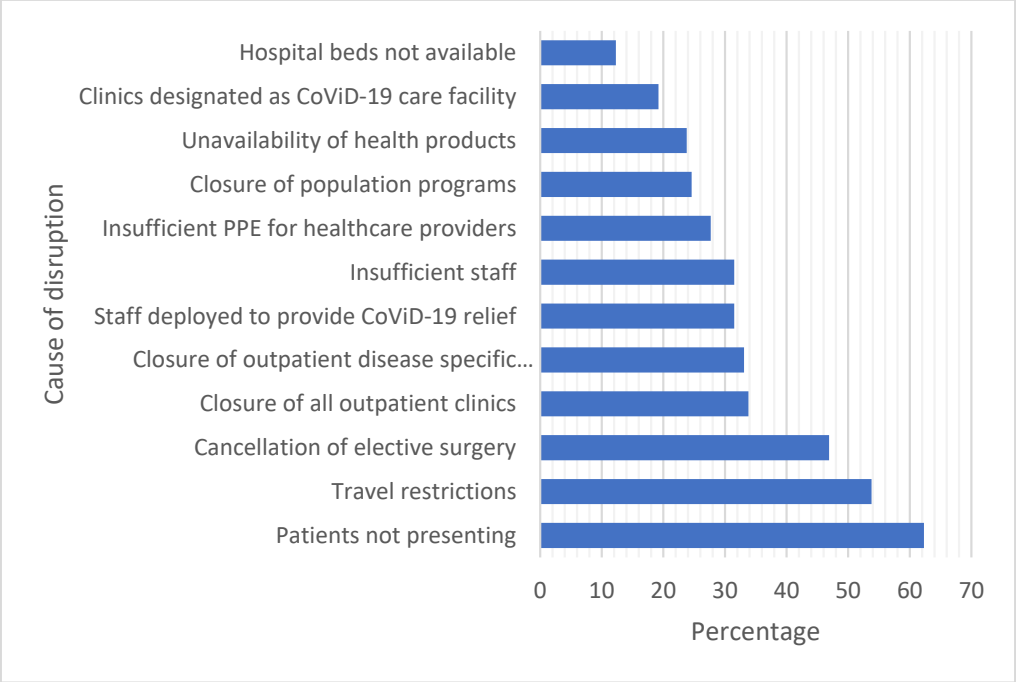
started. The purpose of this chapter is to assist the reader in understanding the impact of the measures taken and the lessons learned from the experience.

COVID-19

The World Health Organization declared that the widespread severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which soon became known as the coronavirus disease 2019 (COVID-19), was a global pandemic in March 2020. Many public health measures were implemented, such as 'lockdowns' and 'social distancing', and other infection control measures to contain the COVID-19 pandemic. Inadvertently, these measures also had unintended consequences, disrupting occupational engagement to many people across the world (Culleton, 2022) as well as forcing people to adapt to new ways of living (Maynard, 202). The impact of COVID-19 on mental and neurological health and substance use services (MNS) has now been evaluated, and leading causes of disruptions are identified in below (WHO, 2020).

Table 1. Leading causes of disruptions in MNS-related intervention/services



*Data sourced from WHO 2020, under the Creative Commons Attribution-licence-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

The occupational balance and mental health of the population, especially those who already had a previous history of mental illness, were affected negatively (WJHO, 2021). There were also negative effects on people's physical health, including pulmonary, cardiac, and muscular problems and neurological manifestations that directly affect mobility (Grabowski *et al*., 2020) and the performance of activities of daily living (Grabowski *et al*., 2020; Sánchez-Guarnido *et al*., 2021).

Measuring the Impact of COVID-19

According to Moreno *et al* (2020), p.819, the following indicators should be continuously assessed during and after the pandemic and compared with corresponding indicators before the pandemic to establish pandemic-related changes in local and national delivery systems for mental health:

- The proportion of all mental health services provided in inpatient, emergency, institutional (*e.g*., prisons), outpatient, community, and home-based settings
- Rates of face-to-face, video, and telephone contact with different types of mental health providers
- Rates of prescription and use of psychiatric medication
- Access to, and use of, different mental health services both by people with pre-existing mental health disorders and those with new incident cases of mental illness, and the sociodemographic characteristics of these users
- Quality of care of different mental health services (including acceptability and satisfaction with health-care providers), with a focus on user expectations and satisfaction and on functional, vocational, and clinical outcomes (including families' or carers' views)
- Disparities in mental healthcare, with socioeconomic, race, and ethnicity data linked to quality measures
- Integration of mental health services with general health services, social welfare, and other institutions (*e.g*., schools, prisons) and community associations
- Governmental and non-governmental financial support for mental health and social care services and for research focusing on the monitoring and improvement of mental health services" p. 819.

During the COVID-19 pandemic, these measures were not reported. In this chapter, the author will not be reporting on the outcomes as the purpose is to alert the reader to future practice rather than dwell on history. The reader is encouraged to reflect on these outcome measures in their own country and context.

Part 4
Recovery-Oriented Occupational Therapy Practice in Mental Health

CHAPTER 16

Social Determinants of Mental Health: A Critical Occupational Perspective

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Abstract: Living a healthy lifestyle is influenced by personal agency and societal structures, which contribute to a continuum of physical and mental health. The social determinants of mental health offer a perspective on how structural factors may influence a person's lifestyle. These determinants include the conditions in which people are born, live, grow up, and age, shaped by policy decisions and resource distribution within their communities and societies. These social, political, cultural, and economic conditions, along with spiritually problematic situations, may disrupt optimal mental health, increase the risk of mental disorders, and worsen outcomes among those affected. The concept of social inclusion holds great potential in the rights-based examination and redress of challenging social determinants of mental health. Further to this, the chapter proposes drawing on a critical occupational perspective as a paradigm shift from an individualistic medicalised view to a more collective and justice-oriented approach, challenging the taken-for-granted ways of participation and centering participation in meaningful occupations for all.

Keywords: Africa, Disability, HIV/AIDS, Mental health, Occupation, Occupational justice, Occupational perspective, Poverty, Social determinants, Social exclusion, Social inclusion.

INTRODUCTION

Maintaining mental and physical health is important for sustainable human development across the lifespan. Healthy lifestyles are integral, however, there are contextual factors to consider that may be facilitative or restrictive in nature. It has long been demonstrated that healthy lifestyles occur through an interaction between many factors, which could be viewed as including the broad categories of personal agency and societal structures. Some geopolitical situations are historically positioned for worse outcomes because of the social determinants of health dominant in these contexts.

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There are ongoing contestations over how much personal agency compared to societal structures influences the achievement of healthy lifestyles (Cockerham, 2005). Nevertheless, it is evident that agency, which involves the capacity to utilise various causal abilities, and structure, which encompasses established laws and resources within society, both contribute to a continuum of physical and mental health (World Health Organization and Calouste Gulbenkian Foundation, 2014). However, healthy lifestyles are challenged in conditions of ill health and disability and are usually complicated by social inequalities that could lead to social exclusion (Ikkos, 2023). Mental health has been traditionally neglected, and there is a need to explore the complex factors and propose sustainable solutions. To this end, social determinants of mental health offer a perspective with which to understand how structural factors may influence a person's lifestyle, health, and well-being. This chapter begins with a description of the social determinants of mental health and then draws on a critical occupational perspective to discuss how mental illness and the associated exclusions may be addressed.

Mental health is influenced by the social determinants of health, which are social conditions that people experience throughout their lives, such as where they are born, live, grow up, and grow old. These conditions are shaped by policy decisions and the allocation of resources and opportunities in their communities and societies (Sen *et al*., 2007; Shim & Compton, 2020; Silva *et al*., 2016). This means that the environments where people live, and work have an impact on their mental health (Marmot, 2005). The idea of the social determinants of mental health has been widely adopted in the fields of population health, where there is a growing interest in how the social determinants of mental health interact with lifestyle-related diseases (Shim & Compton, 2020). These social, political, cultural, and economic factors, as well as spiritually challenging situations, can affect mental health negatively, increase the likelihood of mental disorders, and worsen the outcomes for those who are already affected (Lund *et al*., 2018a; Shim & Compton, 2020). There have been many efforts to better understand and address the social determinants of mental health, as shown by the increasing number of publications, commissions, reports, and task forces on this topic (Satcher & Shim, 2015; Sen *et al*., 2007; Shim & Compton, 2020; Silva *et al*., 2016). All are designed to promote good mental health in an inclusive and equitable society.

Good mental health is a function of equitable and supportive human and non-human environments. When environments are unsupportive, such as when health inequities prevail, then health disparities exist between population groups (Lund *et al*., 2018a; Shim & Compton, 2020) and poor mental health may occur. Since the social determinants of mental health shape access to and distribution of opportunities and resources for mentally healthy lifestyles, addressing the social

determinants of mental health becomes a necessary priority. It is important to do this in a manner that challenges and changes the values and policies sustaining the normative influences of the social determinants of mental health. Even more, applying this position to the everyday lives and realities of those affected and or at risk of social exclusion can enhance the mental health outcomes of a population.

Addressing Social Determinants of Mental Health in Developing Settings

Mental health challenges in developing settings remain prevalent and complex, with multiple causal roots disproportionately affecting already marginalised population groups. When contemplating what lifestyle changes could promote good mental health in low-resource settings, the historical origins of the political, social, economic, cultural, and physical factors of the environment should be considered. This is necessary since prevalent social inequalities, many of which have colonial descendance, have been implicated in major risk factors for most mental disorders (Lund *et al*., 2018a; World Health Organization & Louste Gulbenkian Foundation 2014) (Fig. **1**). Little has been done beyond blueprints to seek redress to these challenges in most developing countries. Generally, these conditions remain under-researched with scant attention to how they could be considered in the prevention of mental disorders across the lifespan. Understanding social determinants of mental health and other associated concepts as they apply to marginalised population groups is drawn from the first author's doctoral thesis which explored the experience of social inclusion among young adults dually afflicted with substance use disorders and Human Immunodeficiency Virus (HIV) in Zimbabwe, Africa (Nhunzvi, 2021).

There is a need to deliberately target social determinants such as poverty, lack of education, unemployment, conflicts, political and economic crises, and adverse life experiences which continue to drive the unfair distribution of opportunity for lifestyles that promote good mental health. Most of these social determinants are influenced by the geopolitical locations, especially the characteristics of people's immediate neighbourhoods (Silva *et al*., 2016). For example, in the first author's doctoral study with young adults dually afflicted with substance use disorders and HIV in Zimbabwe, unsupportive environments, poverty, unemployment, and political and economic crises were some of the major determinants of mental health (Nhunzvi, 2021). Also major was the challenge of access to resources and opportunities for healthy lifestyles even when one was considering recovery. Below we share P Jay[1]'s situation, emphasising the presence of social determinants of mental health.

CHAPTER 17

Models of Recovery-Oriented Practice & Recovery-Oriented Assessment and Intervention

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Abstract: This chapter views recovery through multiple perspectives, focusing on the lens of personal recovery in the mental health context. The process of personal recovery may be as unique as the individuals experiencing it. However, some common themes are discussed, including the presence of connection, hope, optimism, identity, meaning, and empowerment. This chapter draws on the lived experience of mental health consumers to highlight the role of occupational therapists in recovery and breathe life into the theoretical concepts discussed throughout. Examples of how occupational therapists may use strengths-based and person-centred approaches to facilitate recovery and engage consumers in the occupational therapy process are provided. In addition, this chapter emphasises the importance of shared decision-making and describes the unique considerations when working with diverse populations including culturally and linguistically diverse individuals, individuals who identify as LGBTQIA+, and individuals who are neurodivergent.

Keywords: Mental health, Neurodivergent, Occupational therapists, Personal recovery, Recovery.

INTRODUCTION

In the context of mental health, the term ‘recovery’ has diverse implications and meanings. Recovery could mean the person is no longer experiencing the symptoms of a mental health condition, or it could mean these symptoms are no longer impacting their ability to engage in their usual life activities. For others, recovery might be about experiencing their challenges or symptoms differently (for example, using their experiences of their voices or suicidality as a way of tracking unnoticed fears or burnout), or simply finding new ways to do the things they used to enjoy, or trying new things altogether. Some may find faith as their source of recovery and others may feel that they have nothing to ‘recover from’

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and therefore have no use for this term. Every individual will have their unique relationship with this word, and as occupational therapists, it is important to explore how the individual views recovery, and work within their preferred framework.

In this chapter, three dominant discourses around recovery are defined and discussed: clinical recovery, social recovery, and personal recovery. This chapter presents current models of recovery relevant to occupational therapy practice and provides examples of how occupational therapists can use a recovery-oriented approach to support clients experiencing distress and/or uncommon realities in their recovery journey. Occupational therapists play an important role in promoting the positive shift in attitudes and language within the mental health sector, moving away from entrenched 'illness' talk towards exploring 'valued roles.' In using a holistic, person-centred approach, occupational therapists can begin to contextualise a person's previous experience and meet them where they are, to walk with them to where they want to be.

This chapter blends theoretical concepts defined in the literature with real stories of recovery, told from the lived experience perspective. These rich narratives will provide readers with a deeper understanding of how their theoretical knowledge can be applied in practice to support people on their recovery journey. In addition, these stories highlight some examples of harmful or unhelpful interactions between clinicians and individuals with mental health lived experiences, from which students and clinicians can learn.

What is Recovery?

Recovery is a complex and multifaceted concept in that it can mean different things to different people, or the meaning may shift depending on where the person is in their recovery journey. Because of this, there is no single, universally accepted way to define the term 'recovery'. Instead, multiple complementary definitions of recovery have been proposed in the literature, reflecting different understandings of health and wellbeing, which can be broadly categorised under the following three domains.

Clinical Recovery

Clinical, sometimes referred to as symptomatic, recovery takes a medicalised approach to recovery with a focus on symptoms, or lack thereof. Unlike the other categories of recovery described in this chapter, clinical recovery does not consider the person's unique contextual factors, and can therefore limit one's ability to achieve 'recovery' by this definition.

"Clinical recovery refers to the absence of symptoms, either as a result of them being eradicated by treatment, or because the treatment is suppressing or controlling them. The essential concept of clinical recovery is that the recovery process occurs because of the effectiveness of the clinical treatment." (Coleman, 2011, p. 31)

The concept of clinical recovery refers mostly to reducing or eradicating symptoms of mental ill health through the use of psychological and/or pharmacological interventions (Pelletier *et al*., 2020). Access to evidence-based interventions and the opportunity to continue accessing services long-term is essential for facilitating clinical recovery (Lloyd *et al*., 2008). However, it is important to note that, even with ongoing access to treatments and services, total recovery from a clinical perspective may not be an achievable outcome for all individuals experiencing a mental health condition. Unlike recovery from a physical ailment such as a broken leg, the road to mental health recovery may be filled with peaks and troughs and individuals may encounter setbacks in their recovery as a result of adverse life events outside of their control. It is for this reason that other, less limiting definitions of recovery have been suggested.

Societal Recovery

"Social recovery … views the recovery process as the person's ability (or lack of) to interact in a particular way within society." (Coleman, 2011, p. 53)

Societal, or social, recovery incorporates functioning and the person's ability to participate in such areas of their life as work/productivity, social interactions and relationships, and housing/independent living (Castelein *et al*., 2021). Societal recovery is grounded in the premise that one does not have to be clinically recovered to begin taking control of their life and returning to community activities that were perhaps made difficult by the presence of mental health symptoms. This approach involves acknowledging the need for ongoing support to develop skills and capacity, while providing the person with opportunities to build or re-build their identity in terms of social roles (Tew *et al*., 2012).

Personal Recovery

Personal recovery is a term created by lived experience and fought for by the consumer/ survivor/ex-patient (CSX) movement (Morrison, 2009). It was the lived experience response to the pathologizing and limiting (clinician-led) clinical recovery and social recovery. It is no small feat that lived experience has seen this term accepted and embedded within mental health services across the globe. Arguably the most important concept of recovery in the context of mental health, personal recovery refers to *"shifting emphasis from clinical symptom reduction*

CHAPTER 18

The Future of Occupational Therapy: Recovery, Participatory Citizenship and the Impact of Technology

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Abstract: This chapter was co-authored by a peer researcher with lived experience. People with mental health challenges are often pushed to the margins of society, and experience powerlessness, which prevents them from being able to access their full rights as citizens. The chapter explores the concept of citizenship within the context of mental health and occupational therapy. Limitations of the recovery approach are discussed and opportunities for enacting participatory citizenship to address the limitations are explored. The intersection between participatory citizenship and occupational justice is examined.

The chapter also delves into the impact of technology on citizenship, discussing the opportunities and challenges it presents for individuals with mental health conditions. It highlights the importance of considering technology's role in shaping social norms, facilitating participation, and promoting inclusion. In an increasingly technological society, occupational therapists could play a key role in public health and through 'occupation' support people with their identity and finding meaning. It is essential that occupational therapists engage in promoting digital citizenship, people's interaction with AI, and participation in the virtual world.

The chapter suggests reflective exercises for readers to consider; these can be undertaken individually or collaboratively as part of group activities. These reflections are designed to support a shift in thinking towards a more participatory approach to promote citizenship, address occupational injustice, and create inclusive societies for individuals with mental health challenges.

Keywords: Digital citizenship, Mental health, Occupational justice, Occupational therapy, Participatory citizenship, Recovery.

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INTRODUCTION

People with mental health challenges are often pushed to the margins of society and experience powerlessness, which prevents them from being able to access their full rights as citizens (Hamer *et al.* 2017). This results in mental health service users being at a significantly higher risk of experiencing occupational injustices such as occupational marginalisation, occupational alienation, occupational inconsideration, or occupational deprivation than the general population (Wilcock and Townsend, 2009; Chichaya, Joubert and McColl, 2019; Khronenberg and Pollard, 2005). To ameliorate the risk, the participatory occupational justice framework (PJOF) is growing in popularity within the field of occupational therapy. The PJOF is a useful conceptual tool when working from an occupational justice lens in occupational therapy practice and is in line with the ethos of citizenship (Whiteford *et al.* , 2017). There is also a drive from within occupational therapy for a focus on participatory citizenship and how we work collaboratively with people with disabilities and mental health services to increase inclusivity and promote social justice (Fransen *et al.* , 2015; Fransen *et al.* , 2013).

Citizenship is an increasingly prominent concept within mental health as a way of promoting the rights, participation, and inclusion of people with mental health challenges within society (Davidson *et al.* , 2021; MacIntyre *et al.* , 2021). This is for two reasons: firstly the social change promised by the Recovery Approach, whilst leading to some changes for people with mental health challenges, has not delivered the transformation of services and communities that had been promised (Rowe and Davidson 2016; Brannelly 2018); and secondly, the nature of citizenship is changing with the rapid uptake of technology (Morgan *et al.* , 2020).

This chapter will first define citizenship in the context of mental health and its relationship with Recovery. This will be followed by a discussion of citizenship within occupational therapy. Following this conceptual exploration, there will be a focus on the key themes from the mental health citizenship research and a discussion of the implications for occupational therapy. The chapter will move on to explore the impact of technology on citizenship and what this means for occupational therapy practice now and in the future. This section is predominantly based on a small-scale research project undertaken by Phil Morgan as part of a PhD, and elements of his thesis are reproduced throughout this chapter. Bex Symons worked with Phil as a peer researcher on this project. The chapter will conclude with a call to action and a proposed approach to implementing citizenship approaches.

In each section, there will be reflective exercises for you to consider as you work through the chapter (these can be undertaken individually or as part of a group

activity). These reflections are designed to support your understanding and how you may wish to adopt this thinking in your practice, as well as the challenges and opportunities this will bring.

WHAT IS CITIZENSHIP?

Citizenship in Mental Health

Citizenship is an important and contested concept in mental health (MacIntyre *et al.* 2021). Due to the mental health legislation, for example, the UK Mental Health Act 1983, it could be argued that people with mental health challenges have a unique experience of citizenship as their human rights are dependent on their health status (Hamer and Findlayson 2015; Brannelly 2018). Once you are labelled with mental health challenges, you can be perceived as different, dangerous, and not to be trusted (Hamer *et al.* 2014; Hamer and Findlayson 2015; Vervliet *et al.* 2019; Cogan *et al.* 2021). This, in turn, can lead to a loss of personal power and a collapse in the sense of agency and role in society, which reinforces people's mental health challenges (Hamer *et al.* 2017).

The service user/survivor movement has long fought for full citizenship. However, neither the de-institutionalisation of the 80s and 90s nor the Recovery movement has delivered the level of change that has led to equal citizenship (Rowe and Davidson 2016; Eiroa-Orosa and Rowe 2017). This lack of progress has resulted in social exclusions that perpetuate and sustain inequalities. This is why a focus on citizenship within mental health is being viewed as an important lens through which people's experience of inclusion and exclusion in society can be explored to enhance participation, promote people's rights, and deliver social justice (Rowe and Davidson 2016; Morgan *et al.* 2020; Davidson *et al.* 2021; MacIntyre *et al.* 2021). This is not to say the core principles of Recovery are not important, but rather that exploring citizenship provides a political and social context to understand Recovery and its implementation. Before exploring citizenship, it is important to revisit the concept of Recovery.

Personal Recovery

The Recovery approach evolved out of the survivor/service user movement in the United States, with service user activists such as Pat Deegan promoting the value of lived experience. She aligned the rights of people with mental health challenges alongside those with disabilities in a call for social change (Deegan 1988). The purpose of this was to shift the focus from illness and clinical recovery to one that supported people to build a life and find meaning and purpose. The core components of this were the role of peer support, self-management, valuing the expertise of people with lived experience, and fundamentally people having a

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Tawanda Machingura

Professor Tawanda Machingura is a clinician-academic with 30 years of postgraduate experience. He is passionate about advancing the field of occupational therapy, training future generations of therapists, and enabling individuals affected by mental illness to improve their quality of life and lead satisfying and successful lives.

He obtained his first degree in occupational therapy from the University of Zimbabwe in 1994 before traveling to New Zealand, where he pursued further education and earned a Master of Health Practice (with Honours in Rehabilitation) from Auckland University of Technology in 2006. He later emigrated to Australia, where he obtained a PhD in the School of Applied Psychology, Griffith University, Australia.

Professor Tawanda Machingura is actively involved in conducting research, publishing in journals, and presenting at conferences. His research interests include developing, testing, and evaluating psychosocial, evidence-based interventions to improve the health and well-being of individuals with mental illness or mental health challenges across the lifespan.

At the University of Notre Dame Australia, Professor Machingura is known for his engaging teaching style and commitment to mentoring students. He is currently focused on developing a world-class occupational therapy program that integrates real-world practical skills training, theoretical knowledge, and the university's core values to nurture the next generation of occupational therapists.