ANSWERS TO CHAPTER REVIEW QUESTIONS

CHAPTER 1

1. **What is the role of a peer specialist in providing mental health services?**

   The specific role of the peer specialist varies among agencies employing them. But in general, the people with the lived experience of mental illness are in an ideal position to provide emotional support for others and provide assistance with many life tasks such as negotiating the legal and social service systems. Many peer specialists also take an active role in planning and implementing programming at drop-in and wellness centers which may include one-to-one teaching or running groups.

2. **What is the difference between personal recovery and clinical recovery?**

   Personal recovery is a highly individualized process that is focused on finding meaning and purposes in one's life. The recovery path is contextualized within one's environment, experiences, and culture. Clinical recovery is focused on the reduction or elimination of symptoms. These concepts are not incompatible, but the extent that the symptom reduction and professional mental health intervention are included in one's personal path to recovery is highly variable.

3. **What kinds of research and outcomes are most suited to a recovery-oriented practice?**

   Collaborative and participatory research, which are typically qualitative or mixed-method designs, are ideal in recovery oriented practices because it stands to reason that if mental health professionals are going to study personal recovery outcomes, then it must be done in collaboration with people in recovery. Occupational therapists should be aware however, that it is often difficult to publish such research,

and advocating for further inclusion of this perspective in the scholarly literature is needed. Outcome studies are highly valued in the scholarly literature, but they typically focus on outcomes that can be applied as a norm to a general population. More valued within the recovery perspective is focus on individually determined outcomes that may be measured by using occupational therapy tools such as the Canadian Occupational Performance Measure. (COPM).

4. **How would you pursue developing collaboration with a client?**

   The most important skill in collaborative work is the willingness to truly listen; and in order to do so, the clinician needs mastery of a full range of professional therapeutic techniques. These include displaying empathy and honoring the experiences of the individual. It is also important to be willing to let go of one's position of power and authority and respect people's right to choose, even if one does not agree with the individual's choice. The professional's role in a collaborative relationship is to provide specific expertise so the individual can make informed choices.

5. **How are occupational therapy principles similar to recovery principles?**

   There is a natural alignment with the principles of occupational therapy and the principles of recovery. Occupational therapy has always analyzed and incorporated the strengths of clients in their treatment plans, and has focused treatment on meaningful and practical goals that are broken down into achievable, success-oriented steps. Recent literature, which is cited throughout the textbook, has paid special attention to incorporating the client's perspective in assessment, intervention, program planning, and research. There has also been a noticeable increase in the occupational therapy literature on the role of both personal and societal advocacy.

6. **What steps can be taken by occupational therapists to increase our visibility and practice in recovery oriented mental health services?**

   Our most important allies in the endeavor to increase visibility for occupational therapy are the people with the lived experience of mental illness. Presentations to various groups regarding the role of OT in recovery as well as advocating for inclusion in staffing and funding are valuable steps. Demonstration projects, often through grants, have the particular benefit of "showing" rather than "telling" what occupational therapy can offer and can therefore be particularly effective.

CHAPTER 2

1. **How does environment affect assessment?**

   Assessment conducted in a clinical or institutional setting may allow for easier control of the variables of the setting (noise level, arrangement of environment, etc) and limit distractions such as unexpected behavior from other people and interruptions. This is assuming that there is an available "separate space" such as an OT clinic. However, many institutions are very limited in space and the environmental distractions may actually be worse. This is most likely in environments where extensive use of patient monitoring and technology are used. In terms of the effect on assessment, institutional environments are different from where the client will usually engage in occupation and inherently have some degree of unfamiliarity. Therefore, assessment is more likely to measure the potential of the individual rather than actual performance.

   Performance-based assessment that is conducted in the home or community

setting is considered in vivo or more realistic regarding the individual's actual participation in occupations. These in vivo settings may provide a level of familiarity, comfort, and routine for the client that improves performance. On the other hand, the home and community environments may also contain more distractions, and it is not possible to control the actions of others in a social or familial situation. Nevertheless, this is important evaluative information as the occupational therapist may then be able to make helpful recommendations for environmental modifications and to work with the client on developing compensations and coping strategies for elements of the environment that cannot be changed.

2. **Why is it important for occupational therapists to be familiar with TM/CAM?**

The use of traditional, complimentary, and alternative medicine is on the rise worldwide. Furthermore, as worldwide demographic and immigration patterns continue to change, the likelihood increases that occupational therapists will be working with clients with different health care beliefs than their own. In order to work in a client-centered or recovery-oriented model, OTs must be able to access and understand the experiences and perspectives of the clients.

It is very important for occupational therapists (and all health care providers) to be able to suspend judgment regarding an individual's use of TM/CAM. There are many unknowns or unacknowledged benefits to interventions that fall outside of the domain of allopathic medicine. Furthermore, as occupational therapists continue to define their unique role in health care, we are separating ourselves from the "medical model". Philosophically, we may have more in common with some TM/CAM approaches than with western medicine. The ability to address the whole

person in context that includes such issues as spirituality and personal meaning is more consistent with some TM/CAM approaches than with allopathic medicine. However, it is equally important to be knowledgeable about the safety and side effects of TM/CAM approaches and be able to discuss this fairly with the client. People often use an eclectic mixture of health care techniques and some of these combinations may have adverse effects or may simply be ineffectual. The health care provider, whether an individual professional such as the occupational therapist or a team, that can develop a trusting relationship with the client and present factual information in a non-judgmental way is far more likely to be able to work with the client to develop goals and plan interventions that are both personally meaningful and effective.

3. **How does cultural competence affect OT assessment and intervention?**

   Cultural values affect every aspect of OT intervention. Assessment is particularly problematic, as clinicians must be aware of the inherent bias found in many standardized tools. A culturally competent assessment addresses cultural factors such as language, relationships, and time sense (See Table 2-4). A culturally competent occupational therapist is aware of values such as formality, communication, locus of control, and culturally appropriate roles within the family and community and is able to incorporate those values of the client into treatment. This may be especially difficult if there is an inherent clash with the culture of the therapist, the dominant culture of the society, or the culture of the institution. For example, differing values regarding time sense are often cause for conflict and may need to be negotiated with the client. Also, some values, such as independence, are part of not only western societies' cultures but also the culture of occupational therapy. In a client centered

and culturally competent practice, understanding the values of the client takes precedence. Activities chosen as part of treatment should be personally relevant and meaningful to the client. Therefore, an understanding of the cultural world of the individual including roles, style of ADL's (e.g. cooking, tool use, arrangement of space, etc), hobbies, and rituals are helpful in developing culturally competent intervention.

CHAPTER 3

1. **What are the mental health research priorities of the WHO and the NIMH? How do the research priorities of AOTA/AOTF (or other professional bodies in other countries) align with these priorities?**

   Current international and national research priorities reflect the need to understand the nature of mental health disorders and how these disorders affect people's lives and health status, including the functioning of communities. Since disparities in access to mental health care are also widespread due to financial barriers, stigma, lack of coordinated and culturally appropriate systems of care, and lack of awareness, research initiatives also emphasize the development and provision of effective mental health services. AOTA and AOTF priorities for mental health intervention research include client-centered (individualized) interventions, occupation-focused interventions, and basic research exploring the experience of disability for individuals and their families. Individual professional bodies, such as AOTA, support a socially oriented research focus aimed at meeting societal needs,