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Occupational Therapy in Outpatient Behavioral Health

Abstract

Mental illness and substance use disorders are common in the United States and can significantly inhibit occupational participation. The aim of this study was to evaluate existing outpatient behavioral health services and determine if occupational therapists can make a distinct contribution to this population's needs. An electronic survey created via Qualtrics was provided to licensed outpatient behavioral health providers in the United States utilizing a convenience sampling method. Results showed concerns related to areas of daily life and barriers to function within the scope of occupational therapy practice. Results highlight gaps in current outpatient behavioral health services, supporting a distinct value for occupational therapists in this setting.

Occupational Therapy in Outpatient Behavioral Health

Behavioral health focuses on behaviors impacting both mental and physical health; it encompasses all cognition that impacts behaviors of daily life.[1] Within the area of behavioral health, mental health is specifically defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community"[2(p1)] Many factors may inhibit a person's ability to achieve their desired behavioral health functioning including mental illnesses and substance use disorders. Research has shown mental illness is among the United States' most common health conditions, as 1 in 5 children and 1 in 25 adults have a serious mental illness.[3] This study will discuss the contributions occupational therapy (OT) can make in treating the functional challenges associated with behavioral health and specifically the impacts of mental illness in the outpatient setting.

Impact of mental illness

Within the United States, the most prevalent mental illnesses are as follows: anxiety disorders, major depressive disorder, post-traumatic stress disorder, bipolar disorder, borderline personality disorder, obsessive compulsive disorder, and schizophrenia.[4] These mental illnesses, when left untreated, can cause severe emotional, behavioral, and physical health problems impacting individuals and their surrounding community.[5]

Mental illnesses can negatively impact individuals' engagement in self-care, socialization, productivity, and leisure activities. Individuals may experience difficulties with regulating their emotions in addition to appropriately processing information and utilizing sound judgment, which may make it difficult to create and maintain healthy social relationships.[6] Many experiencing mental illness may struggle to reintegrate and reestablish roles following mental

health inpatient treatment.[7] Heightened feelings of restlessness may create an inability to fall or stay asleep at night.[8] Anhedonia, a symptom of depression and schizophrenia, is the loss of feeling pleasure or enjoyment for typically pleasurable experiences and leads to decreased participation in and enjoyment of leisure activities.[9] Individuals with bipolar disorder often experience symptoms including impaired focus and short-term memory, which may affect one's ability to carry out tasks related to managing a home such as maintaining a yard and consistently performing laundry duties.[10] Compulsions caused by obsessive compulsive disorder may lead individuals to take repeated actions in order to decrease anxiety, which may reduce productivity in various activities.[11] Additionally, the rate of unemployment is higher among adults who have a mental illness (5.8%) when compared to those who do not (3.6%).[4] These various difficulties create barriers to a person's ability to care for oneself both physically and emotionally, thus leading to a need for professional intervention.

Professions within behavioral health

Many professions can work together in behavioral health settings in order to provide holistic services which meet the wide range of behavioral health needs presented by clients. Key professions that often make up this team include social workers, psychologists, and psychiatrists.[12] Social workers create plans, provide therapy and support, and advocate for inclusion and access to resources.[13] Psychologists use talk therapy to gain insight into how a person thinks, feels, and behaves in order to cope with difficulties.[14,15] Psychiatrists are medically-oriented and have the ability to prescribe medications.[4,16] Each of these professions is distinct in their scope of practice and how they intervene to improve well-being.

Continuum of care in behavioral health

There are many resources in place to address the behavioral health concerns described above. The continuum of care in behavioral health has seen promising growth in recent years. Only a few decades ago, psychiatric hospitals were the only available treatment resource.[17] Today, behavioral health concerns are often first addressed in general medical settings.[18] Depending on the severity of the patient's needs, they may receive a variety of services. The most intensive services include hospital treatment, residential treatment facilities, and crisis and community residences. In these settings, recipients of care are living full-time in their treatment setting.[19] In a partial hospitalization program, the patient receives treatment services during the day and goes home in the evening.[19] Some individuals receive treatment at offices or outpatient clinics with the number of visits per month being dependent on the individual's needs.[19] Although behavioral health services are highly valued, there may be barriers to accessing services that meet all needs.

Barriers in behavioral health care

Access to behavioral health care is a considerable concern in the continuum of care. Unmet needs are particularly common for individuals with lower income, without health insurance, or living in rural areas.[18] Of those affected by mental illness in the United States, about 30.5% are treated.[20] Often, there is a long gap between the onset of mental illness and the commencement of treatment. During this time, functioning can decrease which further complicates the rehabilitation process.[18] Furthermore, due to the structure of programs such as Medicaid, many psychologists and psychiatrists are unable to receive the reimbursement necessary to treat individuals with behavioral health concerns.[18] These factors make it challenging for those in need of behavioral health care to access necessary treatment.

While outpatient behavioral health specifically provides a vast array of services to support clients, various barriers exist which prevent these particular professionals from addressing and improving certain aspects of their clients' livelihood. Clinicians may have the requisite knowledge about a diagnosis, but may not have access to resources or training to fully address certain diagnoses.[21] Over the last twenty years, managed health care companies have expanded the roles and responsibilities of non-medical providers, primarily clinical social workers and clinical psychologists, while narrowing the scope of psychiatric practice.[22] Due to the continued expansion of managed care, many social work programs found traditional curricula were no longer adequate to prepare students for practice; managed care's emphasis on contained costs requires specialized practice skills, particularly rapid assessment, brief treatment, and the ability to document treatment outcomes.[23] It has also been stated that professionals need to develop practices that help people with behavioral health issues identify and realize their own needs and maintain a broad social view of mental health problems in regard to discriminatory practices, civil rights, and social justice.[24] While these responsibilities are typically lent to professions such as social workers, psychologists, and psychiatrists, other professionals can be contributors to this objective.

Occupational therapy in behavioral health

Although less commonly associated with a behavioral health team in the United States, occupational therapists can provide service in behavioral health care. Prior to addressing potential interventions and goals of occupational therapy (OT) services within this setting, it is important to understand the profession's foundational roots and scope of practice. Within the Occupational Therapy Practice Framework, a guiding document for OT professionals, OT is summarized as "the therapeutic use of everyday life activities (occupations) with individuals or

groups for the purpose of enhancing or enabling participation in roles, habits, and routines at home, school, workplace, community, and other settings."[25(p44)] Occupational therapists' central focus is enabling maximum participation in life activities, or occupations, meaningful to the individuals whom they serve.[26] When initiating treatment, a client's environment and context is considered in addition to their typical habits and routines of occupational engagement.[26] The process of OT services is encompassed within evaluation, identification of strengths and barriers to full participation, intervention planning, and delivery of services tailored to meet the unique goals of each client.[26] Treatment may include education and training for a client and their support system, role development, socialization, advocacy for access to services and resources, adaptation and modification to equipment, an environment, or an activity to practice skills and promote engagement.[26] Throughout the entire OT process, occupational therapists are focused on providing person-centered, holistic care.[27,28]

Within a community behavioral health setting, the American Occupational Therapy Association (AOTA) defines the purpose of OT as "increasing an individual's ability to live as independently as possible in the community while engaging in meaningful and productive life roles."[29(p1)] Occupational therapists work to promote participation within communities in occupations such as steady employment, formal education, or leisure pursuits.[29] The specific nature of the individual's goals and treatment are dependent on their roles, values, and contexts. Occupational therapists seek to create personalized treatment plans promoting the individual's unique skills and needs to develop and maintain participation in meaningful activities.

Theory used in behavioral health

When discussing OT practice, there are several theoretical models that can be used as guidance. Occupation-based models are broad and provide a lens through which to understand

interactions among an individual, their environment, and their participation in occupations. In behavioral health settings, it is appropriate for occupational therapists to use the Model of Human Occupation (MOHO).[30] A survey of practicing occupational therapists in the United States resulted in almost half of the respondents choosing MOHO as the theory most used in their practice due to its value related to occupation-based, client-centered care.[31] MOHO places focus on how engagement in occupation is influenced by interactions between the person and their environment.[32] The model "asserts that what a person does in work, play, and self-care is a function of motivational factors (volition), life patterns and routines (habituation), nature of skills and abilities (performance capacity), and environmental influences."[32(p96)] Occupational therapists seek to learn more about an individual's values, routines, motivations, interests, and their view of what roles they occupy.[32] It is important for occupational therapists to be educated and proactive in incorporating current theories into their practice as it guides their implementation of the OT process.

Concerns addressed by occupational therapists in outpatient behavioral health

Occupational therapists have a distinct scope of responsibility in outpatient behavioral health. The person-centered nature of OT practice is well-suited for interaction with this population.[27] Occupational therapists provide "a holistic perspective, meaningful activities, and occupation-based interventions focused on helping clients gain, regain, and sustain function in everyday life," and are thus "well suited to provide mental health rehabilitation services."[28(p2)] The occupational therapist's contribution to behavioral health treatment may include:

> Identifying individual strengths, goals, skills, and other factors important for wellness and recovery planning; performing psychosocial evaluations that include housing, vocational, and educational status as well as social support networks and

> community participation; helping clients develop day-to-day independent living skills and improve their functional capacity; teaching compensatory strategies that mitigate the impact of the illness and reduce symptoms through engagement in healthy roles and routines; and promoting health and wellness through the use of everyday activities.[27(p2)]

A systematic review of evidence for OT intervention with individuals with serious mental illness resulted in strong evidence for the use of occupation-based interventions to address "life skills, empowerment, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and occupational goals."[28(p3)] There were limitations in study of skills training as an intervention and insufficient evidence for cognitive-based interventions and technology-supported interventions.[28] The existing research provides some evidence for the efficacy of OT interventions in a behavioral health setting.

Occupational therapy intervention effectiveness in outpatient behavioral health

Within outpatient behavioral health, there is a growing need for OT interventions due to the impact behavioral health problems have on an individual's engagement in necessary and meaningful occupations. Results of a study of patients' experience in outpatient behavioral health services showed participants' willpower, energy, and ability to try new things increased.[34] In addition, research examining the effectiveness of interventions used by occupational therapists in behavioral health settings showed interventions providing room for self-rediscovery, healing, identity formation, and community participation were valued higher by clients than short, psychological-based interventions which were focused on case management and the assessment of mental stability.[33] Therefore, OT treatment for outpatient behavioral health services can stimulate patients to use their capacity to the fullest, take advantage of the possibilities offered, and develop a sense of willpower.[34] Through further evaluation of evidence and studies on

intervention, a more integrated view of occupational therapy's practice and effects in behavioral health can emerge.

National evidence

There are currently only 11 states where an occupational therapist is included as a qualified mental health professional (QMHP).[35] Within certain circumstances, states have adopted terms related to QMHP, such as a behavioral health professional or practitioner.[35] A state's Medicaid manual may specify these qualifications rather than a statute or regulation in some cases.[35] In Minnesota, a group of occupational therapists developed a free-standing community-based psychiatric occupational therapy clinic, which serves adults who suffer from significant mental health diagnoses.[36] Their range of services and interventions include sensory integration, skills training in the areas of socialization, stress management and coping, in addition to education-based treatment.[37] A study examining client satisfaction showed they were not only satisfied with the services they were receiving but also saw the effects of the OT services in their lives practically through a greater sense of autonomy and general wellbeing.[37] Such research supports that occupational therapy is beneficial in the outpatient behavioral health setting, and may be more clearly supported if OTs are distinguished as qualified mental health professionals.

Conclusion

Within the United States, mental health diagnoses affect the ability of many individuals to successfully participate in the expected and desired activities of their daily lives. Those seeking services concerning mental health conditions are often met with barriers to treatment based on factors related to their financial status, insurance coverage, or the region in which they reside. The preliminary literature review indicates OT does not currently have a distinct role in

the outpatient behavioral health continuum of care. Professions such as social work, psychology, and psychiatry fulfill many valuable needs in the behavioral health field; however, there may be opportunity within outpatient behavioral health for occupational therapists to provide services.

Research indicates OT has a distinct value in a variety of inpatient, outpatient, home, and community settings, and the profession's focus on increasing participation in meaningful activities has the potential to be valuable in outpatient behavioral health settings. Current OT programs and organizations treating mental health diagnoses nationally have demonstrated the significant and effective role of professionals with this population. Further research must be done to advocate for the distinct value of occupational therapy in behavioral health care. The need for OT services could be further supported by data that indicates a need for support in occupational engagement within this population. To gather such data, the researchers intend to survey outpatient behavioral health providers in the United States to identify gaps in outpatient behavioral health treatment that may be fulfilled by occupational therapists.

The purpose of this study was to evaluate currently existing services and potential gaps in services in outpatient behavioral health. In conducting this study, the following research questions were developed: (a) in the outpatient setting, do patients have needs that are not currently addressed by behavioral health professionals?; and (b) can occupational therapy make a distinct contribution in outpatient behavioral health? To investigate these questions, the researchers developed a survey for outpatient behavioral health professionals in the United States.

Methods

Participants

The desired population of interest was licensed professionals working in outpatient behavioral health settings throughout the United States. Criteria for inclusion were those in any profession providing services in an outpatient behavioral health setting. Potential participants were excluded if they provide behavioral health services in an outpatient rehabilitation clinic or similar setting. The researchers contacted various behavioral health professional organizations and chapters throughout the United States, including locally in West Michigan and throughout the Midwest region, via e-mail or social media. Hence, researchers utilized a convenience sampling method to recruit participants who work in behavioral health fields. With convenience sampling, a major disadvantage is that researchers cannot be sure how representative the information collected from the sample is of the population.[38] Regardless of this disadvantage, the researchers have deemed convenience sampling as the most appropriate method. Research has shown challenges in response rates of outpatient behavioral health professionals, so the researchers chose a sampling method that could facilitate a larger sample size.[39]

Materials

Researchers created a survey using Qualtrics consisting of a combination of multiple choice and open-ended questions. A survey was chosen as a method of collecting data using structured questions and self-reports from a sample of clinicians.[40] Surveys can be distributed in many modalities and allow for a fast turnaround rate with little responsibility of researchers between the point of distribution and examination of results.[41] In addition, surveys allow researchers to discover possible trends and attitudes related to their research question.[42]

Although there are many benefits to survey methodology, potential concerns may include sampling bias, self-selection bias, and response bias. In a sampling bias, the sample may not be an accurate representation of the population of interest, a self-selection bias indicates those who

respond may be different than those who did not, and a response bias suggests those who respond may have felt pressure to respond in a certain manner.[39] While bias will always be a factor in the research process, maximizing responses rates helps to minimize the potential of biased responses.[39] With this knowledge, the researchers chose to use a convenience sample in order to maximize response rate and limit potential bias. Providing an incentive is a commonly used method to increase response rate, but research suggests while they are helpful in paper surveys, the increase they solicit in online surveys is minimal.[43] The social exchange theory, which suggests individuals are motivated by what their participation may do for others, implies the desire for civic engagement and societal contribution may be enough to compel one's survey engagement.[44] The researchers carefully constructed the invitations for participation in a way that appealed to practitioners' emotional connection to the objective.

Procedure

Prior to distributing the survey, the researchers piloted the survey with a group of licensed professionals who work at a local, outpatient behavioral health clinic in order to increase the survey's face validity. Conducting a pilot study prior to the main study can enhance the likelihood of success of the main study.[45] The survey was electronically distributed to these licensed professionals, and they had two weeks to complete the survey and provide constructive feedback after it was sent. Following the pilot study, the researchers evaluated the data and made revisions to the survey before it was sent to Grand Valley State University's IRB to gain approval.

For the main study, the survey was distributed electronically with the ability to participate using a smart device or computer. Upon opening the survey, participants were asked to provide consent before survey questions were made available to them. The consent form outlined the

purpose and procedures of the study, potential risks and benefits, voluntary participation, confidentiality, and contact information. Participants completed the survey questions, some requiring responses to continue and others being optional. Participants were instructed ahead of time that they could end their participation at any time without penalty. De-identified survey data was shared among researchers and a statistician committee member via Grand Valley State University Google Drive and e-mail. Participants' identities were kept confidential as no identifiable information such as name, phone number, or e-mail address were collected through the survey.

Following the process of distributing the survey and collecting responses, the researchers analyzed the responses. The study yielded categorical results descriptive of the respondent's opinions; descriptive results are organized based on the use of a nominal or ordinal measurement scale. A nominal measurement scale does not have an implied order and can organize data using bar charts and summarizing statistics such as frequencies, percent, and mode. An ordinal measurement scale does have an implied order and can also organize data using bar charts and summarizing statistics such as frequencies, percent, and mode in addition to range, median, and interquartile range (IQR). Survey responses were analyzed based on these characteristics, and patterns observed during data analysis informed the researchers about the possible role of occupational therapy in outpatient behavioral health settings.

Results

Participants (*n*=71) were asked to share demographic information about their profession, typical clientele, and typical strategies of treatment. Respondents were most commonly social workers (n=15, 26.79%) or licensed professional counselors (n=12, 17.86%). The full distribution of professions can be found in Figure 1. The most commonly treated diagnoses

included anxiety disorder (n=38, 53.5%), major depressive disorder (n=34, 47.9%), post-traumatic stress disorder (n=33, 46.5%), and bipolar disorder (n=26, 36.6%). The full distribution of diagnoses can be found in Figure 2. Professionals reported primarily using cognitive behavioral therapy (n=33, 46.5%), mindfulness (n=28, 39.4%), and motivational interviewing (n=27, 38%) in treatment of these populations. The full distribution of treatment strategies can be found in Figure 3.

Participants rated their level of concern regarding areas of daily life, barriers to function, and barriers to the provision of services. Options given for level of concern were Not Applicable, No Concern, Little Concern, Moderate Concern, and Major Concern. The percentage of participants who rated an item as a moderate-major concern was extracted. The top five moderate-major concerns regarding areas of daily life include social participation (n=17, 40.47%), safety (n=15, 35.71%), health management (n=14, 33.33%), play/leisure participation (n=13, 30.95%), and financial management (n=10, 24.40%) (Table 1). The top five moderate-major concerns regarding barriers to function include emotional regulation (n=31, 77.50%), motivation (n=27, 67.50%), social interaction skills (n=25, 62.50%), daily habits and routines (n=18, 45.00%), and process skills (n=17, 42.50%) (Table 2). The top five moderate-major concerns regarding barriers to services include budget limitations (n=17, 68.00%), patient willingness (n=14, 56.00%), family support (n=13, 52.00%), insurance coverage (n=13, 52.00%), and size of caseload (n=11, 44.00%) (Table 3).

Additionally, three short answer questions were posed which gave participants the opportunity to type in a free response which would allow them to provide further thoughts and explanations on the given question. Each researcher completed an individual analysis of these

responses by grouping the responses into categories. Researchers then collaborated to compare categories and develop themes. Representative comments were chosen for each theme.

The first free response question asked, "Are there services or supports you wish you could provide in your treatment, but typically feel unable to provide?" to which 65% of participants (*n*=40) said yes. Researchers themed the participants' responses into Resources, Specialized Services, and Face-To-Face Treatment. For this question, 29.2% of responses were sorted into Resources, 58.3% were sorted into Specialized Services, 8.3% were sorted into Face-To-Face Treatment, and 4.2% of responses did not fit within the selected themes. Mentioned below is each theme and chosen representative comments.

In regard to Resources, one participant wrote:

"Transportation services are often needed."

Various participants mentioned Specialized Services they wish they were able to provide which include:

"Physical health… yoga, a walking program, nutrition."

"Increased resources for job coaching."

"Sensory integration."

A desire to have more Face-To-Face Treatment was shared by participants who stated:

"I am often required to provide too much case management...which prevents me from having time or ability to focus on actual treatment."

"More face to face time and less time doing paperwork, more time on experiential treatment."

The second free response question asked, "Is there a procedure followed if a patient needs services that are not provided by outpatient behavioral health?" to which 87% of respondents (*n*=39) said yes. The main theme extracted from the participants' responses was

Referrals. For this question, 70% of responses were sorted into Referrals, while 30% of responses did not fit within this theme. Listed below are some representative comments regarding the referral process:

"Referrals are made to community providers, sometimes in other neighboring communities. Depending on the situation, we may make calls to said providers and do more assistance in coordinating services."

"Assist in initiating and implement the referral."

The final free response question was "Are there ways in which occupational therapists could play a role in outpatient behavioral health?" In response 49% of participants (*n*=39) responded yes, 41% responded maybe, and 10% responded with no. Researchers themed the participants' responses into Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) Engagement, Holistic Care, and Sensory Needs. For this question, 44.4% of responses were sorted into ADL/IADL Engagement, 11.1% were sorted into Holistic Care, 18.5% were sorted into Sensory Needs, and 26% could not be sorted into the selected themes. Noted below is each theme and corresponding representative comments.

Regarding ADL/IADL Engagement, one participant stated:

"Help with cooking, cleaning, shopping, self-care, money management skills."

When discussing Holistic Care, one participant wrote:

"*Most people who have mental health needs would benefit from OT...Holistic treatment is desirable for improving the outcomes of our clients."*

When considering Sensory Needs, a survey respondent noted:

"Sensory integration with children who have experienced trauma in order to increase attachment, regulation, emotional regulation, and decrease hyperactivity."

After answering "no" to the noted question, professionals elaborated on their response with some of the following thoughts:

"Perhaps I am not sure of their (occupational therapy) *scope of practice."*

"My practice is a very small private practice. Very few clients present with disability that occupational therapy might be of help. Though, I have a great deal of respect for the profession and am aware they provide a much needed service for many."

Discussion

Based on the responses of behavioral healthcare professionals surveyed, the greatest concerns related to areas of daily life of their clients were social participation, safety, play/leisure participation, health management, and financial management, while the greatest barriers to function in these areas were emotional regulation, motivation, social interaction skills, daily habits and routines, and process skills. While literature affirms the impact of mental illness on self-care, socialization, productivity, and leisure, current research connecting this occupational impact to the need for outpatient OT intervention is limited.[6] However, the occupation areas and client factors identified in survey results are all appropriate to be addressed within the scope of occupational therapy practice.[46]

The literature identified barriers to behavioral health care including lack of insurance, living in rural areas, or lower incomes.[18] Survey results affirmed these factors, but indicated further services or supports behavioral health professionals feel they are unable to provide. Examples including transportation, specialized services, and adequate face-to-face treatment from the survey results were not evident in the literature. The top barriers to providing these services included budget limitations, patient willingness, family support, insurance coverage, and size of caseload; although these are valid concerns, the researchers were expecting to learn the

scope of practice or expertise of those who currently work in the behavioral health field was a barrier. When these barriers occur, behavioral health professionals indicated referrals are made for additional services.

The researchers' review of the literature found minimal research on occupational therapy in behavioral health and minimal research studies affirming the effectiveness of OT intervention in this setting. Existing research, however, does assert that occupation-based interventions have proven to be beneficial in the treatment of serious mental illness.[28] The majority of behavioral health professionals surveyed responded with "yes" or "maybe" when asked if they believe occupational therapists could play a distinct role in the outpatient behavioral health setting. When asked why they chose "no," respondents indicated a lack of understanding of the OT scope of practice. A lack of knowledge among the general public and medical professionals regarding the services of occupational therapy has been shown to be a barrier in expanding practice settings for occupational therapists.[47] Increased awareness and familiarity with the OT profession by policymakers, professionals, and referrers could potentially strengthen occupational therapy's position in outpatient behavioral health.

The main responses for why occupational therapists could likely play a distinct role in the outpatient behavioral health setting were to enhance engagement in activities of daily living and instrumental activities of daily living, address sensory needs, and overall increase holistic care provided to clients, which proves consistent with the suggestions in current literature for OT's role in this area of practice.[28,37] Due to the results of the survey, the researchers concluded occupational therapists could play a distinct role in outpatient behavioral health. This addition of the occupational therapy profession could potentially benefit both clients and outpatient behavioral health professionals. If occupational therapy had a distinct role in outpatient

behavioral health, occupational therapy practitioners would have the opportunity to provide targeted interventions to address a variety of client barriers to function, specifically the barriers mentioned by the participants of this survey. Providing these targeted treatments might allow for other members of the outpatient behavioral health team to lighten their caseload and focus on treatment modalities that result in higher reimbursement levels, potentially enhancing their practice. Further research affirming the efficacy of occupational therapy in behavioral health would help to solidify this distinct role. However, for further research to take place, occupational therapists must first be given a seat on treatment teams in this practice area. Consideration of the literature findings and survey results suggests that the behavioral health field has a need for, and would benefit from, the contributions of occupational therapists.

Limitations

While limitations were minimized, there were some which should be discussed. Researchers applied for and received a presidential research grant from Grand Valley to purchase access to a ListServ to survey over 2000 members from the American Mental Health Counselors Association; however, due to the timing of being approved for the grant and coordinating logistical information, the survey was disseminated on two different dates. This could have created confusion or frustration as it is possible professionals received a request to participate twice if they were members of multiple groups where the survey was disseminated. As researchers were able to initially analyze the first set of data collected, this could have created bias in their interpretation or type of final conclusions drawn after the second group of participants completed the survey.

Additionally, the COVID-19 pandemic significantly altered the type of patient interaction many outpatient behavioral health professionals were accustomed to. Many transitioned to

utilizing teletherapy, and not only could their patients' conditions have shifted but also the quantity of patients they are seeing due to the economic and psychological impact of the disease. In addition, participants were asked to recall information about patients seen within the "last month." However, practitioners were being asked about the last "typical" patients they worked with in March 2020, and completing the survey in August or September 2020. This lapse in time may have posed a challenge to participants trying to recall experiences related to the survey questions and ultimately affected the accuracy of the results.

Finally, the noted results were gathered using a convenience sample group from professionals across the United States utilizing social media and email, which cannot be generalized as representative of the entire population of outpatient behavioral health professionals. However, due to data suggesting the challenges with the response rates of this population and researchers' desire to maximize the sample size, this method was ultimately deemed the most appropriate.

Implications for Behavioral Health

This research yields potential implications for the role of OT in outpatient behavioral health. A majority of participants agreed OT could contribute to this practice setting. Further incorporation of OT principles and practices in behavioral health could lead to more high quality, holistic care, thus hopefully contributing to overall positive treatment outcomes.

The data collected through this research project provided objective information that can be considered through the lens of the Model of Human Occupation. For example, the researchers wish to know what specific skills are most challenging for those receiving outpatient behavioral health services. Survey results highlighted practitioners' perspectives of what skills are most prominent challenges. With this in mind, researchers can consider through the Model of Human

Occupation how OTs may support clients with behavioral health needs in acquiring these skills. One study highlighted the redevelopment of an occupational therapy program for individuals with acute mental health diagnoses based on the foundational concepts of MOHO; this integration included assessments that focused on current habits and routines, their volition related to engagement in a variety of occupations and environmental analysis and interventions that addressed person-centered concepts such as adapting routines and skill development in many occupations.[31]

Additional research could explore if the presence of OT in outpatient behavioral health has a statistically significant impact on patient outcomes such as independence upon discharge or satisfaction with quality of care. Further evidence to OT's value in this setting could influence future hiring decisions and expand employment opportunities for OTs while also expanding treatment opportunities for clients with behavioral health needs.

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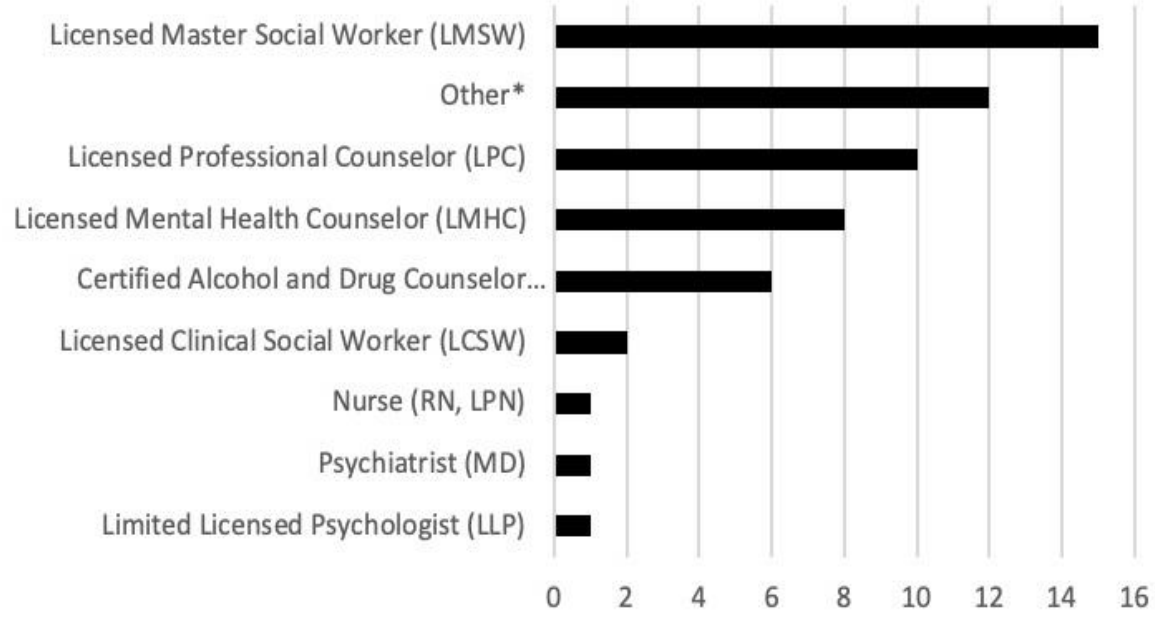

Figure 1

Professions of Respondents

*Board certified behavior analyst (BCBA), case manager (LBSW, QMIP, QIDP), chief program officer, employment services specialist, licensed addiction counselor, licensed baccalaureate social worker (LBSW), licensed clinical alcohol and drug counselor (LCADC), limited licensed master social worker (LLMSW), phlebotomist (CPT), and verteran navigator

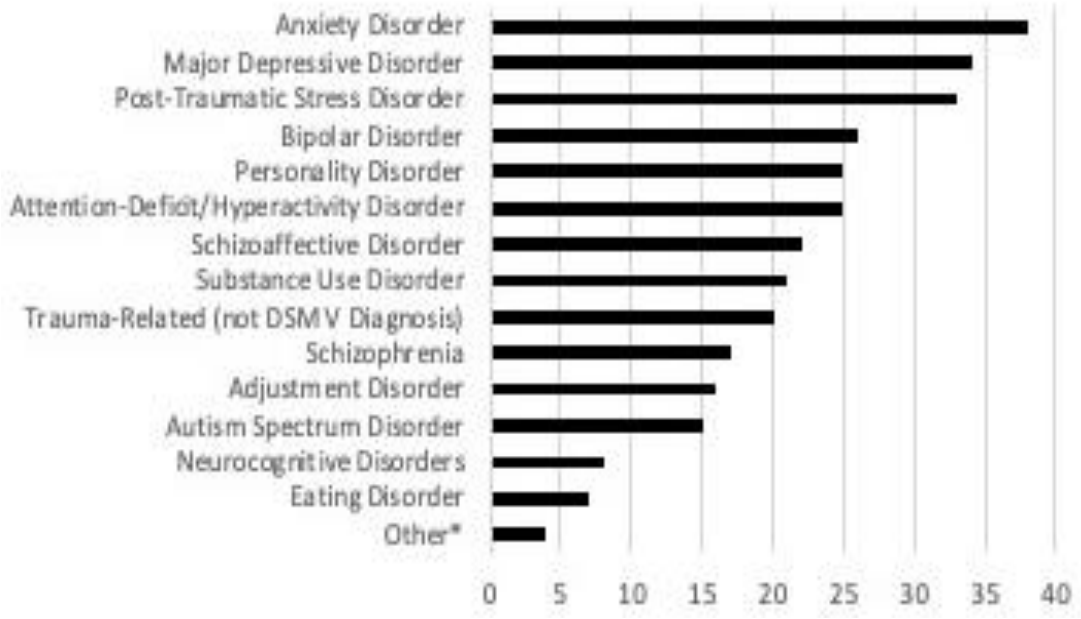

Figure 2

Diagnoses Treated

*Dissociative identity disorder, gender dysphoria, grief, and oppositional defiant disorder

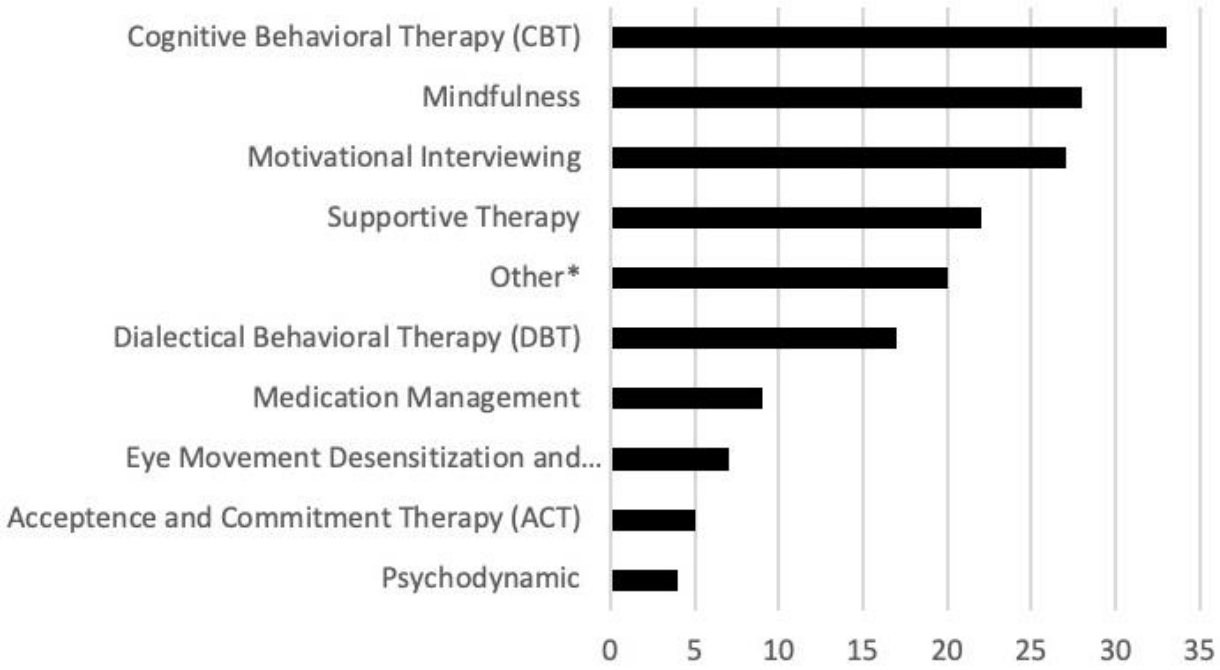

Figure 3

Treatment Strategies Used

*Applied behavioral analysis, brainspotting, choice therapy, emotional freedom technique, existential therapy, hypnotherapy, interpersonal neurobiology, matrix intensive outpatient treatment, parent-child psychotherapy, progressive counting, psychosocial rehabilitation, rapid trauma resolution therapy, solution-focused therapy

Top Moderate-Major Concerns in Areas of Daily Life	
Social Participation	n=17, 40.47%
Safety	n=15, 35.71%
Health Management	n=14, 33.33%
Play/Leisure Participation	n=13, 30.95%
Financial Management	n=10, 24.4%

Table 1

Participants who rated areas of daily life as moderate-major concern.

Top Moderate-Major Concerns in Barriers to Function	
Emotional Regulation	n=31, 77.5%
Motivation	n=27, 67.5%
Social Interaction Skills	n=25, 62.5%
Daily Habits and Routines	n=18, 45%
Process Skills	n=17, 42.5%

Table 2

Participants who rated barriers to function as moderate-major concern.

Top Moderate-Major Concerns in Barriers to Services	
Budget Limitations	n=17, 68%
Patient Willingness	n=14, 56%
Family Support	n=13, 52%
Insurance Coverage	n=13, 52%
Size of Caseload	n=11, 44%

Table 3

Participants who rated barriers to services as moderate-major concern.