Association of Occupational Therapists of Ireland

Occupational Therapy in Child and Adolescent Mental Health Services

A document compiled by the AOTI Child and Adolescent Mental Health Advisory Group 2008
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1.0 INTRODUCTION

In June 1998, a group of Occupational Therapists working in child and adolescent mental health in Ireland came together to form a support network for Occupational Therapists working in isolation in this specialist area. This group is affiliated to the Association of Occupational Therapists of Ireland (AOTI) through the Child and Adolescent Mental Health Advisory Group.

In 1999, the group put together a document outlining the role of Occupational Therapy in Child and Adolescent Mental Health [CAMH] services in Ireland. This document was circulated to senior clinicians and managers within the health services, and was instrumental in furthering the understanding of the role of Occupational Therapy in CAMH services and increasing the number of Occupational Therapy posts around the country. This document was subsequently revised in 2004 and in 2006 to reflect national policy developments.

The Report of the Expert Group on Mental Health ‘A Vision for Change’ (Department of Health and Children, 2006) states that there are now 39 expanded Child and Adolescent Community Mental Health Teams [CMHTs] in Ireland. “Despite the fact that Occupational Therapists are identified in ‘A Vision for Change’ as key member of the multi-disciplinary Child and Adolescent Community Mental Health Teams, they are currently significantly under-represented in these teams around the country with only 10 Occupational Therapists currently employed in the child and adolescent mental health service” (Department of Health and Children, 2006). The Position Statement on Psychiatric Services for Children and Adolescents in Ireland produced by the Irish College of Psychiatrists (2005) cites that 58.3% of CMHT’s have no occupational therapist and a further 30.6% have less than the one recommended in the First Report of the Working Group on Child and Adolescent Psychiatric Services (2001a).

The purpose of this document is to clearly outline the role of Occupational Therapy in CAMH services in Ireland. It contains information on the services provided by the Occupational Therapist and offers guidelines for the establishment of Occupational Therapy services within existing and new teams. It is hoped that this document will serve as a useful framework that will support the expansion of Occupational Therapy service provision nationwide.
2.0 BACKGROUND POLICY CONTEXT

‘The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive’

World Health Organization, 2003, p.2

The mental health needs of Irish children and adolescents have been the subject of increasing public, professional and political attention in recent years. The extent of adolescent alcohol misuse and youth suicide is a matter of national concern. High profile court cases have highlighted the inadequacies in services for children and young people with autistic spectrum disorders and severe emotional and behavioural difficulties. The National Children’s Strategy (Department of Health and Children, 2000a), the National Health Promotion Strategy (Department of Health and Children, 2000b), Best Health for Children (National Conjoint Committee on Child Health, 1999) and Best Health for Adolescents (National Conjoint Committee on Child Health, 2001) all address the issue of services for children and adolescents with mental health difficulties and call for the development of coordinated, child and family centred, multi-disciplinary community-based and in-patient services.

In February 2001, the Working Group on Child and Adolescent Psychiatric Services (Department of Health and Children, 2001a) published its first report. The authors acknowledged that international best practice for the provision of child and adolescent psychiatric services is through the multi-disciplinary team. The Working Group recommended that there be one whole time equivalent Occupational Therapy post per community based multi-disciplinary team, and estimated that 55 multi-disciplinary teams were required nationally. In addition to this, the report detailed proposals for the establishment of child and adolescent psychiatric in-patient units. It was recommended that 7 inpatient units should be developed throughout the country, with an allocation of one whole time equivalent Occupational Therapist per unit. The new national health strategy Quality and Fairness – A Health System for You (Department of Health and Children, 2001b) endorses the recommendations of the Working Group.

The Working Group noted that many of the child psychiatric teams in place throughout the country did not have the full complement of team members. Team members should be permanent with full-time commitment to the relevant clinic/service – but it is reported that a large number are still working part-time or on temporary contracts (Department of Health and Children, 2001a). ‘Psychologists, mental health social workers and occupational therapists are widely underrepresented on these teams. Each member of a team supplies a unique and essential service and incomplete teams cannot by definition supply a quality service despite their best efforts’ (Amnesty International Irish Section, 2003, p.26). It is recommended that priority should be given to the recruitment of the required expertise for the completion of existing teams (Department of Health and Children, 2001a; Amnesty International Irish Section, 2003).

The Working Group on Child and Adolescent Psychiatric Services in June 2003 published a second report. This examined the state of services for 16-18 year olds and made recommendations for service development and delivery. It recommends the recruitment in each health board area of a full multidisciplinary team; assertive outreach services to provide services in the home, school etc.; day hospital services to include a mix of Occupational Therapy, group therapy, social skills and an educational focus; rehabilitation and step-down...
services. Specialist in-patient services and acute same day in-patient admission should be available to adolescents who require it.

In September 2003, Amnesty International Irish Section published a report entitled ‘Mental Illness – the Neglected Quarter - Children’. It sought to determine the degree to which Irish legislation, policy and practice pertaining to children’s mental health complies with the requirements of international human rights standards. Ireland ratified the United Nations Convention on the Rights of the Child in 1992. The Convention supports the important role of the child in the family context and of access to education, rehabilitation and a wholesome community life. In ratifying the Convention, Ireland promised before the eyes of its citizens and the world to do everything in its power to respect the right of its children to basic mental health services and to dignity. This report calls for increased revenue and capital funding in children’s mental health services; adequate funding for the development of community based early intervention services; structured programmes for the identification, assessment and treatment of children with emotional and behavioural problems and the prompt delivery of sufficient and geographically equitable age-appropriate in-patient facilities for all children and young people.

3.0 CURRENT POLICY CONTEXT

In 2006, the Expert Group on Mental Health Policy published its report entitled ‘A Vision for Change’ (Department of Health and Children, 2006). This expert group was appointed in August 2003, on foot of recommendations in the national health strategy ‘Quality and Fairness’. The report proposes a framework of mental health service delivery with the service user at its centre. The report is based on a ‘recovery’ approach and the delivery of person-centred services by skilled community based multi-disciplinary teams.

Child and adolescent mental health services are addressed in Chapter 10 of the report. The proposed framework for child and adolescent mental health services includes health promotion/early intervention services and primary care/community care services. It is recommended that two specialist child and adolescent CMHTs should be appointed to each sector (population: 100,000), with an additional child and adolescent CMHT in each catchment area (300,000 population) to provide liaison cover. It is further recommended that child and adolescent CMHTs should develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area. These services should cater for children and young people aged 0 – 18 years. These teams should be based in a community mental health centre which should accommodate outpatient and day hospital services. A Vision for Change recommended that there be one occupational therapist on each CMHT. It also suggested the plan for inpatient units be implemented with occupational therapists included as members of the multidisciplinary teams.

The Expert Group on Mental Health Policy in ‘A Vision for Change’, reviewed the Occupational Therapy provision in mental health services in Ireland. It recommended that ‘in order to increase the attractiveness of mental health occupational therapy posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision and poor facilities should be addressed’ (Department of Health and Children, 2006, p. 195.)

4.0 INTRODUCTION TO OCCUPATIONAL THERAPY IN CHILD AND ADOLESCENT MENTAL HEALTH
4.1 Definition of Occupational Therapy

Occupational Therapy is defined as a process that involves a person in activity (occupation) to improve his/her physical, psychological and social well being and to help him/her to cope more effectively with everyday life consisting of school/work, play/leisure and activities of daily living. At the core of occupational therapy is client-centred practice, which is the commitment to focus on the client as an active agent seeking to accomplish important day to day activities. It believes that clients have a unique knowledge of their own occupational lives and thus know their needs better than anyone else. Occupational therapy focuses on meaningful and purposeful occupations selected by clients and performed in their typical settings. Its holistic approach views the client as a whole being, integrated in mind, body and spirit whose everyday experience cannot be understood outside of its environmental context (CAOT, 1997, Crepeau et al., 2003). The uniqueness of the Occupational Therapy approach to psychosocial dysfunction lies in the philosophy of human beings having the ability to influence their own health through occupation (Creek, 1997). The Canadian Model of Occupational Performance (CMOP) is “a conceptual framework that describes occupational therapy’s view of the dynamic, interwoven relationship between persons, environment and occupation that results in occupational performance over a person’s lifespan” (CAOT, 1997). The major concepts in this model are as follows:

- The person is connected to the environment, and occupation occurs as an interaction between persons and their environments
- Change in any part of the person-environment-occupation interaction affects the other parts and the consequent performance
- The person is illustrated as the centre to highlight the client-centred perspective
- Spirituality is at the core of the person, shaped by the environment and giving meaning to occupations.

4.2 Occupational Therapy Body of Knowledge

The body of knowledge of Occupational Therapy consists of selected theories from the biological sciences, psychology, sociology, the arts, medicine, and theories generated from occupational therapy practice (Mosey, 1986). In recent years, the new scientific discipline of Occupational Science has emerged, which is defined as ‘the study of the human as an occupational being, including the need for and capacity to engage in and orchestrate daily occupations in the environment over the lifespan’ (Wilcock, 1991, p297). The goal of Occupational Science is to generate a systemic base of description and understanding concerning participation in occupations. Such basic scientific knowledge will support and enhance the applied practice of Occupational Therapy.

In addition to their undergraduate professional education, Occupational Therapists working in the specialist area of child and adolescent mental health often undertake further training to enhance their clinical practice e.g. sensory integration therapy, play therapy, family therapy, cognitive-behavioural therapy, psychodrama etc.

4.3 Professional Skills of the Occupational Therapist
The internationally acknowledged best practice for the provision of child and adolescent mental health services is through the multi-disciplinary team (Department of Health and Children, 2001). Occupational Therapists work as valued members of multi-disciplinary teams in Child and Adolescent Mental Health Services (CAMHS).

The professional skills of the Occupational Therapist can be categorized into three groups: core skills, shared skills and acquired skills.

4.3.1 Core Skills

*Occupation Centred Assessment*: the ability to assess the extent to which impairment in physical and/or mental health and/or environmental constraint is affecting the child’s ability to successfully participate in everyday occupations (school/work; play and leisure; and self-care).

*Activity (Occupational) Analysis*: the ability to break activities into physical, cognitive, interpersonal, social, behavioural and emotional demands made on the individual child and an understanding of how these may be used effectively to develop and enhance a child’s skills. The grading and adaptation of tasks and/or the environment provides the ‘just right challenge’ that ensures success and skill development.

*Occupation Based Intervention*: the Occupational Therapist, in collaboration with the child and his/her family determine the appropriate intervention for any problems identified. Selected activities (occupations) that have a purpose and meaning to the child are used as therapeutic media. This emphasis on doing as opposed to talking can frequently create a strong bond between the child and therapist that enables the child to openly acknowledge and discuss issues of concern. Therapy can provide a safe environment for problem solving.

Therapeutic Intervention can be provided in two ways: direct intervention and indirect intervention.

- **Direct intervention** involves therapeutic work with the child or young person. Therapy may be provided to the child individually or in groups of between two and eight children. Individual treatment is usually provided as a block of therapy – six or eight weekly sessions. Depending on his/her needs and therapeutic programme, the child or young person may benefit from participation in an Occupational Therapy group with other children with similar difficulties. Activity groups are used therapeutically to evaluate, facilitate, restore or maintain the child/young person’s ability to function competently within his/her daily occupations. Some examples of group programmes include handwriting groups, motor-sensory groups, anxiety management groups, self-esteem groups and social skills groups. Direct therapeutic intervention usually takes place in the clinic, but may also be provided in the home, school or community.

- **Indirect intervention** is provided by the Occupational Therapist through consultation with family/carers; school and other professionals. Services provided through consultation include the provision of home and/or school therapeutic activity programmes; advice on equipment and environmental adaptations and educational/preventative programmes for families, schools, community groups and other health professionals.

4.3.2 Shared skills

Shared skills in CAMH include a basic knowledge of psychopathology, observation, problem solving, education, research and management skills. There is often common experience in
group work skills and knowledge of different therapeutic approaches such as cognitive-behavioural, psychodynamic, and systems theory (Lougher, 2001). Multidisciplinary group interventions can include parenting programmes, anxiety management groups, social skills groups, school transition programmes and teenage problem solving groups to name but a few.

4.3.3 Acquired skills

Acquired skills and qualifications are obtained through individual interest, enthusiasm and clinical experience. Acquisition of these skills requires further training and supervision and includes play therapy, family therapy, sensory integration therapy and psychodrama (Lougher, 2001).

5.0 WHY SHOULD A CHILD BE REFERRED TO OCCUPATIONAL THERAPY?

There are a variety of reasons for which a child or young person may be referred to occupational therapy. These include:

- Delayed Milestones
- Clumsiness/Poor coordination
- Sensitive to touch, movement or sound
- Difficulty with puzzles/jigsaws
- Slow to learn basic self-care skills
- Underachieving at school
- Difficulty colouring/writing
- Difficulty learning new skills
- Poor concentration
- Constantly tired/on the go
- Lack of organisational skills
- Poor motivation (e.g. play, school, social interaction and self care)
- Lack of structured daily routine
- Poor use of leisure time - too many solitary hobbies vs. social ones or too much time on sedentary activities
- Maladaptive occupational performance e.g. spending all day drinking, using drugs, antisocial behaviour
- Anxiety
- Fear of failure
- Poor self-concept
- Lack of social skills affecting functioning in school, peer group, social environment
- Need for life skills training (e.g. budgeting and vocational skills)

6.0 FUTURE DIRECTIONS OF OCCUPATIONAL THERAPY IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN IRELAND

6.1 Clinical Practice

6.1.1 Primary and Social Care Networks

Primary and Social Care Networks are the first points of contact people have with local services. The Health Strategy 2001 (Department of Health and Children, 2001b) set out a new direction for primary care as the central focus of the delivery of health and personal social
services in Ireland. These services are evolving under the HSE Transformation Programme. There is growing recognition of the value of and need for mental health promotion, prevention and early intervention for children and young people.

Occupational Therapists in specialist CAMH services share their knowledge and skills with local services through advice and consultation on a range of subjects such as play and development, mental health promotion in schools, parenting programmes, leisure enhancement programmes etc. There is a strong recognition that links between local and specialist services are vital to promote best practice. There is currently inequity of CAMH service provision throughout Ireland. There are inadequate numbers of occupational therapy posts within existing teams.

6.1.2 In-patient Services

Occupational Therapists have an important role to play in the design and delivery of therapeutic activity programmes in the existing and planned inpatient and day hospital services.

6.1.3 Clinical Specialist Posts

A number of Clinical Specialist Occupational Therapists have been appointed in Ireland within other specialisms such as Hand Therapy, Adult Mental Health, Paediatrics etc. With the introduction in 2008 of the planned new CAMH teams, this Advisory Group hopes that clinical specialist posts will be created in CAMH in Ireland. This will greatly enhance the development of evidence-based practice and facilitate ongoing research and education of therapists in this area of occupational therapy. A report on clinical specialist posts in Ireland was presented to the HSE in 2008 and showed that the presence of these posts contributes to an improved service for clients.

6.1.4 Rotational Posts

The ongoing development of Primary and Continuing Community Care Services (PCCC) including mental health, and the community paediatric posts which are already in existence in some Health Service Executive (HSE) areas, will give opportunities for the development of rotational staff grade posts. In this way new graduates will have the opportunity to gain experience in the three areas above, under the direct supervision of a Senior Occupational Therapist/ Occupational Therapy Manager. This will be an important advance ensuring a supply of experienced therapists at senior level for CAMH.

6.2 Education

6.2.1 Undergraduate Education

In 2001 The Bacon Report identified an insufficient number of training places contributing to the underdevelopment of community based multidisciplinary services (Bacon, 2001; Amnesty International Irish Section, 2003).

There are now three undergraduate Occupational Therapy programmes in Ireland (Trinity College Dublin, University College Cork and National University of Ireland, Galway) and one graduate entry programme in the University of Limerick. Occupational Therapy in Child and
Adolescent Mental Health is incorporated into the curriculum. Occupational Therapists working in CAMH in these regions offer specialist workshops to these programmes.

6.2.2 Practice (Fieldwork) Education

Students are required to complete 1000 hours clinical fieldwork, a proportion of which must be in mental health services. Supporting student education is an important professional responsibility, which often yields long-term benefits for the employing body. A number of CAMH services are actively involved in student education and more will be required to do so in line with the increase in training places. Since 2006 as a result of provisions of the Expert Group Report on Various Health Professions an annual allowance of €250 (pro rata) is payable to all therapists supervising student therapists. This allowance is to be drawn down for professional educational development.

6.2.3 Postgraduate Education

Continuing Professional Development (CPD) is an important requirement for state registration, which is soon to be introduced in Ireland. Therapists will have to demonstrate that they are committed to CPD. Modular Occupational Therapy Certificate, Diploma, Masters Degrees Clinical Doctorates are being introduced in Ireland. It is likely that modules in CAMH and related areas will be offered at Masters Level.

6.2.4 Clinical Tutor Posts

Clinical Tutor Posts have been developed in various areas of occupational therapy clinical practice. This Advisory Group would recommend and welcome the development of clinical tutor posts in child and adolescent mental health to support learning and enhance recruitment.

6.3 Research

Research will go hand in hand with the development of higher education programmes and this in turn will contribute to the development of services. Opportunities now also exist for doctoral level research work in Occupational Therapy in Ireland.

7.0 MINIMUM REQUIREMENTS FOR THE ESTABLISHMENT OF AN OCCUPATIONAL THERAPY SERVICE IN CHILD AND ADOLESCENT MENTAL HEALTH

7.1 Budget Requirements

A basic battery of standardised assessments is required, as well as additional assessment tools to meet the needs of the particular client group. Assessment equipment will need to be updated in line with research findings and developing trends in Occupational Therapy practice. Therapeutic equipment requirements will vary according to specific caseloads. The equipment budget should include start up equipment, petty cash and an annual budget to allow for updating of the equipment.

Occupational Therapists have a responsibility to keep abreast with developments within the profession, including assessment, intervention and management. An annual budget for training and continuing professional development will be required to ensure therapists comply with the
Health and Social Care Professionals Council requirements for state registration. Therapists will also require the additional resources of professional books, journals, videos, library, e-mail and Internet access.

7.3 Accommodation Requirements

The Occupational Therapist working in a child and adolescent mental health will ideally require access to two therapeutic spaces to meet the varied needs of the two separate populations – a child-centred space and a group therapy room. The child-centred space should be designed to accommodate sensory integration, motor and play equipment. Suspended therapy equipment will require ceiling reinforcement or a specially designed steel frame. In his article on designing these spaces, Dr G Reinoso states that ‘sufficient physical space for suspended equipment, mats, free standing structures, climbing equipment, crashing mats as well as a space to withdraw from interactions’. [SensorNet issue 28, April 2008]

The group therapy room should include a kitchen/craft area. In-patient services will require a developmental space for children and a multi-functional activity room. Access to other activity areas such as kitchens, Activities of Daily Living rooms, art room, sports / recreational facilities are required.

A large storeroom adjacent to the therapy spaces is required to ensure the safe storage of equipment when not in use. Office accommodation separate to the treatment space is vital and a desk/study space for students on placement is desirable. Access to waiting area, toilets for staff and clients and staff kitchenette is also required.

This Advisory Group is available for consult on current criteria.

7.4 Supervision and Support

The Occupational Therapist will require access to formal professional supervision from an Occupational Therapy Manager or a suitably qualified professional. Best practice would suggest that this should come from the specialist area of child and adolescent mental health. A supervision contract should be drawn up and signed by line managers, supervisor and supervisee. Formal supervision training would be welcomed and is likely to enhance practice and aid staff retention and job satisfaction.

Peer supervision with other paediatric and/or child and adolescent mental health occupational therapists will provide support and facilitate continuing professional development. It is recommended that clinicians be encouraged to attend all relevant Advisory Group meetings.

8.0 CONCLUSION

This document aims to describe the unique and valuable role of the Occupational Therapist within the multi-disciplinary child and adolescent mental health team. It is hoped that the information contained in this document will be useful to senior clinicians and administrators and thus facilitate the continued expansion of Occupational Therapy in this specialist area.

Where possible this Advisory Group can offer advice and consultation to services wishing to employ an Occupational Therapist. In particular, assistance can be provided with recruitment (interviewing, job descriptions etc.).
Information on the competencies required for all grades of Occupational Therapists can be found on the AOTI website and are also available through the AOTI office. For further information, contact the Association of Occupational Therapists of Ireland (AOTI) or the contributors listed below.

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