

OCCUPATIONAL THERAPY IN COMMUNITY MENTAL HEALTH:
PAPER VERSUS PRACTICE

by

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DEDICATION PAGE

“The only person you are destined to become is the person you decide to be.”

-Ralph Waldo Emerson

To my loves, Everett & Carmen- thank you for supporting me in making my own destiny

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ABSTRACT

Community mental health teams are commonly made up of workers with different educational backgrounds fulfilling a dual role including both generalist (e.g., case manager) and specialist duties (e.g., Occupational therapist) (Culverhouse & Bibby, 2008; Parker, 2001). The nature of holding a dual role makes one accountable to multiple governing bodies (e.g., Employer, professional college) and generates the potential for conflicting messages around role expectations. While much research has been conducted exploring the advantages and challenges of assuming a dual role, little has been done to examine how occupational therapists working on community mental health teams understand their professional roles in relation to existing governing documents.

Using the theory of interpretive phenomenology (Heidegger, 1962), this study set out to gain a deeper understanding of lived experiences of occupational therapists working on community mental health teams. Methods included a document review and content analysis to identify the messages and expectations being delivered via governing texts (the role on paper), compared and contrasted against individual interviews highlighting the day-to-day experiences of occupational therapists (the role in practice).

The study finds that clear and specific direction is lacking from governing texts related to occupational therapy on community mental health teams. As a result of this gap in direction, occupational therapists' practices are informed largely by previous student and work experiences, client needs, individual therapist skills, and team makeup. In fulfilling their dual roles, therapists frequently find themselves experiencing seemingly opposing views (e.g., Wide scope of practice vs. narrow scope; all alone in a crowd; 'I do it all' vs. 'its all teamwork'). The lens through which one chooses to view one's practice heavily influences one's perception of just how much day-to-day work is designated as being occupational therapy specific.

Four priority areas for improvement emerged from the study: 1) increasing job satisfaction, 2) enabling more evidence-informed practice, 3) addressing role clarity, and 4) supporting clinical student placements in community mental health.

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CHAPTER 1 INTRODUCTION

June 2008: I was over the moon about accepting my first job as an occupational therapist, a position on an Assertive Community Treatment Team. Ever since the second week of my clinical student placement working in community mental health I had known this is where I wanted to focus my practice upon graduation. I joined a newly formed community mental health team, which had not yet had an occupational therapist on staff. Like most community mental health teams, mine consisted of professionals from various disciplines working together to serve the needs of clients with mental illness. I was assigned a dual role, which has been widely implemented in community mental health teams, involving each team member taking on a combination of generalist duties as case manager and specialist duties as occupational therapist (Culverhouse & Bibby, 2008; Parker, 2001). The very nature of holding a dual role made me accountable to the expectations of my employer and my professional regulatory college, and challenges ensued. In my practice, I maintained a busy pace, working with clients to support their occupations in areas of medication management, medical appointments, grocery shopping, apartment hunting, job interview preparation, cooking lessons and group trips to the bowling alley - just to name a few. What were considered the generalist duties and what fell under the occupational therapy heading? Was the work I did really considered occupational therapy? Being a new graduate, I was anxious to know that I was doing my job correctly and I sought out resources in an attempt to find affirmation.

Expectations are expressed to professionals through various governing texts, such as job descriptions, mission, vision, value statements, position statements, standards, practice guidelines, policies, and strategy reports. I found that governing texts regarding occupational therapy and community mental health practice provided minimal or no guidance. While a number of papers have explored the advantages and challenges of assuming various roles (Culverhouse & Bibby, 2008; Harrison, 2003; Parker, 2001), little has been written to answer the question: How do occupational therapists working in a community mental health setting understand their professional role in relation to existing governing texts? And so this study began.

The study comprised three phases; the first examined messages delivered to occupational therapists via governing texts (role on paper); the second examined occupational therapists' role in reality (role in practice); and the third phase compared the role on paper to the role in practice (See Table 1).

Table 1 Summary of phases

Phase	Objective	Methodology
1	Establish role on paper	Document review using content analysis of governing documents
2	Establish role in practice	Semi-structured interviews with occupational therapists on community mental health teams
3	Compare role on paper to role in practice	Analysis of data collected from phases 1 & 2

This study has the potential to impact the profession of occupational therapy. This research identifies areas of agreement between texts (role on paper) and actual practice (role in practice) that further strengthen the position of occupational therapy in community mental health. Secondly, areas of discord between the role on paper and the role in practice are highlighted to direct future efforts towards building a stronger and more clarified role of occupational therapy in community mental health. Another type of discord identification are the gaps between the description of the role on paper and how the role plays out in everyday practice. At a higher level, conclusions drawn from this study may clarify the occupational therapy role in community mental health, generate improved occupational therapy referrals, a higher professional profile, and the potential for new positions for occupational therapists. Ultimately, people living with mental health conditions will benefit from improved clarity around the occupational therapy role; as a strong and powerful profession is better positioned to provide optimal care as well as improve access to those in need of the services (Townsend, Polatajko, Craik, & Von Zweck, 2011).

This thesis is comprised of six chapters: Chapter two focuses on methodology, outlines the theoretical framework of interpretive phenomenology, and describes the three phases of the study. Chapter three explores how the document review and content analysis of governing texts completed in phase one of the study formed 'the role on paper'. Chapter four explores phase two, in which semi-structured interviews were conducted with practising occupational therapists on community mental health teams to inform 'the role in practice'. Chapter five discerns the areas of agreement, discord and

gaps that exist in both the role on paper and the role in practice. Finally, in Chapter six, recommendations for the future and overarching conclusions are provided in alignment with the interpretive phenomenological approach in qualitative research. Throughout the document, you will find my own experiences have been interwoven with emerging themes.

CHAPTER 2 THEORETICAL FRAMEWORK & METHODOLOGY

2.1 INTERPRETIVE PHENOMENOLOGY

The tradition of interpretive phenomenology was used for this research study.

Interpretive, or hermeneutic, phenomenology is based on the concept of bringing to light that which “is normally hidden in human experience and human relations.” (Lopez & Willis, 2004, p.728). Specifically, uncovering meanings that are not necessarily apparent to participants, but which are discovered by the researcher through analysis of collected data, is moving a step beyond describing the phenomena at hand (Lopez & Willis, 2004). Interpretive phenomenology recognizes that the outside world impacts one’s personal reality and that the two cannot be separated and studied independent of each other. This acknowledgement that experiences cannot be wholly compartmentalized and reduced to individual core components is consistent with the interdependent relationships of person, environment and occupation, which is a strongly held framework in occupational therapy (Townsend, 2002). Heidegger (1962) coined the term ‘being-in-the-world’ to reflect this sentiment of one being unable to separate from the world in which you live. He employed the term ‘lifeworld’ to describe an individual’s lived experiences and recognize that one’s environment has important impact on the reality one experiences (Heidegger, 1962). Linked with the idea of interdependence is the concept of situated freedom. Situated freedom is viewed as individuals having freedom to make choices, while recognizing that one’s world impacts the type and number of choices that are available (Leonard, 1999).

A key epistemological feature of interpretive phenomenology is that of viewing the researcher's personal knowledge on the topic as valuable, rather than something that needs to be bracketed and removed as much as possible (Geanellos, 2000). Personal knowledge contributed greatly to the formation of the research and was necessary to uncover hidden meaning in the data that were collected. This reflects a final product that was co-created by both the researcher and the participants. As such, the data arising from the researcher's personal experiences and reflections about working on a community mental health team are included alongside the data arising from the document analysis (phase one), the data brought forth by the participants (phase two) and the comparison of 'paper' to 'practice' (phase three). An interpretivist framework complimented interpretive phenomenology as it recognized that each individual held a different understanding of life experience, therefore producing multiple realities that could not be evaluated in terms of correctness, but rather a degree of depth of understanding (Lavery, 2003). In line with this co-creation viewpoint is the acknowledgement that the researcher could never fully grasp the experience of the participant and that the participant could not recount experiences with absolute accuracy and detail. However, by recognizing these facts the researcher and participants came together upon a 'fusion of horizons', a place of shared reality and common ground (Gadamer, 1976; Koch, 1999). Arriving at the point where the horizons intersect was accomplished via the dialogue between the researcher and participants in phase two of this study. The goal of the study was to gain improved understanding, rather than the creation of new knowledge. The focus was not to solely seek out what the role of

occupational therapists working in community mental health teams looked like, but to better understand what, if any, effects did governing texts have on occupational therapists' understanding of their roles.

2.2 PERSONAL EXPERIENCE

Following the tradition of interpretive phenomenology, my personal experience having worked a dual role within a community mental health team influenced the way the issue was researched. One way that this was implemented was by giving conscious thought to my individual assumptions and views and how they influenced the collection and interpretation of data. The thoughts were documented throughout the study and included alongside relevant themes throughout the paper (Conneeley, 2002; Lavery, 2003). This is in line with a general qualitative ontological view recognizing that all research is biased to researchers' personal perceptions and takes steps to acknowledge, rather than mitigate or ignore it (Krauss, 2005). Engaging in this self-reflection process brings reflexivity into the research process (Whalley-Hammell, 2002). The self-reflections were shared with my thesis committee to better inform them of my personal biases, allowing them greater awareness of my location within the research when participating in simultaneous analysis that occurred throughout the phases.

2.3 MAIN RESEARCH QUESTION

How do occupational therapists working on community mental health teams understand their professional role in relation to existing governing texts?

The study was conducted in three phases. Each phase comprised its own research objectives that informed the main research question. The subsequent chapter outlines the theoretical framework of interpretive phenomenology and the methodology that was followed to conduct the study.

2.4 PHASE ONE

Phase one comprised identifying ‘the role on paper’ through a document review of relevant governing texts. Phase one addressed the following research objectives:

1. What governing texts define the role of occupational therapists working in community mental health care? (e.g., position statements, profiles, strategic visions, job descriptions)
2. How is the role of occupational therapists working in community mental health care defined in **governing texts**? (e.g., what is the role on paper?)

2.4.1 Content Analysis Tool

A content analysis tool was developed to serve as a template for reviewing, organizing, categorizing, and analyzing information from documents identified by a document review (see Appendix A: Content Analysis Tool). Tool development was influenced by discourse analysis (Lysack, Luborsky & Dillaway, 2006) and served to deconstruct the texts to enable the researcher to re-construct the occupational therapy role in community mental health ‘on paper’. Having a consistent tool ensured each document was examined in the same manner (reliability). It aided in focussing the analysis of

documents on the aims of the study and allowed for a larger body of literature to be efficiently captured (Bryman, 2004). Additionally, the resulting summaries were available during the interviews and participants could provide additional commentary during their interviews. For instance, participants could be asked about their understanding of various documents, or stances on issues within the governing documents. The researcher tailored the content analysis tool to the purpose of the study, as an appropriate existing tool could not be located in the literature. In developing the content analysis tool, a two stage process was used; 1) principles to consider when creating a content analysis tool were reviewed (Krippendorff, 1980); and 2) the overall research question and research objectives for each phase were considered. Finally, the researcher and a member of the thesis committee conducted a parallel analysis of two documents. Each used the content analysis tool at the same time, but separately, to extract and organize data from the documents and then review, compare and contrast its use. This simultaneous analysis increased the rigour of the study and facilitated appropriate revisions of the tool. A limitation to the content analysis tool is that the researcher designed it, so while it was individualized to the particular aims of the study, it had not been piloted or applied in research before.

2.4.2 Document Review

Documents governing occupational therapy practice in community mental health within Ontario were gathered and analyzed using the content analysis tool. Data illuminated role expectations of occupational therapists on community mental health teams. The

review of governing texts was integral, as texts hold the power to influence and direct individual's behaviour and actions both consciously and unconsciously (Campbell & Gregor, 2002). Inclusion criteria for documents can be viewed in Table 2, Criteria reflected the focus and scope of the project and balanced the extraction of relevant data with available researcher resources. For example, all documents were available online, focussed on community mental health care and were the most current version. Documents more than twenty years old, not accessible online and/or focused on in-patient mental health care were excluded. This document review was not intended to be exhaustive, as this was not the focus of the project. The aim was to identify accessible documents, currently in circulation, and most applicable to the research objectives.

Table 2 Inclusion criteria for document review

Sources	Canadian (National & Ontario) Organizational (Governmental, Non-Governmental) Professional Associations Regulatory Bodies
Topics	Occupational Therapy Community-Based Mental Health Care
Type	Strategic Reports Guidelines & Standards for Practice Position Statements Policy Documents

2.4.3 Analysis of Document Review

The review was a construction of the role expectations of occupational therapists working on community mental health teams to ultimately illuminate agreement, discord and gaps; between 'paper' and 'practice'; it served three main functions. First, in alignment with interpretive phenomenology, the information gathered through the document review served as one form of data collection, representing the description of the role of occupational therapy in community mental health from the perspective of the system, or 'the role on paper'. Secondly, the review gathered relevant common terms across the document set (e.g., collaboration, consultation, client-centred practice, etc.). Finally, the review processes aided in developing the participant interview guide used in phase two. Following co-analysis of two documents, further document analysis included the researcher reading each document, highlighting key words and the addition of summary statements and interpretive codes noted in the margins. Codes were collapsed into categories. Categories were then further collapsed into preliminary themes. The process was iterative in nature, with the researcher going back and forth to the documents to ensure consistency between the data and the identified themes (Smith, Joseph & Das Nair, 2011). Interpretation was circular in nature; as new themes were explored in documents, previously analyzed documents were reviewed to search for the newly identified themes (Smith, Joseph & Das Nair, 2011). After all documents had been reviewed individually, documents were compared to each other to look for common themes across texts (Rassool & Nel, 2012). Preliminary themes were then further collapsed to create a final list of themes. At this point, the researcher again

returned to the documents to verify that the final themes were supported by the data (Rassool & Nel, 2012). The end product of this analysis culminated as ‘the role on paper’. Analysis was carried out using features within Microsoft Word.

2.5 PHASE TWO

In the next phase, semi-structured interviews were conducted with occupational therapists to gain information about the individual ‘lifeworlds’ of occupational therapists working on community mental health teams. Dialogue focused on describing the meanings of the individuals “‘being-in-the-world’ and how these meanings influence the choices they make” (Lopez & Willis, 2004, p. 729). This phase served to establish ‘the role in practice’. Interviewing participants to hear their experiences is in line with the overarching interpretive paradigm where intersubjectivity, or mutual recognition between the research and the participants is both fostered and valued (Weaver & Olson, 2006). The contributions of both researcher and participant were viewed as being necessary to produce a meaningful result.

Phase two addressed the following research objectives:

1. How do occupational therapists working in community mental health care **understand** and interpret their role? (e.g., how is the role perceived?)
2. What governing texts do occupational therapists working in community mental health care report using to **understand** their role? (e.g., Job descriptions,

mission, vision, value statements, position statements, guidelines/standards for practice, strategic reports, and policy documents)

3. How are governing texts **interpreted** among different individual occupational therapists in community mental health care? (e.g., Understanding individual meaning- similarities/ differences, value of documents, priority of documents)

2.5.1 Sampling and Recruitment

For inclusion, participants met the following criteria: 1) registered occupational therapist in Ontario and currently working in a community mental health team; 2) served clients above the age of sixteen. This second criterion served to select a sample that practices within a similar environment: mental health services for children and youth are governed via the Ministry of Children and Youth Services in Ontario, and focus efforts on prevention and early identification of mental illness, whereas adult services are administered by the Ministry of Health and Long Term Care and focus on treatment and management of a mental illness (Ministry of Health and Long-Term Care, 2011); 3) located in Southern Ontario. As this is a densely populated area of the province it provided access to an appropriate and varied sample (e.g., Urban and rural settings) and allowed the researcher to conduct face to face interviews due to realistic travel distances.

The Canadian Association of Occupational Therapists' served as the source of potential participants. The Canadian Association of Occupational Therapists website has a section entitled 'OT Networker' which provided access to contact information of occupational

therapists who have agreed to being contacted by other Canadian Association of Occupational Therapists' members with similar interests. The 'OT Networker' enabled a search that specified both region (Ontario) and area of interest (mental health). Recruitment involved sending out a formal electronic mail invitation outlining the aims of the study, (see Appendix B). The benefits of this strategy included sending personalized invitations, speed and cost effectiveness associated with electronic mail, and lack of pressure due to a face to face or telephone invitation. Those who were interested in participating were asked to contact the researcher by electronic mail or telephone. The researcher followed up with potential participants via electronic mail and telephone messages to screen for the inclusion criteria and address any questions or concerns about participation and confidentiality (see Appendix C). After experiencing a low response rate, a revision of the ethics application was submitted to expand the search strategy which was approved. With the newly expanded search capabilities, the researcher was able to find additional participants by searching LinkedIn™ using the same inclusion criteria. Participant recruitment generated seven occupational therapists from community mental health teams in southern Ontario. Thus, findings identified here are not designed to be extrapolated across the province or country. The qualitative study was not intended to be generalizable; it does however illuminate several issues that may resonate with occupational therapists and other professionals working on community mental health teams across the country.

The goal to obtain a sample size of six to twelve participants was based upon the following principles. First, interpretive phenomenology is concerned with collecting in-

depth perceptions and understanding, rather than generalizable claims (Smith & Osborn, 2008). Secondly, research into data saturation and variability have suggested saturation often occurs within completion of twelve interviews, with meta-themes emerging as early as six interviews (Guest, Bunce & Johnson, 2006). Due to the amount of data gathered from one-on-one semi-structured interviews, it was essential that data collection remained manageable for a Master level project (Smith & Osborn, 2008). Additionally, the range of six to twelve participants allows for reflexivity based on the information collected. No new significant themes were identified after the completion of the seventh interview, suggesting saturation. The seven participants represented one to ten years of experience, various geographic settings (urban-suburban-rural), and different program intensities (short term-long term, case management- intensive), see Table 3. Participants were all represented by a pseudonym in the reporting of the results.

Table 3 Overview of participants

Pseudonym	Geography	Setting	Years' Experience
Martha	Urban	ACT	5+
Barbara	Rural	ACT	9+
Claire	Urban	Out-patient clinic	9+
Peggy	Urban	Out-patient clinic	11+
Lynn	Mixed	Crisis team (short term involvement)	2+
Taylor	Mixed	ACT	>1
Nova	Urban	ACT	>1

2.5.2 Semi-Structured Interviews

The semi-structured interview guide is an outline of questions and topics addressed during the participant interviews. Unlike a structured interview schedule which does not allow for deviation, the interview guide provided direction, reminders, and potential probes. The semi-structured interview guide ensured that core concepts were discussed, yet left flexibility for unexpected information to be discussed, and for participants to talk about what was important to them, a key concept when learning about the 'lifeworld' or lived experience (Bryman, 2004). It contributed to participation being a mutually beneficial experience. The participants engaged in guided self-reflection, while the researcher collected data for the study at hand. It allowed for a more comprehensive examination of 'paper vs. practice' by not limiting interview questions to a fully scripted outline (DiCicco-Bloom & Crabtree, 2006; Taylor & Kielhofner, 2006). Semi-structured interviewing reflects a relatively relaxed interviewing style that aided in creating a trust-filled environment, ultimately eliciting deep thoughts and moving beyond superficial investigation. This approach provided the opportunity for participants to hold back information if they chose. Open-ended questions allowed for individual interpretation, creating a vast quantity and breadth of information (Bryman, 2004). Potential pitfalls to semi-structured interviews were that interviews could get off track due to loose structure and as such, the interviewer needed to actively manage the direction of the interview in alignment with the purpose of the study (Lysack, Luborsky & Dillaway, 2006). The researcher developed the interview guide; therefore, while individualized to the particular aims of this study, it had not been utilized in any prior studies. These

concerns were addressed in three different ways: 1) the researcher reviewed principles to consider when creating an interview guide (Lysack, Luborsky & Dillaway, 2006) such as incorporating open-ended questions to facilitate participants' expression of their individual viewpoints and speaking about the topics that are more important to them (within the scope of the study); 2) the researcher considered the overall research question as well as the research objectives. Specifically, information to aid in answering the three research objectives in phase two was targeted. The initial interview guide served as a foundation and was further developed during phase one (document review) and phase two (interviewing); 3) the interview guide was piloted with the first two participants, then the researcher employed the assistance of a member of the thesis committee. The researcher and thesis committee member reviewed the interview transcripts individually, yet simultaneously and recommended refinements of the interview guide. Observations focused on the content, number, sequence, and delivery of the questions. This simultaneous analysis served to increase rigour and resulted in small changes of the interview guide that better met the research objectives. In qualitative research, the semi-structured interview guide is seen as a dynamic document. As such, the guide continued to evolve over the course of data collection and included additional concepts and considerations from earlier interviews on which later participants provided additional perspectives, and confirmed early emergent themes. See Appendix F.

Interviews required a time commitment from participants and coordination of timing with the researcher. Interviews were completed face-to-face at a private location of

mutual convenience, at participants' workplaces or home residences. All interviews were audio recorded and transcribed verbatim for analysis. Prior to conducting the interview, participants were sent a formal consent form over electric mail (see Appendix D) which they read, signed, and brought to the interview. Participants were provided the opportunity to ask any questions prior to signing consent over electronic mail, phone and/or in person just prior to scheduled meeting. The researcher reviewed the consent form with the participant at the beginning of the scheduled interview meeting (see Appendix E). The researcher had multiple copies of the consent form, so participants wishing to keep a signed copy for their own records were able to do so.

2.5.3 Analysis of Transcripts

The interpretive phenomenological approach was followed for data analysis, influenced by the analysis laid out in Olszewski, Macey & Lindstrom's article *The practical work of coding: An ethnomethodological inquiry* (2006). It is of note that analysis of data was conducted within Microsoft Word™ software program. This program allowed for customization of tables and figures, use of multi-coloured highlighting, creation of customized margins, and the use of the 'find' tool for data organization. Analysis began by reading a transcript and noting summary descriptions and interpretive codes in the margin, creating many codes, often with multiple coding. Two rules were applied when coding a segment of text: 1) the segment was substantive enough to demonstrate the code; and 2) the segment was coded adequately in length to make the passage coherent. Following transcript coding, the codes in the margin were collapsed into

categories. This process was iterative in nature, with the researcher going back and forth to the transcripts to ensure that the data supported the identified themes (Smith, Joseph & Das Nair, 2011). Interpretation was circular in nature, as new categories were explored in transcripts, previously analyzed transcripts were reviewed to search for the newly identified categories (Smith, Joseph & Das Nair, 2011). The focus was on coding segments that reflected how the occupational therapist understands his/her role. Codes for generalist, specialist, and dual role attributes were documented, along with emergent sub themes. Analysis also identified the governing texts participants used to aid and shape the understanding of their roles.

After all transcripts had been reviewed individually, transcripts were compared to each other to look for common themes across interviews and participants (Rassool & Nel, 2012). Themes were further collapsed to create a final list. The researcher checked the transcripts again to ensure that the data represented the themes (Rassool & Nel, 2012). The end product of this analysis serves as 'the role in practice', found in chapter five.

2.5.4 Rigour

To establish rigour, two main strategies were applied: 1) simultaneous analysis; and 2) member checking. Rigour is also inherent in the methodology, as multiple types of data (paper and practice) have been collected from multiple sources (documents and participants).

After two initial interviews, the researcher employed the assistance of a member of the thesis committee to conduct a simultaneous analysis of the transcripts. Each reviewed the interview transcripts independently and followed the transcript analysis procedure described above. Once individual analysis was complete, the researchers compared content of coding, length of segments coded, and identification of emergent categories and themes. This simultaneous analysis served to increase rigour, and aided in uncovering hidden themes in the data to increase alignment with the tradition of interpretive phenomenology and meeting research objectives.

As a means to reinforce the co-creation of knowledge gained from the study, after all interviews were completed and initial analysis took place, participants were asked to provide their perspectives on the thematic analysis of their respective individual interviews. Participants were provided with the categories and themes identified in their transcript and asked to comment on items with which they agreed, disagreed, and found to be important, along with the freedom to make additional comments (Pack, 2012). Five of the seven participants completed the individual review and only one minor phrasing change resulted.

Feedback was also sought in regard to the group thematic analysis. Three of the seven participants provided feedback on the group analysis and no edits were suggested. Participants expressed how re-affirming and comforting it was to discover that other occupational therapists shared many similar experiences and thoughts about their work.

Involving participants in the research beyond the scope of being interviewed fits well with a humanistic view, where individuals are seen as being capable of self-reflection, resulting in seeing from a different perspective, with the ultimate goal of self-realization (Hackley, 2003). In this sense, participants' involvement with thematic analysis of their individual interviews served as member checking, and a way to distribute power between researcher and participant (Conneeley, 2002).

2.6 PHASE THREE

This phase consisted of a comparative analysis between 'the role on paper' and 'the role in practice'. Analysis focused on finding areas of agreement, discord and gaps within the two data sets collected.

Research objective for phase three:

1. What **agreements or discord** can be identified between the role on paper and the role in practice?

2.6.1 Analysis

Data analysis in phase three also followed the interpretive phenomenological approach, with an aim "to try to understand the content and complexity of those meanings rather than measure their frequency" (Smith & Osborn, 2008, p.66). Phase three involved looking for associations, connections, thoughts, contradictions, similarities, differences and gaps between 'the role on paper' and 'the role in practice' to uncover emergent

themes. High level themes were sought, with attention paid to ensure these were still clearly linked to the data (Smith & Osborn, 2008). Special attention was paid to how the emergent themes related to the identified research questions and accompanying research objectives.

CHAPTER 3 THE ROLE ON PAPER

3.1 INTRODUCTION

Phase one involved assembling documents from professional and regulatory organizations, community mental health practice documents, and documents published by the provincial (Ontario) and federal government regarding mental health services in Canada. Common themes were identified to establish ‘the role on paper’ for occupational therapists working on community mental health teams. Phase one set out to answer the following questions:

1. What governing texts define the role of occupational therapists working in community mental health care? (e.g., Position statements, profiles, strategic visions, job descriptions)
2. How is the role of occupational therapists working in community mental health care defined in **governing texts**? (e.g., what is the role on paper?)

3.2 QUESTION #1: GOVERNING TEXTS

The following texts were consulted to reflect how the dual role of case manager (generalist) and occupational therapist (specialist) is described, see Table 4.

Table 4 List of texts in document review

Title	Year	Intended Audience	Type
1. Canadian Association of Occupational Therapists Position Statement: Occupational Therapy & Mental Health Care	2008	Canadian Occupational Therapists	Occupational Therapy Self-promotion Recommendations
2. Canadian Association of Occupational Therapists Report of the Professional Issue Forum on: Occupation & Mental Health Care	2004	Canadian Occupational Therapists	Occupational Therapy Recommendations for future Position Statement (Title #1)
3. Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO]. College of Occupational Therapists of Ontario Essential Competencies of Practice for Occupational Therapists in Canada	2011	Canadian Occupational Therapists General Public- Canadian	Occupational Therapy Prescriptive Competency Framework Self-promotion
4. Canadian Association of Occupational Therapists: Profile of Occupational Therapy Practice in Canada	2012	Canadian Occupational Therapists General Public- Canadian	Occupational Therapy Descriptive Self-promotion
5. Ontario Government: Open Minds, Healthy	2011	Provincial Government	Identification of

Title	Year	Intended Audience	Type
Minds: Ontario's Comprehensive Mental Health & Addictions Strategy		General Public- Ontarians	priority goals Strategies for system change
6. Ontario Government (Minister's Advisory Group): Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health & Addictions Strategy	2010	Ministry of Health & Long Term Care (Ontario) General Public- Ontarians	Recommendations Self-promotion Stepping stone to inform next steps
7. Ontario Government (Select Committee on Mental Health & Addictions): Navigating the Journey to Wellness: The Comprehensive Mental Health & Addictions Action Plan for Ontarians	2010	Ontario Legislative Assembly	Recommendations Action plan Stepping stone to inform next steps
8. Ontario Government (Ministry of Health and Long Term Care): Every Door is the Right Door	2009	Ontarian Occupational Therapists Mental Health Service Providers General Public- Ontarians	Self-promotion Seeking feedback
9. Mental Health Commission of Canada: Changing Directions, Changing Lives: The Mental Health Strategy for Canada	2012	Mental Health & Addictions System General public- Canadians National Government	Recommendations Self-promotion

Title	Year	Intended Audience	Type
10. Mental Health Commission of Canada: Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada	2009	General public- Canadians National Government	Recommendations Seeking feedback Stepping stone to inform next steps
11. Ministry of Health and Long Term Care: Ontario Program Standards for Assertive Community Treatment Teams	2005	ACT Service Providers ACT Administrators	Service Delivery Model Prescriptive

3.3 QUESTION #2: DEFINING THE ROLE ON PAPER

Of eleven documents selected for content analysis, four occupational therapy-based documents were consulted, representing national, provincial regulatory, and professional organizations. Two of the documents were intended for occupational therapists in all settings (Essential Competencies of Practice for Occupational Therapists in Canada, 2011; Profile of Occupational Therapy Practice, 2012) and two were specific occupational therapy in mental health services (Report of the Professional Issue Forum on Occupation and Mental Health Care, 2004; Canadian Association of Occupational Therapists Position Statement Occupational Therapy and Mental Health Care, 2008).

The seven government documents reflect federal and provincial documents published since 2005. Five of the documents come from the Ontario provincial government, and include strategies, action plans, and program standards (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011). Finally, two of the government documents are published by the Mental Health Commission of Canada (Toward Recovery & Well-Being, 2009; Changing Directions, Changing Lives, 2012), of which both are mental health strategy documents.

In reviewing the documents, six main themes emerged about the role of all service providers on community mental health teams. 1) recovery-based care; 2) collaboration; 3) advocacy; 4) competencies; 5) evidence based practice; and 6) professionalism and administration. Each theme is discussed in detail in the following section. Refer to Table 5 to see where phase one rests in the overall research project design.

Table 5 Summary of phases- phase one

Phase	Objective	Methodology
1	Establish role on paper	Document review using content analysis of governing documents
2	Establish role in practice	Semi-structured interviews with occupational therapists on community mental health teams
3	Compare role on paper to role in practice	Analysis of data collected from phases 1 & 2

3.4 RECOVERY BASED CARE

This theme includes statements related to the principles of recovery and psychosocial rehabilitation. Sub-themes that appear most often include client empowerment, client-centred practice, self-management principles, forming client partnerships, and providing care within a community setting. The principles carry a common thread of providing individualized care that is built upon a power sharing relationship between client and service provider. Although collaborating for individualized care is a concept associated with this theme, the references made toward that topic were so frequent that it warranted its own theme (see section 3.5).

3.4.1 Empowerment/ Client-centred/ Self-management/ Client partnerships

Six of the seven government documents are represented within this category (not evident is Navigating the Journey to Wellness, 2010). Almost all sources made ample reference to the concepts of working from a client-centred approach, empowering clients via strong client-service provider partnerships, and incorporating self-management strategies. Emphasized was explicit mention of adopting recovery principles in six of the government documents (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012). In this theme, all documents went beyond vague mention of recovery principles and provided further detail as to what recovery principles really are. Recurrent examples included:

- Working from a client-centred approach (e.g., individualized plans, flexibility to care needs)
- Working from a self-management approach (e.g., learning about self/ illness/symptoms, self-determination, self-care, increase individual skills/ knowledge)
- Working *with* clients, rather than *for* clients (e.g., shared responsibility for decision making, providing options to enable clients to make informed choices, involvement in goal setting)
- Identifying client strengths and acknowledging client preferences and individuality
- Fostering hope and empowerment, promoting dignity and respect (e.g., aim to reduce power imbalances, least restrictive intervention possible, client rights, respect the lived experience, develop self- confidence and mastery)
- Keeping a holistic view (e.g., see whole person, see beyond the illness)
- Aiming for an overall goal of a meaningful life

The government documents explicitly express that community mental health service providers need to work from recovery-based, client-centred, self-help, and psychosocial rehabilitation approaches.

All four of the occupational therapy based documents speak of recovery and psychosocial rehabilitation, however those specific terms are not used within the details about the roles and responsibilities of occupational therapists. The one exception is occupational therapists' contributions to recovery research (Report of the Professional Issue Forum on Occupation and Mental Health Care, 2004; Canadian Association of

Occupational Therapists Position Statement Occupational Therapy and Mental Health Care, 2008). Largely, the occupational therapy documents outline actions and attitudes illustrating recovery and psychosocial rehabilitation principles, for example, collaborating with stakeholders, engaging in shared decision-making, creating individualized, flexible and holistic care plans, recognizing client strengths, and taking client preference into consideration. This suggests that overarching occupational therapy values and beliefs are in-line with recovery principles and psychosocial rehabilitation, further endorsing the natural fit between occupational therapy and community mental health. Two of the occupational therapy documents are intended for occupational therapists across settings and are not specific to mental health, therefore the lack of reference to mental health-specific terminology such as recovery-based care and psychosocial rehabilitation is not surprising (Essential Competencies of Practice for Occupational Therapists in Canada, 2011; Profile of Occupational Therapy Practice, 2012).

3.4.2 Community Based Care

While nine out of the eleven total documents consulted are represented within this sub-theme (Report of the Professional Issue Forum on Occupation and Mental Health Care, 2004; Profile of Occupational Therapy Practice, 2012; Ontario Program Standards for ACT Teams, 2005; Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012), the

content does not all speak to the same concept. In addition, the content tended to be short and direct in nature.

All seven of the government documents underscored the need for community-based care. Four of the documents make explicit the importance of providing service within the community (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012). The three remaining sources implicitly encourage community-based care by stating the need for community adjustment, citing the importance of community-based services, and generally helping clients reach their potential, and find meaning through community involvement (Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; and Respect, Recovery, Resilience, 2010).

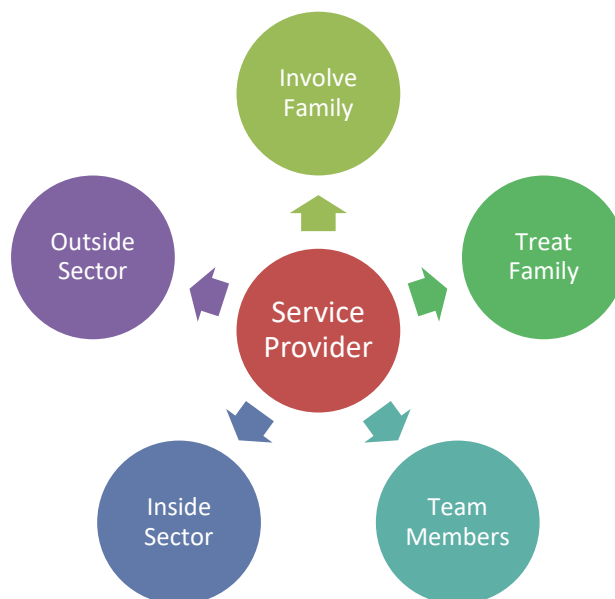
In contrast, two of the four occupational therapy documents made mention of the need for community based services (Report of the Professional Issue Forum, 2004; Profile of Occupational Therapy, 2012). The statements from the occupational therapy documents spoke specifically of a future role involved with increasing community integration, outreach, as well as the role for occupational therapy within community development.

3.5 COLLABORATION FOR INDIVIDUALIZED CARE

This theme highlights the need for community mental health service providers to communicate, collaborate, coordinate, and partner with all relevant sources and

stakeholders. Respectful and regular communications are stressed as main components enabling individualized and adaptive care. Five different types of relationships are identified within the theme: 1) involve family in service/ care; 2) provide service/ care to family directly; 3) team member partnerships; 4) inside the sector partnerships; 5) outside the sector partnerships. See Figure 1.

Figure 1 Service provider collaborations for individualized care



3.5.1 Involve Family in Service/ Care

The first type of relationship denotes the service provider collaborating with the client's family. This collaboration with family could be for the client's direct benefit, for example, getting feedback from family on the client's function, or getting relevant background information for a more informed view.

All eleven documents speak to the importance of involving family in service provision. This ranges from engaging family: as additional information, as part of treatment planning, and ensuring clear and open communication. Specifically, the occupational therapy-based documents spoke often of 'collaborating with stakeholders', and families are considered to be one of the stakeholder groups relevant to client care. Emphasis is placed on developing, managing, and maintaining relationships via respectful, understandable, and regular communication.

The occupational therapy-based documents are consistent in describing the role surrounding 'involving family in service/ care'. All of the documents mention the need for collaboration and communication with family members, as they can be a particularly good source of additional information as well as being key stakeholders. The occupational therapy documents, however, do not explicate that this type of collaboration is specific to the role of occupational therapists. The manner in which the government documents describe the need for community mental health team members to involve families in service provision embraces the generalist approach. In the government documents there is no mention of family involvement being a discipline-specific role.

The government documents also consistently list the need for and importance of having family involvement in the provision of services. Inconsistent among the government documents is the level of detail used to explore this involvement. Six of the seven government documents (Toward Recovery & Well-Being, 2009; Every Door is the Right

Door, 2009; Respect, Recovery, Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012) make vague mention of family involvement, or only refer to one specific aspect of service provision (e.g., recognize and engage family, empower family to make informed choices, include family in evaluation, include family in continuity of care, involve family in care). Only one government document (Ontario Program Standards for Assertive Community Treatment Teams, 2005) lays out in detail, with multiple roles, what it means to have 'family involvement'. It specifies the need to provide family-centred services by including family in planning, providing feedback, promoting family involvement and family relationship, regular collaboration and communication, and generally involving family in the service as much as the client permits.

Perhaps the documents purposely make reference to family involvement in a vague manner to allow for individual interpretation. If discussed in detail, it could come across as prescriptive in nature and limit the role of family involvement. The ambiguity of the terms allows clinicians to involve families in as many or as few aspects of client care as is permitted and feasible.

In relation to language throughout the documents, the occupational therapy-based documents consistently used the term 'stakeholders': family is considered to be one type of stakeholder. The term stakeholder was largely lacking from government documents, with only one of the documents (Toward Recovery & Well-Being, 2009) clearly listing family in a stakeholder role.

3.5.2 Provide Service/ Care for Family Directly

The second type of relationship is collaboration with a client's family, for the family's direct benefit. For example, providing psychoeducation to family members to better understand their loved one's condition and function, family self-help or support services. It is highly likely and intended that by providing direct services to family members the client would benefit as well.

A stark difference is evident between government and occupational therapy documents. All seven of the government documents mentioned the need to provide direct service to families, in addition to the primary client. In comparison, none of the four occupational therapy documents spoke explicitly about providing direct service to families as a part of the occupational therapist specialist role. While occupational therapy documents strongly support involving family in care, they also have a unified view of who is the client and who should be the recipient of direct service. This result points towards the idea of occupational therapy specialists working from a client-centred approach, rather than a family-centred approach, the latter endorsed in the government documents.

Five of the government sources (Ontario Programs Standards for Assertive Community Treatment Teams, 2005; Toward Recovery & Well-Being, 2009, Respect, Recovery, Resilience, 2010, Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011) spoke of 'supporting families' and mentioned self-help/ peer support services.

Four of the seven government sources (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Toward Recovery & Well-Being, 2009; Respect,

Recovery, Resilience, 2010; and Changing Directions, Changing Lives, 2012) identified education for families, including psycho education, education to aid in early identification of issues, learning problem-solving skills and assisting with system navigation.

While this topic was found among a majority of the government documents, only the Ontario Program Standards for Assertive Community Treatment Teams (2005) and Toward Recovery & Well-Being (2009) provided significant detail to outline the role. The others presented lesser focus on the provision of service directly to family members.

3.5.3 Team Member Partnerships

The third type of relationship is community mental health team members collaborating with members within their team (e.g., Interdisciplinary collaboration). This could involve occupational therapists interacting with social workers, nurses and doctors to name a few. This relationship highlights the need for service coordination and the team working together to meet the often vast needs with which a client presents.

Two of the four occupational therapy documents referred to the need for collaboration with team members (Essential Competencies of Practice for Occupational Therapists in Canada, 2011; and Profile of Occupational Therapy Practice, 2012). These documents are designed to guide occupational therapy practice overall, not specifically mental health. The documents make brief references by stating the need to communicate and collaborate between all stakeholders. The researcher has interpreted 'stakeholders' to

include team members. The two occupational therapy documents that did not mention the importance of team member relationships were the two documents specific to occupational therapy and mental health.

Only one of the seven government documents referred to the need for collaboration with team members (Ontario Program Standards for Assertive Community Treatment Team, 2005). The document does not explicitly state the requirement of team members to form partnerships with other team members. Rather, the documents include the need to include other stakeholders in creating an individualized plan, and to provide 'coordination of care', involving team organization and communication.

The expression of care coordination is in line with the generalist role, indicating that each member on the team has a responsibility to perform this function. It also supports the argument for the specialist role, suggesting that one individual cannot provide all the services required, and that drawing upon others with differing backgrounds is necessary to provide high quality and comprehensive service.

One of the core concepts of community mental health teams is the inclusion of service providers from various educational backgrounds and disciplines. As such, it is surprising that so few documents explicitly mention the need for team members to form supportive relationships with one another. Perhaps this concept is so foundational to community mental health teams that it is assumed.

3.5.4 Inside the Sector Partnerships

Community mental health team members are expected to develop, nurture, and maintain a relationship with other programs and workers outside of their team, but still within the mental health sector. This includes gathering and sharing information with other members of the circle of care as necessary. For instance, this includes consumer groups, family groups, non-government organizations, in addition to other formal mental health service providers (e.g., hospitals, clinics, across geographic areas).

Two of the seven government documents mention the need for intra-sector partnerships (Ontario Program Standards for Assertive Community Treatment Teams, 2005; and *Toward Recovery & Well-Being*, 2009). The Ontario Program Standards for Assertive Community Treatment Teams (2005) document explicitly mentions the need to work with community partners, including organizations and institutions to help with service coordination on the whole, specifically to speed up the intake process, as well as to facilitate continuity of care among all service providers. *Toward Recovery & Well-Being* (2009) makes brief mention of the need to partner with all stakeholders, which has been interpreted to include intra-sector collaboration.

All four occupational therapy documents list the need for intra-sector collaboration. The *Essential Competencies of Practice for Occupational Therapists in Canada* (2011) makes a brief and vague mention of the need to plan and collaborate with all stakeholders. The other three documents (*Report of the Professional Issue Forum on Occupation and Mental Health Care*, 2004; *Canadian Association of Occupational Therapists Position*

Statement Occupational Therapy and Mental Health Care, 2008; and Profile of Occupational Therapy Practice, 2012) build upon this statement, listing the need to work with communities, groups, populations, consumer groups, and non-governmental organizations. These suggest the need for collaboration for both direct client service provision and indirect client benefits such as advancing mental health strategy, promoting services among partners, and increasing access to services and opportunities for clients. Given the number of vague statements referring to the need for collaboration with all stakeholders, many of these comments have been included in three or more of the sub-themes in this larger theme.

3.5.5 Outside the Sector Partnerships

The final type of relationship that community mental health service providers are expected to ensure is collaborating and forming relationships with other programs and service providers outside of the mental health sector. This approach stresses the need for integration across sectors to enable the best possible service provision. Examples of partnering sectors include, but are not limited to: addictions, criminal justice, education, employment, housing, social services, child, youth, adult, senior, developmental, neurological and immigration. This theme focuses on forming, managing, and using various cross-sector relationships to benefit the client.

Six of the seven government documents mention the need for developing partnerships with stakeholders outside of the mental health sector explicitly or implicitly. One of the documents (Toward Recovery & Well-Being, 2009) makes brief and vague mention of

the need to partner with 'all stakeholders'. Five of the government documents give specific examples of partnerships outside the mental health sector. The Ontario Program Standards for Assertive Community Treatment Teams (2005) states the importance of working with community partners to create efficient intake procedures. The document also lists the expectation of providing service coordination, which can involve communicating with partners outside the mental health sector. The 2010 Respect, Recovery, Resilience document recognizes the need for multi-system involvement. Specifically the criminal justice, housing, and immigration sectors are identified as possible partners, as well as opportunities for collaboration between communities, long term care facilities, schools, and recreation centres. Navigating the Journey to Wellness (2010) also mentions inter-sector partnerships, aiming to divert appropriate individuals out of the criminal justice system via the involvement of mental health and addictions service providers, and increased education for police. In the 2011 provincial strategy document, Open Minds, Healthy Minds, the education, employment, income, housing, criminal justice, and social services sectors are referenced as opportunities for much needed multi-sector cooperation. Finally, the 2012 Changing Directions, Changing Lives National Strategy document mentions the need to reduce fragmentation, increase integration, and improve collaboration among various sectors (child, adult, youth, senior, developmental, addictions, and neurological) and levels of government (municipal, provincial, and federal).

All four occupational therapy sources list the need for partnerships with those outside of the sector, but do not explicitly identify which sectors. There are indirect statements

around the importance of ‘communicating and collaborating with all stakeholders’. The term ‘all stakeholders’ is interpreted to include potential individuals, groups, and organizations outside the mental health sector. Due to the vagueness of the frequent citing of ‘all stakeholders’, many of the comments captured in the ‘family, co-worker and inside the sector partnerships’ sections are also captured within this category.

3.6 ADVOCACY & CHANGING ATTITUDES

This theme contains statements about the role and responsibility that community mental health team members have to include advocacy within their daily practice. Advocacy includes targeting the general public to benefit clients, targeting the system (mental health and beyond) to benefit clients, and advocating for the specific profession of occupational therapy with individuals, groups, and systems.

3.6.1 Target the General Public for the Benefit of the Client and the General Public

Five of the seven government documents are represented in this section (Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Open Minds, Healthy Minds, 2011; Changing Directions, Changing Lives, 2012). Statements relate to the role that community mental health team members should play in raising public awareness around mental health and mental illness, hoping to reduce stigma and discrimination, and increasing early identification of mental illness. The level of detail given to this theme varied across the documents: two

government documents make vague references to changing attitudes, and reducing stigma (Every Door is the Right Door, 2009; and Changing Directions, Changing Lives, 2012), while the other three documents gave tangible examples of how community mental health service providers can fulfill this responsibility (Toward Recovery & Well-Being, 2009; Respect, Recovery, Resilience, 2010; and Open Minds, Healthy Minds, 2011). Using respectful language, talking about mental illness with others, questioning inaccurate portrayals, participating in creating a supportive atmosphere, engaging in anti-stigma training, and leading by example are a few of the suggestions noted. This how to approach was somewhat unexpected, given that the documents are largely strategic in nature, rather than implementation-based.

Overall, objectives regarding public awareness and attitudes seek to reduce social injustices, and create supportive communities. The documents imply that by having a more informed and knowledgeable public, attitudes will also shift, resulting in those living with mental illness experiencing less injustice, and becoming more involved in community life. These recommendations were interpreted as being connected to the idea that if stigma and discrimination are reduced or eliminated, clients can participate more fully in community life, gaining better quality of life, and reducing the need for overall system supports in the long term. This theme focused on prevention, early identification, and treatment, in addition to quality of life and economic benefits.

The sole occupational therapy source that mentions this topic is the Profile of Occupational Therapy Practice in Canada (2012). It briefly outlines the role occupational

therapists have in educating others, raising awareness of diversity, and generally advocating within and outside of the health care system.

3.6.2 Target the System for the Benefit of the Client & the General Public

Five of the seven government documents mention the need to direct advocacy efforts within the mental health system in order to create benefits for clients and the general public (Towards Recovery & Well-Being, 2009; Respect, Recovery & Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012). Examples of ‘targeting the system’ include reducing barriers to engaging in life by making mental health a priority within government, enforcing anti-discrimination legislation and upholding rights, including more mental health and addictions workers within the justice system, eliminating stigma within services, and supporting marginalized populations by creating supportive communities. Throughout the government documents, this topic was well represented and accompanied by many specific descriptions. The statements were in the vein of to do, rather than how to, as the nature of the documents is to report the current state, and point in a future direction or strategy, rather than implementation.

One of the occupational therapy-based documents mentions this topic (Profile of Occupational Therapy Practice in Canada, 2012). The Profile advises occupational therapists to advocate inside and outside of the ‘system’, with populations, communities, and clients in hopes of improving policy, funding management of services

and programs, as well as society in general. Interestingly, the occupational therapy documents are almost silent about this as a role for occupational therapists, yet the government documents, which support the generalist role, makes it clear that this is a responsibility for community mental health team members. This is an area where a clear disconnect between the messages from government versus the profession of occupational therapy is evident.

Also included in this section are additional vague statements (e.g., reduce stigma/discrimination) in that they were not explicitly identifying where efforts should be targeted. The researcher interpreted these as applicable toward the general public, as well as the mental health system.

Advocacy within the system seeks to reduce social injustices inherent in our current mental health system, and to promote attention given to high risk and marginalized populations via programs and services.

3.6.3 Target the Profession of Occupational Therapy

None of the seven government documents mentioned the need for service providers to advocate for the profession of occupational therapy. This is not surprising given that the documents support shared core competencies and a generalist model of service, rather than endorsing specific disciplines.

While it is fitting that occupational therapy-specific documents mentioned the role that occupational therapists have in promoting and advocating for the profession, of note is

that all four documents touched on this point (Report of the Professional Issue Forum on Occupation and Mental Health Care, 2004; Canadian Association of Occupational Therapists Position Statement Occupational Therapy and Mental Health Care, 2008; Essential Competencies of Practice for Occupational Therapists in Canada, 2011; and Profile of Occupational Therapy Practice, 2012). This unified and recurrent message makes it clear that the profession sees occupational therapists having a role well beyond direct patient care. Specifically, the documents speak to the need to clarify the specialist role, and encourage access to programs and services that promote active participation in valued occupations.

Canadian Association of Occupational Therapist's Profile (2012) makes explicit mention of the concept of professional identity and occupational therapists' "privilege and responsibility to promote recognition and accountability of the work of occupational therapists. Occupational therapists are therefore actively encouraged to proclaim and celebrate their professional identity, regardless of practice context". (p. 16). There is a strong push for occupational therapists to identify with their profession, despite their official job titles or practice settings. The Canadian Association of Occupational Therapists document (2012) suggests that despite title or context, occupational therapists can make use of their profession specific knowledge, skills, and abilities throughout their careers.

3.7 COMPETENCIES

This theme presents information about tangible roles and responsibilities of all community mental health service providers. Overall, the statements describe what service providers should do, and what they should know. This theme captures both generalist and specialist roles and responsibilities.

3.7.1 Core Competencies/ Shared Roles

All seven government documents are represented within this topic (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012). Each document dedicated space to discussing the expectations for service providers, as well as providing tangible examples.

Examples of core competencies include: providing service coordination, employing crisis skills, providing counseling, maintaining confidentiality, providing individualized care, working from a recovery based approach, implementing problem solving skills, implementing prevention skills (illness, suicide), applying varied approaches (mainstream and alternative), possessing a range of experiences, and creating balanced life for client. Community mental health team members are expected to address housing, employment, family, independent living skills, social skills, psychological needs via offering support, as well as vocational rehabilitation, and leisure activities.

All occupational therapy documents mention roles and responsibilities including being client centred, advocating for/with clients, being evidence based, and managing one's time effectively and efficiently. Occupational therapy documents are lacking in explicitly stating that these skills are not exclusive to the profession of occupational therapy.

None of the four occupational therapy documents explicitly mention the concept of shared roles. This is not surprising in that occupational therapy documents aim to speak to the specialist role. Given that the mental health system is embracing a generalist, or core competency approach, should occupational therapy sources be expanding their views to **formally** address the generalist role in community mental health teams?

3.7.2 Occupational Therapy Specific Roles

Three of the seven government documents listed the occupational therapy-specific role (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Toward Recovery and Well-Being, 2009; and Respect, Recovery, Resilience, 2010). It was somewhat surprising to find such frequent reference to specialist roles in the government documents. The initial assumption was that government documents would speak to the need for core competencies and generalist roles, whereas occupational therapy documents would heavily encourage and advocate for the specialist occupational therapy role.

The earliest of the government documents, Ontario Program Standards for Assertive Community Treatment Teams (2005), is a program-specific document, outlining a team

that embraces the need for both generalist and specialist roles, and as such it is not surprising that it makes mention of specific occupational therapy roles. The Assertive Community Treatment Team guidelines states that occupational therapists are to: enable occupation in the realms of self-care, productivity and leisure, address physical, mental, social, and spiritual needs, all while emphasizing client meaning, choice, individual purpose, roles and environments. Occupational therapists are expected to provide assessment and intervention in these areas. Of note is that addressing vocational needs of Assertive Community Treatment Team clients is considered a role that can be carried out by either a vocational counsellor or an occupational therapist, reinforcing that many skills possessed by occupational therapists may also be in the tool kit of other members of the community mental health team. This view is mirrored when describing the assessment of activities of daily living, which is listed as being a role for either occupational therapy or nursing.

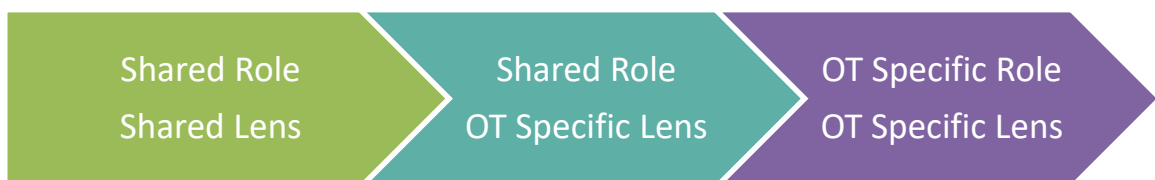
Personally, this is a document that I consulted heavily when beginning my tenure on the Assertive Community Treatment Team. I found the guide to provide a reasonable level of clarity around role expectations and scope of practice. Specifically, it helped me to feel confident in taking on clients' vocational goals within my occupational therapy scope, where no vocational counsellor was present on my team.

The Toward Recovery & Well-Being (2009) document briefly mentions occupational therapy as a necessary specialty on a community mental health team. Specific roles include building upon strengths and reducing barriers. Given that the 2010 document

(Respect, Recovery & Resilience) was largely influenced by the 2009 document (Toward Recovery & Well-Being), it makes sense that this specialist role is yet again noted. While the document does not explicitly elaborate the occupational therapy role, it encourages psychosocial rehabilitation, and other topics that are in line with occupational therapy skills and values (e.g., independent living skills, social skills, vocational rehabilitation, occupational roles/relationships, and functional outcomes). One could argue that some of these topics could also be carried out by other disciplines (generalists), and as such they are also included under ‘core competencies’. While not expressed explicitly, an emerging trend from the documents is one that suggests that occupational therapy principles (or an OT specific lens) are well suited to fulfilling the dual role in community mental health.

The concept of competencies can perhaps best be demonstrated via a visual continuum with shared generic skills at one end, to shared roles being carried out via a specific lens, to profession specific skills at the other end. (See Figure 2).

Figure 2 Competency continuum



Three of the four occupational therapy documents mention the occupational therapy specific role (Profile of Occupational Therapy Practice in Canada, 2012; Canadian

Association of Occupational Therapists Position Statement Occupational Therapy and Mental Health Care, 2008; and Essential Competencies of Practice for Occupational Therapists in Canada, 2011). It is not surprising that many of the occupational therapy documents spoke explicitly of the specialist role. Occupational therapy documents denote roles such as: generating a plan based in occupation, providing holistic care, enabling occupation, considering contexts, incorporating all environments into treatment plans, addressing occupational performance issues, working from a strength-based view, applying theory, goal-setting, developing interventions, documenting, power sharing, adapting to change, and overcoming barriers as roles expected to be carried out by specialists. What is unclear is if these occupational therapy sources consider these competencies to be solely within the occupational therapists' wheelhouse, or if they consider some of these roles to be core competencies, possessed by multiple disciplines.

3.8 EVIDENCE BASED PRACTICE

This theme discusses service providers making use of and contributing to research, in addition to engaging in continual evaluation of outcomes and services. Comments pertain to general community mental health team members and occupational therapists.

Six out of seven government documents are represented within this topic (Toward Recovery and Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; Navigating the Journey to Wellness, 2010; Open Minds, Healthy Minds,

2011; and Changing Directions, Changing Lives, 2012), and the content related to the theme was quite lengthy in each government source. Documents expressed the need for service providers to utilize: best available evidence, best practices, guidelines, and standards (where they exist). The documents encouraged service providers to contribute to conducting and disseminating research, and producing further evidence in order to generate additional best practices, guidelines, and standards (examples of knowledge translation). Measuring outcomes was presented as a responsibility that community mental health team members are expected to meet. Outcome measurement serves to measure client experiences, and hold service providers accountable for the care they provide. Research was viewed as an area for increased client involvement, which is in-line with recovery-oriented practice.

All four occupational therapy-based documents had long sections on evidence-based practice (Report of the Professional Issue Forum on Occupation and Mental Health Care, 2004; Canadian Association of Occupational Therapists Position Statement Occupational Therapy and Mental Health Care, 2008; Essential Competencies of Practice for Occupational Therapists in Canada, 2011; and Profile of Occupational Therapy Practice in Canada, 2012). They provided clear expectations for occupational therapists to provide evidence based care, measure client outcomes, be a lifelong learner, contribute to research and education, and raise the research profile. In occupational therapy documents, measurement included measuring client outcomes, processes, workload, performance, systems costs, quality of life, and self-evaluation. Priority areas for further research included: recovery, occupation, enabling client-centred practice, quality of life,

empowerment, justice, interventions, systems costs, and roles of community and environment in occupational engagement.

All of the documents (government and occupational therapy) lacked details around how service providers can and should be achieving these recommendations. It is unclear if it is expected that service providers contribute to research as a part of their current roles, or if that is expected to be taken on outside of their main employment. Is there support for this type of involvement from a management perspective? Are team members given time to devote to clinical research? In addition, there was no mention of providing open access to existing research databases and journals that often require paid subscriptions. In terms of evidence-based practice, with respect to generation and incorporation, the documents are at the what is desired stage and not yet at the how to achieve it stage.

Personally, I was lucky enough to maintain an affiliation with a University occupational therapy program (serving as a problem-based tutorial leader) which granted me access to online journal databases. As such, I was able to access and incorporate high quality, up to date evidence into my daily practice. This access is limited for those not affiliated with a health authority or university.

3.9 PROFESSIONALISM & ADMINISTRATION

This theme presents the roles and responsibilities of community mental health team members that happen ‘behind the scenes’ to help maintain a professional practice that impacts both clinical and non-clinical duties. Some statements are specific to the

expectations placed on occupational therapists. Five of the seven government documents are represented within this topic (Ontario Program Standards for Assertive Community Treatment Teams, 2005; Toward Recovery & Well-Being, 2009; Every Door is the Right Door, 2009; Respect, Recovery, Resilience, 2010; and Open Minds, Healthy Minds, 2011).

There is brief mention in government documents concerning service providers reflecting upon their values and attitudes and ensuring a respectful and culturally competent, stigma-free working relationship. The documents lack details about how this can or should be achieved, and leave out what is specifically the responsibility of the individual, versus the responsibility of the team, versus the larger system in relation to generating and maintaining a respectful and open atmosphere. Service providers are expected to be accountable for their actions, provide timely and equitable service, and have clear understanding of others' capacities, roles, and responsibilities. Much like the previous point, the 'how to' aspect of carrying out these expectations is lacking. Documents leave it unclear if it is the responsibility of the team member (e.g., occupational therapist) to educate their fellow team members (e.g., nurse, social worker, vocational counsellor, addictions counsellor, etcetera), to ensure that their role is understood (e.g., occupational therapists educating team about occupational therapy role). By contrast, is it the responsibility of each individual team member (e.g., occupational therapist) to ensure understanding of colleagues' roles (e.g., occupational therapist is responsible to seek out information and ensure understanding other team members' roles).

Additionally, if role definition is provided, where should it come from? Overarching

documents are not program-specific, however they do convey a consistent message.

Alternatively, if role definition came from the individual service provider's understanding and interpretation of their role, it may include more details, however would vary from program to program. Overall, the questions generated from this topic indicate that the documents are at the what is desired stage and have not yet made it to the how to achieve it stage.

Two of the four occupational therapy documents detailed the expectation for professionalism and administration (Essential Competencies of Practice for Occupational Therapists in Canada, 2011; Profile of Occupational Therapy Practice in Canada, 2012). This is not surprising, given that occupational therapy is a regulated profession, and the title for this theme came from language used in occupational therapy sources.

Occupational therapists are expected to demonstrate effective communication skills, practice ethical care, have insight into personal values and limits, be autonomous, comply with all legal requirements, keep their knowledge up to date, conduct themselves with integrity, understand roles and responsibilities within the team, deliver timely and resource efficient care, complete documentation, and generally actively manage their practices. Canadian Association of Occupational Therapists' Profile (2012) made explicit mention of the concept of professional identity and occupational therapists' "privilege and responsibility to promote recognition and accountability of the work of occupational therapists. Occupational therapists are therefore actively encouraged to proclaim and celebrate their professional identity, regardless of practice

context” (p. 16). There is a strong position within the occupational therapy documents to identify with their profession despite their official job title or practice setting.

Canadian Association of Occupational Therapists (2012) suggests that despite title or context, occupational therapists can make use of their specific knowledge, skills and abilities throughout their career. Overall, the government and occupational therapy documents share an emphasis on accountability, self-reflection, provision of timely and effective care, understanding the roles/responsibilities of others, and conducting oneself in a respectful manner.

3.10 ROLE ON PAPER SUMMARY

The documents reviewed represented many different stakeholders’ assessment of the state of community mental health within Ontario, as well as a general desires for future directions. While the documents may originate from different stakeholders and have varying intentions and intended audiences (see table 4), it is interesting and promising to note that there were many shared messages across the sources. The following chapter will examine the role of occupational therapy on community mental health teams from yet another perspective: that of practicing clinicians.

CHAPTER 4 THE ROLE IN PRACTICE

4.1 INTRODUCTION

Occupational therapists working on community mental health teams were interviewed about their roles on teams, and the documents they consult in their unique dual role of case manager generalist and occupational therapist specialist. Occupational therapists described both the positive and negative aspects of their roles within community mental health teams. This phase of the project sought to answer the following two questions:

4. How do occupational therapists working in community mental health care **understand** and interpret their role? (e.g., how is the role perceived?)
5. What governing texts do occupational therapists working in community mental health care report using to **understand** their role? (e.g., Job descriptions, mission, vision, value statements, position statements, guidelines/standards for practice, strategic reports, and policy documents)

After interviewing seven occupational therapists working on various community mental health teams in the southern Ontario region, a total of seven contradictory practice themes emerged: 1) wide scope versus narrow scope; 2) everything I do is OT versus nothing I do is OT; 3) we're the same, but different; 4) best job versus burnt out; 5) all alone in a crowd; 6) the tools are lacking & I like it that way; and 7) I do it all versus it's all teamwork. The opposing viewpoints existed not only between therapists, but many times both ends of a spectrum were expressed by individual therapists in relation to

their unique roles on their teams. In addition to these opposing themes, three additional themes emerged from the interviews: 1) what influences my OT role; 2) the 'it' factor; 3) recovery, psychosocial rehabilitation, & occupational therapy principles. Refer to Table 6 to see where phase two rests in the overall research project design.

Table 6 Summary of phases- phase two

Phase	Objective	Methodology
1	Establish role on paper	Document review using content analysis of governing documents
2	Establish role in practice	Semi-structured interviews with occupational therapists on community mental health teams
3	Compare role on paper to role in practice	Analysis of data collected from phases 1 & 2

4.2 WIDE SCOPE VERSUS NARROW SCOPE

The first contradictory theme relates to the participants' perceived scope of practice undertaken on a regular basis. The following section will explore the occupational therapists' reported scope of practice which ranged from extremely wide to incredibly narrow. Perceptions around occupational therapy-specific roles led to discussions around job satisfaction.

At one end of the spectrum are occupational therapists describing their scope of practice as being extremely wide, essentially encompassing anything and everything a

client may need, want, or have to work toward. Claire explained that she understands occupational therapy as “a health profession that empowers people of all ages to overcome barriers in their everyday lives so that they can do more and live better.” As a result of her definition, she feels that occupational therapists have “no limits that we can put on how to help somebody achieve what it is that they’re looking to achieve.” Claire very clearly subscribes to the ‘everything is occupational therapy’ end of the occupational therapy scope spectrum.

Peggy expresses a similar sentiment, “So our title here is case manager. My professional background is as an occupational therapist, so I think I’m a case manager through the lens of the models of occupational therapy.” In this manner, Peggy introduces the concept of an occupational therapy lens, indicating tasks that appear generalist on the surface are always filtered through her occupational therapy foundations. The introduction of the occupational therapy lens indicates that while two case managers may be asked to complete the same task, the occupational therapist would execute it in a unique manner as compared to a case manager with a differing educational background (e.g., nursing, social work).

In reflecting back on my time working on a community mental health team, I can see how, over the course of my two year tenure, I slowly adopted the same mindset as Peggy. As my confidence and skill grew, so did my ability to frame the majority of tasks through an occupational therapy lens, thus allowing for a stronger sense of personal affirmation ‘Yes, the work I am doing is occupational therapy-based’.

When asked to name the occupational therapy specialist aspects of their roles, the therapists unanimously indicated activities of daily living and instrumental activities of daily living as occupational therapy-specific domains. They listed occupations such as hygiene, cleaning, cooking, shopping, budgeting, and mobility. Additionally, many participants felt that helping clients in academic, employment, and leisure pursuits were within the occupational therapy scope of practice.

Participants consistently described themselves as being competent in areas they associated with other professions. They frequently spoke of putting on their different 'hats' and then addressing their clients' wide ranging needs. For example, Barbara describes doing "social worky type of things like applying to [Ontario Disability Support Program], going to banks, working on housing...", Barbara reported completing these tasks frequently, feeling competent in her ability to complete them, and did not categorize them as being occupational therapy-specific tasks. Similarly, Martha describes putting on her "addictions worker hat and talk about their substance use... and I'll put on my nursing hat and we'll have a conversation about the importance of medications, or side effects from their medications."

Some occupational therapists expressed having clear overlap with other professions such as vocational counsellors and recreation therapists: "we have a vocational specialist, but that's also a role that [an occupational therapist] can do with helping clients you know update their resume and cover letter and apply for jobs" (Taylor).

When these specialists were not available on the community mental health team, occupational therapists described having a wider scope encompassing these domains.

This was my clinical experience, too, as my team did not have a vocational counsellor; I frequently assisted clients in achieving their productivity-related goals and felt qualified to do so as an entry level new graduate.

On teams that had vocational or recreation specialists, occupational therapists described having the ability to narrow their focus to reduce overlap and potential duplication of service. Barbara explains that her community mental health team has a “vocational counsellor as well as rec therapist, so when looking at the whole person I don’t have to look at the leisure or productivity parts so much”, suggesting that she focuses most of her occupational therapy specific efforts towards areas of self-care. Claire works on a team with a similar makeup and describes making use of an internal referral process for “substantial recreation programs and vocational, we use for more specific goals of gaining employment.”

To summarize, participants differed in how wide or narrow they felt their occupational therapy scope was, although on the whole they agreed that occupational therapists largely help clients in the domains of activities of daily living and instrumental activities of daily living. Areas where occupational therapists identify potential overlap in roles were most commonly with vocational counsellors and recreation therapists. In particular, the makeup of the team significantly impacts how much or little effort the occupational therapist puts toward vocational and recreational client goals. The next

section will explore in more detail how much (or little) the participants felt they were completing occupational therapy tasks within their daily work.

4.3 EVERYTHING I DO IS OCCUPATIONAL THERAPY VERSUS NOTHING I DO IS OCCUPATIONAL THERAPY

Another spectrum was observed in occupational therapists' perceptions about the amount of occupational therapy work they perform day-to-day. At one end of the spectrum are occupational therapists who felt that the majority of their work could be considered occupational therapy, as they adopted an occupational therapy lens to the completion of all their tasks. At the other end are occupational therapists who feel that only a small portion of their day is spent attending to occupational therapy-specific work. Of particular interest is that while many participants described completing the same tasks, it was the occupational therapist's personal outlooks that decided whether or not a task was interpreted as generic or occupational therapy-specific.

Positioned at one end of the spectrum are occupational therapists like Claire, who when asked "what do you see specifically as occupational therapy in your role?" responded saying "I will pretty much say everything I do... because I get to help the whole person... assist them with their actual day-to-day living." Similarly, Peggy acknowledges that although a major part of her role is to serve as a case manager for her clients, she casts a profession-specific light on all her duties "I think I'm a case manager through the lens of the models of occupational therapy."

In reflecting back on my time working on a community mental health team, I can see how over the course of my two year tenure, I slowly adopted this same mindset as Peggy and Claire. As an example of how my personal occupational therapy lens was applied to daily practice, in conducting more mundane day-to-day activities with clients, I aimed to adopt a 'building block' approach to tasks I would complete. For instance, in completing a medication drop-off and observation I might use the opportunity to help develop a daily schedule and routine with the client (if appropriate). Clients would learn to be awake, washed, and dressed prior to the morning medication drop off. Drop-offs could also include a short walk together, to introduce physical activity, social skills via light conversation, and a foray into the community.

At the other end of the spectrum are occupational therapists who feel very little of their day-to-day work would be considered as occupational therapy services. Most commonly these participants also expressed a desire to "have more time just dedicated to working on occupational therapy-specific goals with clients" (Martha) and a sense of losing their occupational therapy role at times, as a result of the lack of occupational therapy-specific work. Specifically, participants identified tasks they felt were not occupational therapy by outlining how they fit more appropriately under another profession. For instance, Barbara explained that "doing a housing search and attending the viewing and setting it all up... I don't think is something that's necessarily my area."

Positioned in the centre of the spectrum are those occupational therapists who expressed both sentiments at the same time when describing the presence or lack

thereof of occupational therapy in their daily roles. Lynn described her outlook on the service she provides to clients on a daily basis:

[Occupational therapy] specific is few and far between [if we] say physical health [occupational therapy], or mental health [occupational therapy]... in those specific definitions, then no, I would say I'm not doing a lot of [occupational therapy] stuff with most of my clients. But then, we're looking at a person's occupation, so everything is [occupational therapy] {laughs}, right? So when you look at it that way, how can they function in their home if they're hoarding? How can they be safe, how can I prevent the falls, how can I support them in getting a mobility aid or other household safety equipment unless we address the hoarding first? How can I focus on the [occupational therapy] piece- the physical health, or the mental health [occupational therapy] piece unless we're looking at their financial piece?

Taylor also expressed this dichotomy of outlooks in describing her role on a community mental health team. At one point in her interview, Taylor expressed "ideally I'd be doing waaaaay more [occupational therapy] stuff." While at another point, she explains that "[Occupational therapy] is very holistic... it's really easy to adapt to any role and make [occupational therapy] work because almost anything you do can somehow relate back to occupational therapy."

The opinions expressed by the occupational therapists attest to how much impact one's perception has on how one views the role within a community mental health team.

While many participants described a shared experience of conducting tasks such as

medication observations, client transportation, and accompanying clients on appointments, individual occupational therapists apply their unique lens which determines whether they view this as exercising their occupational therapy skills or not. Undoubtedly this is an area requiring clarity, as a full spectrum of perceptions was exhibited by the participant group, showing a lack of unity on the issue.

4.4 WE'RE THE SAME, BUT DIFFERENT

All of the occupational therapists reported teams in which some members are a part of a regulated profession (e.g., occupational therapy, social work, nursing) and some team members are not (e.g., vocational counselling, recreational therapy, social service work, peer counselling). Many participants describe a landscape that, despite differing educational backgrounds, team members hold a shared job title, most commonly referred to as case manager or prime worker. While on the surface team members seem to have the same duties and responsibilities, occupational therapists working on community mental health teams describe an alternate reality including daily differences between regulated and non-regulated team members, often contributing to tensions between the two groups.

Despite having a shared job title and being held accountable to the same set of employer job expectations (see table 7 summary of job descriptions), the difference in professional backgrounds influences daily practice significantly. Martha describes: “those of us who are registered are very aware that we are registered and that we are held to a higher standard.” Participants note that regulated professionals adhere to

more standards and restrictions surrounding documentation, assessing risk, assuming liability, mandatory reporting, engaging in critical thinking, and providing an overall high level of care. Specifically, in relation to documentation, Barbara explains that “it’s not enough for me to say ‘I’m only going to document the important things, if nothing happened then I’m not going to document it’. My College won’t let me do that, whereas other people have the option of being less thorough.” While being a registered occupational therapist comes with a number of duties one must complete, regulation also places certain limitations around clinical practice. Taylor outlines her understanding of what it means to be a registered occupational therapist. “I have standards of practice, so I have things that are expected of me, things that you can and can’t do.” Nova explains how being a regulated professional led her to decline to transport clients in her personal vehicle: “you need to have the insurance, and second of all there’s a lot of boundaries that it could potentially cross. You as a worker, you as a friend, there’s a safety piece. Because reading all the [College of Occupational Therapists of Ontario’s Essential Competencies of Practice for Occupational Therapists in Canada] and everything, I choose not to, all the unregulated colleagues they’re OK to drive them around, I don’t know if there’s anything there for them that guides them in terms of thinking like that.”

Presently, job titles project a perception of shared roles, while digging deeper reveals key differences that contribute to tensions between regulated and nonregulated team members. Regulated occupational therapists are expected to be lifelong learners and contribute back to the profession. This can include serving as a preceptor for student

occupational therapists, participating in on-site lecturing of student occupational therapists at a local university, and serving as an evaluator for student assessments. These commitments mean time away from front line work and can sometimes come with stipends. Tensions also existed around salary, as generally speaking the regulated professionals received a higher pay rate compared to their non-regulated colleagues. Given that many team members shared common titles such as case manager, non-regulated members had difficulty understanding and appreciating the discrepancy in pay as they view all team members fulfilling the same job role. Claire explains, “Rec and voc don’t make as much as [occupational therapy], nursing and social work... they don’t quite understand the difference and why they shouldn’t be paid the same.”

When probed about their habits around collaboration and consultation, participants frequently came to the same realization when exploring this topic. Many occupational therapists recognized that when they are in need of advice or wanting to talk through an issue, they seek out other regulated professionals on their team, most commonly other occupational therapists, nurses and social workers. Peggy shared that “when I struggle or get stuck, or need to process a difficult session for whatever reason I definitely go to my colleagues. The colleagues I predominantly go to are [occupational therapists], but there’s a nurse that I think has similar models and approach with clients.” Occupational therapists felt that non-regulated team members often practised from different models and approaches, and did not always understanding the need to evaluate risk and liability in complicated situations. Claire explains:

When I see staff that aren't in a regulated profession- they're held accountable to hospital expectations but they don't necessarily think of any legal involvement, any- not always about the risk that's involved with certain situations. They're not worried about how their actions are affecting somebody else and it makes me nervous.

While I also sought out nurses and social workers on my team most often, I felt I did so due to their welcoming nature and their ample experience, knowledge, and skill working in the community mental health setting. In hindsight, perhaps this is the reason I went to them initially, but the shared background of being a regulated professional may have strongly contributed to why I returned to them for ongoing support and advice.

All four of the occupational therapists who had been in their role for roughly five years or less reported that this difference in regulation does not create tension on the team. In discussing how regulated and non-regulated team members approach client care, Taylor (less than one year on the team) explains that "so far there hasn't been, there hasn't been any conflict."

This was also my personal experience, as I was a member of my team for just over two years and did not feel notable tensions among co-workers.

In contrast, all three occupational therapists having been in their roles for five or more years reported the regulatory status being a source of tension on the team. Peggy (more than ten years on the team) describes a situation related to serving as a preceptor to a student occupational therapist:

There's been tension in the team around us all being treated as case managers, but yet there are differences because we all have different disciplines and there's different opportunities for different disciplines. One of them being the preceptor stipend and being a part of a union it was perceived that that was not fair and equitable, so we were no longer allowed to claim for the preceptor stipend. So I think there's a misunderstanding I think and a lack of respect to us being different.

Overall, tensions relate to non-regulated team members not understanding and/or appreciating the demands and responsibilities placed upon occupational therapists by the regulatory College that impact their documentation standards (increased frequency), decision-making (regard for risk, liability, professional boundaries with clients) and encouragement to give back to the profession (serving as clinical preceptor, lecturer, assessor). The split between the perceptions of newer versus more experienced occupational therapists suggests that tensions between team members develop over time. As a newer team member, colleagues could be withholding full disclosure or in a 'honeymoon' phase. Tensions could also be small infrequent occurrences that do not register on daily radar but mount to a detectable level over time.

4.5 BEST JOB VERSUS BURNT OUT

Everyone has aspects of their jobs that they enjoy more than others, and occupational therapists on community mental health teams are no exception. However, what may be exceptional is the expansive spectrum experienced by the occupational therapists.

Variety and challenge are among the most appreciated aspects described by the participants, with an acknowledgment that those same aspects often bring the biggest frustrations as well. To manage daily stressors, occupational therapists on community health teams use laughter and frequent self-reflection to keep goals manageable, while looking for client gains, no matter how small.

Unanimously, occupational therapists reported enjoying the variety in their day-to-day work, remarking that “no two days are the same” (Barbara). Knowing that each day will present with different challenges is something participants valued, Barbara expressed that “it’s challenging, but I think that’s what I like about it.” Claire shared in the same sentiment: “sometimes it’s stressful and satisfying and sometimes it’s frustrating.”

Occupational therapists have great pride in their work, and the goals achieved in partnership with their clients. Taylor summed it up as “most of the time I take pride in it. I love what I do and I love my job and I feel very proud to be doing what I’m doing.”

Participants recognized that not everyone has the skills and abilities to meet the demands of the community mental health team occupational therapist role, that the day-to-day work is significantly different from that of the more common and traditional physical health occupational therapy role in a hospital or clinic setting. Challenges faced on a daily basis range from being pulled in many directions (e.g., e-mails, transportation, application forms, medication observations, occupational therapy specific goals, documentation, team meetings), to endless client needs (e.g., recurrent issues, time sensitive emergency issues, many facets of clients lives), while covering large geographic

areas (e.g., travel between multiple cities), and forming and maintaining supportive relationships with community partners (e.g., housing, co-morbidity organizations, government offices, non-government organizations).

In managing daily stressors, occupational therapists use laughter as a coping mechanism. During the interviews, participants frequently expressed their daily frustrations, immediately followed by a laugh. Peggy demonstrates this while talking about the trying aspects of her position: “I think one of the challenges of long term case management is just maintaining that empathy, maintaining that sensitivity, when you feel like ‘gosh, this is so familiar, we’ve done this too many times’ *{laughs}*.”

Once recognizing this trend among the participants, I became almost certain that I engaged in similar behaviour while working for the Assertive Community Treatment Team. This caused me to think that perhaps many community mental health team occupational therapists share this trait, but that it is largely unconscious in nature.

Another strategy occupational therapists implement to manage their workplace stress is reminding themselves to re-evaluate their potentially unrealistic expectations, and to firmly root their expectations with achievability in mind, given their personal and professional resources, as well as the skills, abilities, and resources of their clients. Re-evaluating expectations was often manifested as acknowledging that there are things that occupational therapists cannot change, and lowering expectations from ideal to realistically achievable (e.g., perfectly balanced meals each day vs. three meals each day).

While participants rhymed off their long lists of daily frustrations, stressors, and sacrifices they make to fulfill their role, they express their pride, enjoyment, and satisfaction with their role. Martha shared this example:

I've taught several clients how to actually clean a toilet. Which is kind of gross, but it makes me really happy that's actually part of my job, and those days just kind of make me happy cause I feel like I'm doing an OT thing, I'm teaching them a life skill.

In relation to completing many generalist duties on a daily basis, Barbara expressed her frustrations:

"I feel like a taxi service some days. I would much rather have the opportunity to be more [occupational therapy] specific. I have ideas for people, and I voice those but then they get put on the backburner because something else comes up."

Later in her interview, she went on to say "It's challenging, but I think that's what I like about it. No two days are the same {laughs}."

This feeling of deriving enjoyment, despite ongoing tiresome daily encounters was demonstrated by multiple participants. Achievements in the face of daily challenges are worn as a badge of honour.

Most participants acknowledged great enjoyment in developing long term relationships with clients, specifically juxtaposing it against more common short term involvements

that occupational therapists working in traditional settings experience. Given the nature of severe and persistent mental illness, and the tendency for recovery to ebb and flow in a non-linear fashion, it is not surprising that occupational therapists value the long term relationships many community mental health teams foster. Progress can be slow and minute at times, while goals can be substantial (e.g., independent living), and require the attainment of multiple smaller goals (e.g., money management, grocery shopping, cooking, cleaning, hygiene, etc.). Detecting growth can be difficult to appreciate without having the ability to reflect over an extended period of time. Martha has come to not only recognize this phenomenon, but appreciate how the service delivery model supports this type of relationship:

...the best part about the [service] is that our clients are with us long term. Now that I've been here for several years it's really, really nice to look back and reflect with a client and be like 'do you remember when I started and you were, you were on probation, you didn't have stable housing and you were in and out of hospital? Have you noticed that since you've been taking your injection and you've been taking your medications, you've been off probation, you've had no conflict with the law. You've been at your apartment for a year now, you're doing really good and I'm really proud of you.' That is the best part of my job, building those relationships with clients.

While many jobs have positive and negative aspects, participants paint a picture that working as an occupational therapist on a community mental health team delivers the

full spectrum of experiences on a regular basis. To sum it up, occupational therapists report they have a tough job, and they wouldn't have it any other way.

4.6 ALL ALONE IN A CROWD

Despite being surrounded by a number of team members on a daily basis, being an occupational therapist on a community mental health team can feel lonesome at times, especially when the community mental health team has only one occupational therapist on staff. Overall, occupational therapists on community mental health teams felt that formal supports from occupational therapy associations were lacking. All of the participants discussed how they seek out opportunities to connect with other occupational therapists and aim to find occupational therapists that have similar community mental health team experiences. Supportive connections are also sought out from other members of the team with a similar outlook on practice (see section 4.4). Finally, with a lack of formal and specialized supports, occupational therapists on community mental health teams have to adapt generalized resources to their unique practice areas.

4.6.1 Forming My Own Support Network

Being the only occupational therapist on the team caused participants to describe an atmosphere of being alone in a crowd. Barbara referred to this as being “the lone wolf”, while Martha stated that being the sole occupational therapist made her “feel quite isolated”. Occupational therapists on community mental health teams are aware that in

many other settings, occupational therapists have other occupational therapists readily available with whom to consult and are envious of that daily informal support. Some of the ways participants try to remedy the isolation is by serving as a student preceptor, seeking out the limited formal offerings made by professional associations, and forming their own support networks through sites such as LinkedIn TM, over electronic mail, and networking at professional events.

In my personal journey, I was the sole occupational therapist on my team, as well as the sole occupational therapist within an organization of over 100 people. As a result, I did not have much contact with other mental health occupational therapists. Staying connected to the local university-based occupational therapy program via tutoring, touching base with the in-patient occupational therapists at the local hospital, and attending the Assertive Community Treatment Team Conference were some of the ways that I tried to combat my own 'lone wolf' feeling. In completing the interviews with the participants, I found myself frequently nodding in agreement, finding shared experiences, and reminiscing about my own time working in community mental health. I cannot help but think of the value finding such a network of similarly suited individuals would have served during my tenure working on the Assertive Community Treatment Team.

4.6.2 The Lack of Formal Supports from Occupational Therapy

Organizations

When asked specifically about the formal supports offered by professional associations such as the Ontario Society of Occupational Therapists and the Canadian Association of Occupational Therapists, the participants remarked that while these organizations regularly offer education sessions and resources, "... there's nothing specific to community mental health." (Barbara). Although few and far between, the participants seek out and take advantage of opportunities when possible. Occupational therapists keep abreast of educational offerings and note that while there have been meetings such as a Mental Health Forum in the past, "...there needs to be more regular opportunities for new learning." (Claire). Lynn shared that she had discovered and joined a newly formed mental health interest group via the Ontario Society of Occupational Therapists with the hopes of using it as a forum for discussing concerns in the region.

While formal supports and networks to connect community mental health occupational therapists are lacking, there is no shortage of grassroots linkages being made. Most occupational therapists described needing to reach outside their team to find a fellow occupational therapist with community mental health experience. The participants formed and maintained connections with past classmates, colleagues from earlier positions, and occupational therapists they met at conferences and education sessions. Discussing client and team concerns, bouncing ideas off one another, and comparing

strategies are some of the topics occupational therapists wish to discuss with others working on community mental health teams.

As described above, community mental health-specific resources are few and far between, however that has not stopped the participants from attending educational opportunities when possible such as conferences, webinars, agency meetings or training sessions. Meagan describes her approach: “I went to the [mental health conference] just a few months ago and out of all of the- I mean again [occupational therapy] is really holistic, you can relate us to a lot of the different workshops that were offered, but there wasn’t one that was directly associated with being an [occupational therapist]. Leaves you a little questioning everything...” Attending these more generic educational events requires the participants to regularly engage in identifying, converting, and applying the information to their specific practice setting. This pattern encourages creative thinking and pushes occupational therapists on community mental health teams to find the key messages in materials in order to come out with useful new tools for their practice.

While occupational therapists are making efforts to generate and maintain their own networks of like-minded individuals, there is plenty of room for professional organizations to step in and formally address this issue via a streamlined process of developing and maintaining relationships, to enable the sharing of knowledge and experience within community mental health.

4.7 TOOLS & DOCUMENTS ARE LACKING & I LIKE IT THAT WAY

Two ends of a spectrum were also represented when participants were asked about their feelings towards available formal assessment tools and written guidance around the role of occupational therapy in community mental health.

4.7.1 I Don't Need Standardized Tools to Complete an Effective Assessment

While participants were in agreement that there is a general lack of standardized assessment tools for occupational therapy in community mental health, they have made peace with this reality, and demonstrate confidence in their abilities to draw upon a combination of formal and informal sources of information for assessment and treatment planning purposes.

All participants commented on the lack of assessment tools for independent living, as Barbara explains “There’s nothing ideal for the community, there’s not many tools that are ideal for mental health”. In order to assess a client’s independent living skills and make recommendations to the client and team around living situations, occupational therapists rely on gathering information from multiple sources. The most commonly used formal tool is the Independent Living Scales. Participants noted the limitations of the tool (e.g., outdated, heavily American, cultural bias, cognitive and language requirements) and reported using the tool in both standardized and, more commonly a non-standardized fashion. In addition to the Independent Living Scales, therapists also engaged in loosely structured instrumental activities of daily living observational

assessments (e.g., grocery shopping, cooking), interviewed the client on their perceived skills and challenges, spoke with the case manager in regard to observed client skills, challenges, and insight as well as reviewing client history. By engaging in this multi-faceted assessment process participants expressed confidence in their ability to accurately ascertain present skill levels in order to make recommendations around clients' living situations. Claire describes her individual assessment protocol: "Currently I use the [Independent Living Scales], a grocery shopping trip, a cooking kitchen assessment. The grocery shopping looks at budgeting as well. I have a basic household questionnaire that's not really standardized." Peggy has a similar process, "I'll use a combination of standardized assessments, I interview the case manager... a chart review... interview the client... a lot of hypothetical questions... I do observational assessments in the kitchen and the grocery store..."

The 'homemade' protocols that the participants described were almost identical to my own. It was interesting and comforting to see that while there is no standardized battery of assessments for independent living, individual occupational therapists are following the same general path in relation to independent living assessment.

Community mental health occupational therapists acknowledged the lack of comprehensive, standardized independent living assessment tools, but there was no consistent message expressing a dire need for the creation of a new tool, or to update existing tools. Participants remain confident in their abilities to assess independent living skills in the current landscape of assessment tools. Perhaps this highlights the

importance of making use of clinical judgement skills, and the need to draw upon multiple data sources to generate holistic assessment protocols.

4.7.2 No Role Documents from Regulatory Bodies means I am Free to Shape My Role Myself

Similarly, participants were largely unable to list written documents from professional occupational therapy organizations that provide clear direction surrounding the role of occupational therapy in community mental health. While the gap in guidelines was acknowledged, participants also recognized that this enables them to practice from a wide scope with ample freedom and variety built into their roles.

When asked “How do you know what an occupational therapist working on a community mental health team is supposed to be doing?” many of the participants were stopped in silence for a few seconds before responding. Participants stated that they are driven by client goals, and have learned their role largely via clinical student placements and previous job experiences in similar roles. A couple of participants referred back to their occupational therapy schooling: “I had a mental health class and a portion of it was community mental health... my group’s class too. I pull a lot on both of those.” (Taylor).

None of the participants made mention of written documents from professional organizations unprompted, however when prompted, occupational therapists reported that their practice is influenced by Essential Competencies of Occupational Therapists in Canada (ACOTRO, 2011), legislation such as the Personal Health Information and Protection Act (Ontario Government, S.O. 2004, c 3 Sch A; 2004), the Mental Health Act

(Ontario Government, R.S.O, c.M.7, 1990) and Substitute Decision Act (S.O c. 30, 1992) and a handful of occupational therapy textbooks (e.g., Enabling Occupation, Pedretti's). Participants were unable to confidently cite a written source that lays out the role of occupational therapy in community mental health clearly and concisely. Only Taylor was able to name the Ontario Program Standards for Assertive Community Treatment Teams (Ministry of Health & Long Term Care, 2005) as a helpful resource in that respect.

Like Taylor, I consulted the same document to guide my practice and found it particularly helpful in outlining the service delivery model, with general mention and recognition of the occupational therapy role. It served to confirm some of the thoughts around the occupational therapy role and further detail my responsibilities as a case manager or prime worker.

None of the participants referred to their individual job descriptions as a source of role guidance during their interviews. At the end of their individual interviews, participants were asked to provide the researcher with a copy of their job description if they felt comfortable doing so. No job descriptions were obtained via this request. Through a post-hoc search, two community mental health job descriptions were generated, one representing a dual role on an Assertive Community Treatment team, and one representing a case manager position for a community based multidisciplinary mental health team. See table XXX for themes identified within the job descriptions. Of interest is that despite not listing job descriptions as a source of guidance around job roles, both paper and practice themes were evident within the documents.

Table 7 Summary of job descriptions

Job Description	Paper Themes	Practice Themes	New Themes
Assertive Community Treatment Team: Dual Role (urban)	Recovery-based care (client partnerships, community-based) Collaboration for individualized care (team, outside team) Advocacy (target general public, system) Competencies (core competencies) Evidence-based practice (research, program development) Professionalism & Administration (communication, organization)	Consultation/Collaboration Preceptorship Wide Scope (Psychiatric/ physical needs, crisis, develop/implement treatment plans) Recovery-based/ Psychosocial rehabilitation principles	Ethno-specific services (additional language spoken & cultural knowledge in a targeted community)
Community-based Mental Health Team: Case Manager (urban)	Recovery-based care (client partnerships) Collaboration for individualized care (team, outside team) Advocacy (general) Evidence-based practice (program evaluation) Professionalism & Administration (communication, organization, documentation, stats, responsible, accountable, ethical, legal)	Consultation/Collaboration Preceptorship Wide Scope (comprehensive client plans, develop/implement/monitor/evaluate plans) Recovery-based/ Psychosocial rehabilitation principles	Use of specific standardized tools/ approaches (OCAN, AMPS, CBT, DBT, MI) Driver Additional language preferred

Despite the perceived lack of formal written documents outlining this unique practice area, participants were largely content with this lack of formal guidance, Martha explains that she doesn't think "that a document needs to exist. I think the wonderful

thing about [occupational therapy] in multidisciplinary teams is that we can kind of do anything... we're not boxed in..."

While participants are not consciously expressing a desire for formal written guidance from their professional organizations, the widely held response of being 'stumped' when asked "How do you know what an occupational therapist working on a community mental health team is supposed to be doing?" and the variation of responses suggests such guidance could bring unity and consistency within this practice setting.

4.8 I DO IT ALL VERSUS IT'S ALL TEAMWORK

Another spectrum was discovered around how client needs are met. Perspectives ranged from participants asserting that they manage almost all client needs independently, while teamwork, both inside and outside the community mental health team, was stressed by others. Participants spoke about involving other professionals via a consultative or collaborative approach depending upon the client's goal and the individual occupational therapist's skill level.

Most of the participants reported personally delivering the majority of their clients' services, as Martha puts it "the expectation is that I'm their primary worker and whatever goals they're working on, I'm the one helping with that." When participants are unable to meet particular client needs directly they reach out to others as deemed appropriate. All participants report making referrals to outside agencies on behalf of

their clients (e.g., housing agencies, agencies providing services for co-morbidities) for needs that cannot be met via the community mental health team.

When clients have needs that can be met by other team members, the participants vary in their approach. Two distinct approaches were identified: consultation and collaboration.

4.8.1 Consultation

Consultation is defined as team members with differing educational backgrounds sharing resources and providing advice, while the primary worker delivers the care.

Most participants report consulting with team members with different backgrounds (e.g., social work, nursing, addictions) and gaining ideas and strategies to then implement with their clients directly. For example, Lynn describes consulting with the social services worker on her team to aid in navigating the Ontario Works application process: “She’s giving me the resources and telling me try this and I’m going out and doing that. If I hit a road block, then I go back to them ‘hey, this is what I came across... do you have any other ideas?’” Similarly, participants describe situations where other team members ask for an occupational therapy consult, but do not require the occupational therapist to interact directly with the client. Claire provides an example of an occupational therapy consultation on her team: “If I’m just setting up a calendar system with somebody and they don’t necessarily need to refer to us, they can come and get some ideas.”

4.8.2 Collaboration

Collaboration is defined as a secondary team member being brought in to directly address a specific goal that is within their area of specialty. This is in contrast with a collaborative approach, where occupational therapists have other team members conduct assessments and provide intervention directly to their clients. Lynn describes how collaboration works on her team: “The nurse would deal with the nursing piece, the [occupational therapist] will try to do the more physical assessment”. When asked, almost all participants remarked that other team members most commonly ask for occupational therapy collaboration around assessment and intervention for independent living skills (e.g., home safety, meal preparation, shopping, budgeting).

Overall, the participants aimed to be the ones providing as many of the interventions directly to their prime clients and serve in both consultative (give advice to case manager) and collaborative (conduct independent living assessment to non-prime clients) roles. Despite the diverse multi-disciplinary makeup of the community mental health teams, the participants still found that referrals to outside agencies are a necessity to meet all client needs.

Three other important themes came through the interview process. While they are all unique from each other, they share a common thread exploring variables that influence occupational therapist’s roles on community mental health teams.

4.9 WHAT INFLUENCES MY OCCUPATIONAL THERAPIST ROLE?

The first topic contains ideas that participants put forth about what influences their professional roles on their community mental health teams. Influences are multi-faceted and include different combinations of personal interest, past job experiences, experiences as a student, client needs, and team/management composition. Across the participant group it was made clear that the role of the occupational therapist on a community mental health team varies from team to team, and is a dynamic, ever changing role.

Most of the participants reported personal interest in independent living as a driving force behind how their roles are shaped on their teams. Most of the participants also reported the team makeup (which participants felt they had little to no influence over) influenced which aspects of the wide occupational therapy scope on which they focus. For instance, if the team has a vocational counsellor or recreational therapist, the occupational therapist tends to have little focus on those areas and instead places efforts on other areas of importance that are not already addressed by other team members (consistently independent living skills). There is a conscious effort to avoid overlap and aim to provide as much breadth of service as possible. Barbara has witnessed this first hand, "I think it depends on what the [occupational therapist] is driven to do... on other teams where there's not a vocational person or a rec person there's more of a push for the [occupational therapist] to do those things."

All but one of the participants expressed that previous jobs and student placements played into how they have aimed to shape their occupational therapy role in their current position. Taylor shared that she “[pulls] in a lot of things that I used at [previous job] and on [student] placements.”

At the beginning of my own tenure on the Assertive Community Treatment Team, I was lucky enough to visit two well-established teams and spend the day with two different occupational therapists to experience the day-to-day feel of occupational therapy within their community mental health teams. These experiences influenced how I viewed the pace of the day, including average time for visits, number of visits in a day, as well as type of issues tackled during a visit.

Most of the participants expressed some administrative or systems level influence regarding their roles on the community mental health team. Specifically, a few participants reported their role being influenced by program manuals or mandates and a couple of participants reported their roles being influenced by their manager’s preferred direction. For Barbara, while working on the same team, she experienced a significant change in approaches, led by management and psychiatry:

... we’ve had a lot of change on this team, we had a different manager and a different psychiatrist before that was very different from the way it is now. Our last Psychiatrist was extreme recovery and rehab and not really a medical model... that really drove how the rest of the team worked as well, so, what we focused on versus what we do now.

The majority of participants (all but one of the occupational therapists in their roles over one year) expressed that their occupational therapy role has evolved over the years and they have had the ability to shape the role over time to fit their personal areas of interest and expertise, to reduce overlap with other disciplines (e.g., vocation, recreation), and adapt to client needs and team feedback. Barbara describes her personal journey in the evolution of her role: “I did a lot of medical stuff... it was strictly ‘hey if you happen to do some [occupational therapy] in the middle, that’s great’ {laughs}. I was a new [occupational therapist] at that point, so I just went with the flow... Whereas now being more seasoned, I push for more.”

The variables impacting how the occupational therapy role is shaped in each community mental health team demonstrates that despite common program mandates and similar job titles, the occupational therapist role on each community mental health team is unique and individualized to that particular team. This highlights the occupational therapist’s ability to not only assess need, but also adapt to the identified needs, further re-enforcing the concepts of creativity and flexibility, and a focus on providing the best care possible. Also of note is the role that student placements play in exposing and developing interest in occupational therapists to work in community mental health. Given the lack of formal profession-specific community mental health documents, it is not surprising that learning the role largely comes from hands on experiences. This highlights an area where efforts can be directed as a means to convey important community mental health information specific to occupational therapy, in hopes of developing confidence, competence and unity across the role.

4.10 THE 'IT' FACTOR

There is an intangible quality that occupational therapists who work in community mental health tend to share in common. Occupational therapists call this the 'it factor'. When speaking with the participants, three things became clear: 1) the 'it factor' is required to be happy working in a community mental health role; 2) those who work in the field can see the 'it factor' in others; and 3) the 'it factor' is often identified during a clinical student placement in a mental health setting.

All participants recognize that there is a certain 'it factor' when it comes to working in community mental health and that working on a community mental health team is not for all occupational therapists. Martha describes this as "some people who work in mental health have a sort of 'je ne sais quoi', you just have it. You just have the skills required for the job and you know some people look at you and say 'how can you work in mental health?!' and those people, they don't have whatever 'it' is."

Mental health focused clinical student placements played a large role in all of the participants pursuing employment in community mental health upon graduation, and the participants reported their preceptors making note of them having 'it' when engaged in their mental health student placements. This was true for Barbara, who recalls that "My first placement was mental health and he wanted to hire me from the get go, at the end of my placement he said 'you're going to do mental health, you're meant for mental health'. I think that's true in some ways, some people are just meant to do this job. It's not an easy job, it takes a different kind of skill set than phys. med."

For Barbara, the 'it factor' was viewed as being able to "think on your feet", enjoying a daily challenge and thriving in a setting that is "not cut and dry". For Nova, part of having the 'it factor' is trusting her gut, relying on her occupational therapy foundational knowledge and taking on each new situation as a learning opportunity. Both participants stress an individual who responds well under pressure and embraces the new and unknown.

Much like Barbara, I experienced an influential community mental health clinical student placement the end of the first year of my occupational therapy program and since that time had decided mental health would be my area of practice upon graduation. Of note, is that I was terrified prior to my mental health placement, unsure of what I had to offer, unsure of how I should interact with the clients, worried that my words or actions could 'set off' a client and create disaster for them and myself. However, after less than one week on placement in a skilled and supportive community mental health team, my outlook transformed significantly for the better. Stigma and stereotypes of which I was not even cognizant were broken down on a daily basis and the purging of my fear and uncertainty allowed for interest, passion, and compassion to emerge.

Many of the participants noted that now, as practising clinicians, they can see 'it' in other community mental health occupational therapists as well as student occupational therapists. Two participants specifically noted playing an active role as clinical preceptors and actively recruiting students who they observed to have 'it'. Peggy

proudly shared that “I was a preceptor... and I’m very excited that we were able to recruit some of those [occupational therapy] graduates to come and work here.”

These examples reinforce the concept that the role of occupational therapists on community mental health teams is largely influenced and shaped via real world experience as opposed to formal documents or classroom learning. The phenomenon expressed by participants also encourages a process of handing down knowledge through mentorship and suggests that occupational therapists serving as clinical preceptors may have significant impact in how new graduates shape their views of what an occupational therapist in community mental health should be doing, thus perpetuating how the role plays out in practice. This is the current state of practice, which raises the question: Is this the best practice? This concept will be further explored in chapter five.

4.11 RECOVERY, PSYCHOSOCIAL REHABILITATION, AND OCCUPATIONAL THERAPY PRINCIPLES

All participants agree that recovery, psychosocial rehabilitation and occupational therapy principles of care share common concepts such as: client-centeredness, addressing the whole person or being holistic, working with the client in a partnership, and working from a strength based approach. Theories and frameworks that were viewed as being uniquely applied by the occupational therapist on the team included: Person Environment Occupation (Law et al., 1996), Canadian Model of Occupational Performance and Engagement (Polatajko, Townsend & Craik, 2007), Neuro

Developmental (Bobath & Bobath, 1984) and Sensory Integration (Ayres, 1963). A few occupational therapists expressed that they felt the regulated team members applied recovery and psychosocial rehabilitation principles more regularly than non-regulated team members. For Barbara,

...where I see [regulated versus non-regulated differences] playing out with clients is different models of service delivery. When I listen during team meetings, I see service to be delivered more from a top down approach where there's a power imbalance, it's prescriptive and can facilitate dependency... I still think that people's interpretation of [psychosocial rehabilitation] and recovery is variable with our team...

The observed fit between occupational therapy principles of care and recovery and psychosocial rehabilitation principles further solidifies that occupational therapists have, and will continue to have a clear role, as an essential part of the community mental health team. This creates an opportunity for occupational therapists to actively engage in educating others in the community mental health realm (and beyond) about how the profession and community mental health are a natural fit.

4.12 ROLE IN PRACTICE SUMMARY

Participants working on community mental health teams presented a wide variety of viewpoints about their daily practices in relation to triumphs, values, and challenges. Of particular interest were the often competing and seemingly opposing attitudes

presented on various topics by the participants. Additionally, participants demonstrated how the personal filter or lens through which one's work is viewed can have great impact on the perception, and satisfaction of one's job responsibilities.

The following chapter will explore the relationship between the role identified on paper and that described in practice; finding the areas of agreement, discord and gaps.

CHAPTER 5 ADDRESSING AGREEMENT, DISCORD AND GAPS IN PAPER VERSUS PRACTICE

5.1 INTRODUCTION

Original methodology planned to have phase three of the study discuss areas of agreement and discord between paper and practice. However, in interviewing occupational therapists on community mental health teams, it became apparent that consulting governing documents was not how participants went about understanding their roles. Many of the key themes brought forth by the participants are non-existent in the documents, resulting not only in the identification of areas of agreement and discord, but gaps as well. In order to explore themes more fully, existing literature was also consulted.

In speaking with participants working on community mental health teams, three major topics were brought forth consistently. First, participants spoke about aspects of their jobs that make them uncomfortable and cause them stress. Incorporating laughter as a coping mechanism was frequent. Second, participants articulated their perceived lack of support from formal occupational therapy organizations and described the informal networks they create and maintain independently. The struggle with finding community mental health occupational therapy support contributes to the formation of a vaguely defined role. Lack of formal supports results in individual role definition, contributing to role inconsistencies across the

field. Finally, participants expressed the great importance that clinical student placements play in dispelling misconceptions about individuals with mental illnesses, and getting students interested in practising community mental health occupational therapy. Refer to Table 5 to see where phase three rests in the overall research project design. The experiences of the participants (role in practice) are compared to the documents that form the ‘role on paper’ as well as existing research literature to answer the final research question:

- What agreements or discord can be identified between the role on paper and the role in practice?

Table 5 Summary of phases- phase three

Phase	Objective	Methodology
1	Establish role on paper	Document review using content analysis of governing documents
2	Establish role in practice	Semi-structured interviews with occupational therapists on community mental health teams
3	Compare role on paper to role in practice	Analysis of data collected from phases 1 & 2

5.2 EXPRESSIONS OF DISCOMFORT

Participants expressed many stress-inducing factors in their daily practice. Frustrations originated from systems and individual levels. The expressions of discomfort focused around 1) the lack of knowledge others possessed about their role, and 2) the lack of

understanding non-regulated team members possessed about their professional responsibilities.

5.2.1 Lack of Understanding the Occupational Therapy Role: Individuals as Stressors

While most research revealed high job satisfaction levels among occupational therapists, those working in mental health reported some of the lowest job satisfaction within the profession (Moore et al., 2006). A component of job dissatisfaction includes occupational therapists' perceptions of a lack of understanding from others regarding the occupational therapy roles and responsibilities. Within their teams, participants felt their fellow team members did not grasp the occupational therapy roles, contributing to daily frustrations: "even on the team, I think some people don't fully understand what an [occupational therapist] is." (Taylor). On teams where the understanding of the occupational therapy roles exists, it is largely due to participant educating their teams. Nova explains, "when I first started they had this expectation... of doing employment groups and doing vocational type of work... I thought 'is that all they think I do?' {laughs}... I tried to advocate and share 'this is what else I do, these are the other things I do'... Then people kind of got to 'oh, OK.'". Claire echoed ongoing professional advocacy efforts, stating a "constant kind of education or reminders about what it is that we can actually do."

Participants also frequently found the understanding of an occupational therapist's skills and scope of practice lacking from those outside their teams. Barbara found

understanding to be “lacking {laughs}, even my clients, I explain what [occupational therapy] is... some of my clients I’ve known for nine years and they still call me social worker or nurse.” The lack of understanding goes beyond clients, Claire explains “community agencies or non-community agencies don’t quite get what [occupational therapy] is” either. Lynn described “a battle”, in relation to the occupational therapy roles being understood by “other teams or other agencies”. The Ontario Minister’s Advisory Group on the 10 Year Mental Health and Addictions Strategy identified this issue in their report, *Respect, Recovery and Resilience: Recommendations for Ontario’s Mental Health and Addictions Strategy* (2010). The report recommends “all providers and professionals have a clear understanding of each other’s capacities, role and responsibilities.” (p.29). Supporting documents assert that a lack of role clarity exists and suggests this issue requires remediation before a full understanding of others’ roles can truly be achieved. (Every Door is the Right Door, 2009; and Respect, Recovery and Resilience, 2010). Referred to as “poor professional status” within the literature (Moore et al., 2006, p.20), lack of role clarity and recognition by others is acknowledged as a significant contributor to job dissatisfaction among occupational therapists.

5.2.2 Lack of Understanding of Occupational Therapist

Professional Responsibilities: Team Members

Working within a team following the dual role model (case manager generalist & occupational therapist specialist), Claire describes a landscape where non-regulated members focused on shared responsibilities of the case manager role and had difficulty

understanding the divergence of responsibilities associated with being a regulated occupational therapist: “Rec and voc don’t make as much as [occupational therapy], nursing and social work... they don’t quite understand the difference and why they shouldn’t be paid the same. They also sometimes don’t understand why we can’t do certain things...”.

Participants expressed their non-regulated team members did not understand the professional standards a registered occupational therapist, because they lack their own governing college body. The lack of regulation was perceived as allowing team members “... the option of, you know, being less thorough.” (Barbara) due to the fact that “... they’re not regulated... they don’t have any standards, they don’t have anything holding them accountable...” (Taylor). Nova perceived that “... some of the colleagues that aren’t regulated, they’re very sort of open, open ended and anything goes...” The lack of regulation made participants uncomfortable at times “I think that there should be a certain level of scrutiny around you know the work that we do...” (Martha). Claire perceived the non-regulated members of her team were “... not worried about how their actions are affecting somebody else and it makes me nervous”. Over time, these perceptions contributed to the ‘*us -them*’ divide, generating tension among colleagues. After consulting supporting documents on working in the mental health sector, one would not expect such a divide to exist. While non-regulated service providers may not have a professional college setting out explicit practice requirements, government produced documents describing the role of service providers in mental health stress the importance of service providers being held accountable for the care they provide (Open

Minds, Healthy Minds, 2011) and engaging in self-reflection on their individually held attitudes and values that influence their practice, with an expectation to provide quality, ethical, safe care (MHCC Framework, 2009; Every Door is the Right Door, 2009; Respect, Resilience and Recovery, 2010; and Changing Directions, Changing Lives, 2012).

Occupational therapy governing bodies stress that registrants must adhere to a number of professional standards, including, 1) completing detailed and timely documentation, 2) practicing ethically while being held accountable for their actions, and 3) a commitment to engage in lifelong professional development (ACOTRO, 2011).

Professional development includes continued competence via self-evaluation, maintaining an evidence informed practice, and integrating new learning into practice.

Networking and informal supports are not defined as professional development for these purposes.

Participants echoed these sentiments and noted these principles frequently set themselves apart from non-regulated colleagues. Occupational therapists are aware of the expectations from their regulatory body and with "... the team having different backgrounds, sometimes there's a difference in the practice guidelines, expectations and the standards you set for yourself and the College sets for you..." (Lynn).

A discrepancy related to expectations about documentation, Barbara explained that:

...it's not enough for me to say 'I'm only going to document the important things; if nothing happened then I'm not going to document it'. My College won't let me do that, so, whereas other people have the option of, you know, being less

thorough... It's a- documentation is hard to find the time for and then we end up spending overtime trying to get it in because nursing and me, we have to have it in within a certain timeframe.

Nova described a similar situation "... our manager is saying 'oh you guys have to do a weekly progress note' or something I'm always like 'what about daily?' we have to document everything daily, cause in going back to the [College of Occupational Therapists of Ontario] guidelines." In this case, different regulations impact the state of the client's file (currency and details) as well as workload (frequency and timeliness).

When evaluating risk and making ethical clinical decisions, participants noted disparities within the team: "...a lot of ethical things that happen on the team, those of us who are registered, are very aware that we are registered and that we are held at that higher standard..." (Martha). Nova conveyed how regulation influenced the decision around client transportation:

...the idea of driving clients in your car... there's a lot of boundaries that it could potentially cross... And there's a safety piece and because reading all the [College of Occupational Therapists of Ontario] guidelines and everything, I choose not to, and my other colleagues that are regulated, yeah, funny enough {laughs} all the unregulated colleagues they do- they're OK to drive them around...

Part of the *Essential Competencies of Practice for Occupational Therapists in Canada* (ACOTRO, 2011), requires registrants to "engage in professional development" (p. 25). Presently, this commitment to lifelong learning is absent for non-regulated team

members. Multiple Ontario government documents outline the need for ongoing professional development for mental health workers in their list of recommendations, indicating that this is valued but not yet required (Toward Recovery, 2009; Every Door is the Right Door, 2009; and Changing Directions, Changing Lives, 2012). Peggy chronicled challenges experienced with professional development- maintaining competence with current occupational therapy foundations, and giving back to the profession via involvement with the local university's occupational therapy program:

A challenge I face... respect and understanding from colleagues around the professional development that comes with being an occupational therapist and the value that we have with universities... I've been invited to tutor or to teach one class at a university and been supported by management to do that, but my colleagues perceiving that as favoritism because as an occupational therapist that's an opportunity I can accept, where maybe my colleagues wouldn't have those same opportunities and it can be perceived that I get that afternoon off because maybe I'm not in the office... there's been tension in the team around us all being treated as case managers, but yet there are differences because we all have different disciplines and again there's different opportunities for different disciplines... So I think it's a real- there's a misunderstanding I think and a lack of respect to us being different.

She goes on to show that the impact of this disconnect is "... that there can be a lot of collateral damage within the team around this- when we do go offsite to provide

teaching and that can be very hard on us on a personal level when we return to the office.”

This disconnect could contribute to tension and strained co-worker relationships, ultimately impacting the delivery of quality care (job stress, job satisfaction, employee retainment).

5.3 LAUGHTER AS A COPING MECHANISM

Humour in health care has been found as an effective coping strategy (Wanzer, Booth-Butterfield & Booth-Butterfield, 2005). Occupational therapists implemented humour, specifically laughter when discussing 1) dealing with difficult clients, 2) feeling stressed, and 3) relationships with other team members. Of particular note, the humour exhibited by both the nurses in Wanzer et al.’s (2005) study, and the participants was not targeted at the client, but rather at the general situation, to enable the service provider to cope with stress and remain an effective and productive worker. While incorporating humour as a coping mechanism was apparent in participant’s comments and health literature, this is a gap area in governing documents (government and occupational therapy).

5.3.1 Laughter and Difficult Clients

Occupational therapists did not shy away from expressing the daily frustrations encountered with their clients. It is no secret that therapist and client viewpoints can differ, providing a reminder that the ideal course of action is often not the same as the eventual plan carried out. Barbara saw this occurring during the assessment process:

“Most of the time, our clients- the self-assessment differs from ours and what they view as needs versus what we feel are priority can be very different, so, trying to balance that {laughs}.” Peggy used laughter to cope with the non-linear, and often cyclical nature of mental illness: “I think one of the challenges of long term case management is just maintaining that empathy, maintaining that sensitivity, when you feel like ‘gosh, this is so familiar, we’ve done this too many times’ {laughs}.”

5.3.2 Laughter and Feeling Stressed

When participants talked about their large, diverse, and demanding caseloads, daily stressors came through unmistakably. In discussing the team’s ability to provide quality care, Lynn expressed that “...it keeps getting more and more and more complex {laughs}... sometimes we feel overwhelmed by the referrals...” Her commentary expressed a clear concern, while the laughter suggested an air of acceptance, concurrently. Workplace stress was also expressed relating to the ‘not enough time in a day’ concept: “So there will be days where I have to see clients in like three different cities and so like your days just go, your days go by very quickly {laughs}... we don’t take breaks, you eat in the car {laughs}”. Taylor’s commentary reinforced using laughter as a coping mechanism, to temporarily neutralize distress created by a heavy daily workload.

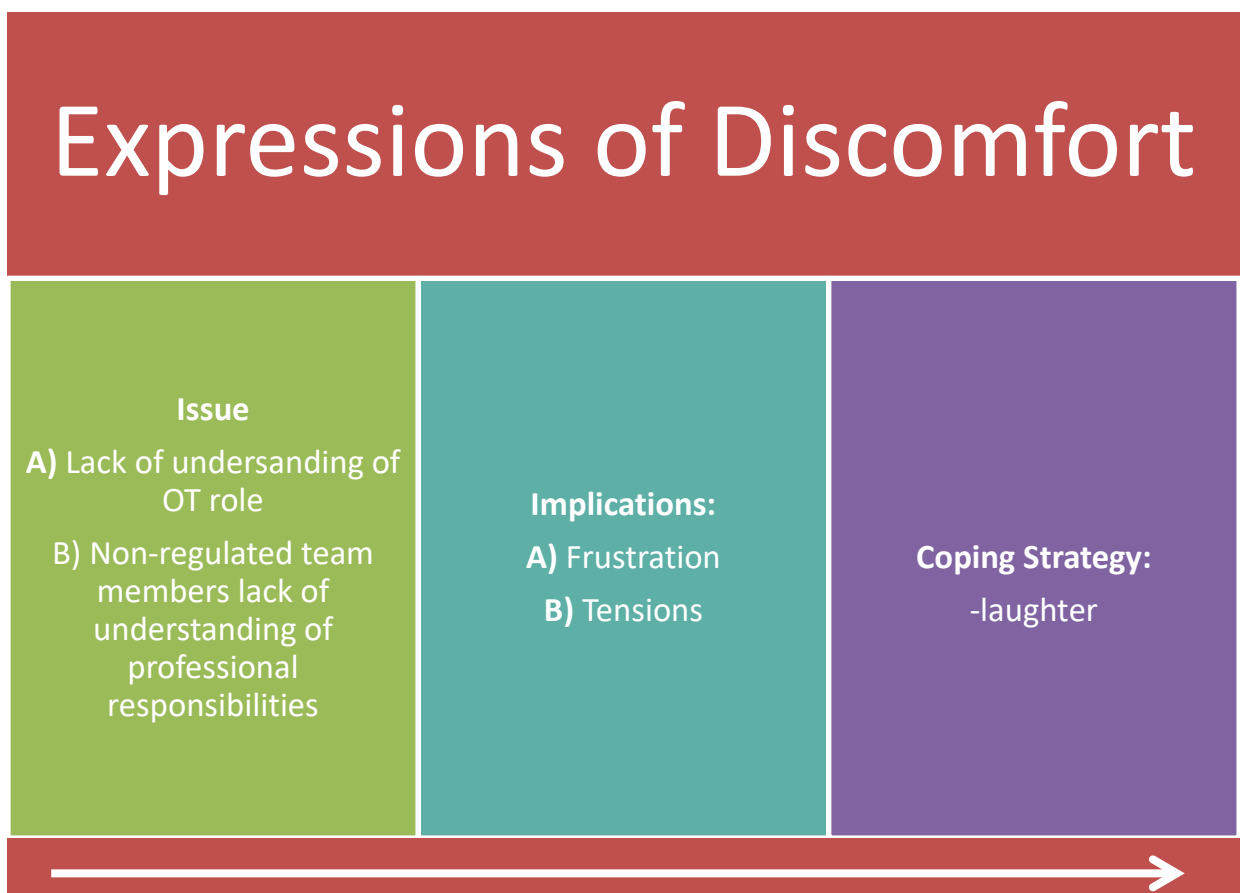
5.3.3 Laughter and Challenging Interactions with Team Members and Colleagues

In addition to strain experienced from difficult client interactions and daily workload pressures, interactions with co-workers and colleagues outside of the team are another source of stress. Within her team, Barbara found that "... there's a lot of overlap in roles, which, there's some things that I feel that, you know wouldn't it be better if somebody else did that? {laughs}". Barbara raised concern around efficient use of resources and maximizing her occupational therapy specific role, and then used laughter to lighten the mood and temporarily ease tension. In interacting with outside stakeholders, a similar pattern of a) identifying an issue, b) stating one's frustration and c) undermining the gravity of the argument with laughter was employed by Nova: "It's been a huge challenge I guess, coordinating with and advocating to I guess the physical health world- that her mental health needs need to be addressed and this is a way for you to take that into consideration is to keep us in the loop {laughs} we can help with that {laughs}." A common thread among the three situations related to laughter providing a temporary relief from distress. Participants unconsciously laughed when talking about troublesome and long standing situations that showed no signs of future resolution. As such, laughter was serving as a mask for underlying issues related to participants feeling stressed and overwhelmed with their caseloads, and frustrated with perceived poor use of resources and limited teamwork among stakeholders.

5.4 EXPRESSIONS OF DISCOMFORT AND LAUGHTER AS A COPING MECHANISM SUMMARY

In describing the aspects of their job roles that cause them discomfort, occupational therapists express their frustrations about the perceived lack of understanding from others around roles and professional responsibilities. In response to these stressors, laughter was frequently used to cope.

Figure3 Expressions of discomfort



5.5 SUPPORTING OCCUPATIONAL THERAPISTS ON COMMUNITY MENTAL HEALTH TEAMS

5.5.1 Introduction

Overall, it is apparent in both the role on paper and the role in practice that formal supports are not readily available for occupational therapists on community mental health teams. Three gaps in support have been identified: 1) occupational therapy organizations offer little to no formal networks to bring this subset of therapists together. 2) Occupational therapy community mental health specific professional development opportunities (e.g., evidence informed practices, research based presentations (conferences, webinars, etcetera) are lacking. 3) finally, participants noted a gap in formal documents from occupational therapy organizations (e.g., Canadian Association of Occupational Therapists, the College of Occupational Therapists of Ontario, and the Ontario Society of Occupational Therapists) explicitly acknowledging and detailing the role of occupational therapy in community mental health and/or the increasingly popular dual role (phase one content analysis confirmed this gap as well). See Figure 4 OT Support.

5.5.2 Networks for Occupational Therapists on Community Mental Health Teams

The Canadian Association of Occupational Therapists lists an 'Occupational Therapy & Mental Health Network' (OTMHN). "The OTMHN is a volunteer group who works with

the Canadian Association of Occupational Therapists National Office staff to develop supports, resources and lobby efforts to build and promote occupational therapy services in mental health and addictions.” The webpage is all but empty, citing a vacancy at the position of Chair and little to no hands-on resources to enable connecting with other occupational therapists working on community mental health teams, or tangible resources to assist in day-to-day work. This reflects the lack of formal support from occupational therapy governing bodies. Not surprising is that occupational therapists working on community mental health teams do not feel they have the time to devote to fulfilling a volunteer committee position on top of their heavy caseload, suggesting that volunteer positions are not an effective strategy to make this resource helpful. In addition, participants frequently spoke about lacking other occupational therapists with whom to brainstorm or discuss clinical issues. Occupational therapists as ‘lone wolves’ were common, with five of seven participants being the sole occupational therapists on their teams or within their entire organization. This solo status caused one occupational therapist to:

...feel quite isolated, compared to the [occupational therapists] who are at the mental health hospital and this whole bunch of them that all know each other and hang out and you know have that opportunity to you know talk about [occupational therapy] specific things and what not. (Martha).

In the other two situations, these occupational therapists started out as the only occupational therapist on their teams and over time, were successful in advocating for

additional occupational therapists to join the team. For Claire, she "... was the only [occupational therapist] involved in the clinic for nine years", before another occupational therapist joined the team as a case manager.

As a result of being the 'lone wolf' and the limited formal support network offered, occupational therapists sought out support in many different ways, including talking to non-occupational therapist team members, reaching out to occupational therapist colleagues in their personal networks, and talking to their occupational therapy students on clinical placement:

The other actual challenge I'm finding is that in terms of having those clinical discussions... it would be great to bounce ideas off of another [occupational therapist], or off of someone who has that familiarity with doing that. So I sometimes find that I don't know who- I have my colleagues, absolutely and they help to kind of hear me out, but sometimes it's nice- I wish I had another [occupational therapist] here, another clinical supervisor... right now I have a student [occupational therapist] actually {laughs}. It's been really great to kind of share, talk about our [occupational therapy] stuff with her...I do connect with other [occupational therapists] that work on other [name of community mental health team] outside of- I guess within my personal network. Yeah, because I sometimes just want to hear what other people think. You know, and if it's not going to happen in my workplace, I'll just touch base outside. (Nova)

Despite these efforts, participants still found the support is less than what they desire and they sought out more formalized support:

... there's nothing in nine years that I've been here. We've talked a lot about having community [occupational therapy] or an... [occupational therapist] type of collaboration, so that if we were each having our own issues or we could talk to each other, or maybe we could get together every couple months and kind of chat about our concerns because our concerns never get brought up in the meetings because nobody else has those concerns, so but then we get weighed down on the day-to-day work and that never happens, so we've talked about it several times, but it's just never come to fruition.

(Barbara)

5.5.3 Educational Opportunities for Occupational Therapists on Community Mental Health Teams

Participants were aware of the College of Occupational Therapists of Ontario's requirement for continuing education, and are dedicated to lifelong learning (ACOTRO, 2011). Lynn and Taylor both described actively seeking out opportunities to further their knowledge and maintain an evidence-informed practice by accessing journal articles, and attending conferences, and webinars. However, all sources accessed were non-mental health specific, for example, journal articles related to geriatric care, and conferences focused on seating and mobility. Even when a mental health specific conference was mentioned, Taylor explained that she "went to the [Intensive CMHT]

Conference just a few months ago and ... there wasn't one that was directly associated with being an OT." Other participants also described a landscape in which community mental health education opportunities specific to occupational therapy are few and far between, resulting in two general reactions. First, occupational therapists attended and consumed general occupational therapy knowledge and individually sought out ways to apply the information to their specific practice context. Claire expressed how she made use of the occupational therapy "...big conference in September that usually will have a few booths that you're able to draw on, even if it's not mental health related, right you can still pull on some of the cognitive stuff that they're offering and the different sessions that can help apply." Similarly, Nova looked "... at the [occupational therapy] inpatient setting, [occupational therapy] and housing and I kind of pick and I pull from the different areas to make it kind of work for me and say 'oh that might be good for our setting'." It is not surprising to hear of a perceived lack of specialized educational opportunities; the sector already largely recognizes the impoverished state of available educational opportunities for mental health service providers in general and recommends improvements in educational offerings (Toward Recovery, 2009; Every Door is the Right Door, 2009; Navigating the Journey to Wellness, 2010; and Changing Directions, Changing Lives, 2012).

Second, despite finding some useful concepts to incorporate into their community specific practice contexts, participants expressed a desire for more community mental health occupational therapy-specific educational opportunities and research to be available: "... we had a mental health forum, two or three years ago. It's just- there

needs to be more regular opportunities for new learning” (Claire). As part of maintaining professional development, the College of Occupational Therapists of Ontario (ACOTRO, 2011) suggests accessing and integrating information from best practices and practice standards documents. In the realm of occupational therapy in community mental health, these documents do not exist. So while some participants were making efforts to engage in meaningful professional development, there is a lack of information to access.

5.5.4 Role Clarity for Occupational Therapists on Community Mental Health Teams from Professional Organizations

Participants noted a lack of formal written documents outlining the roles of occupational therapy in community mental health from governing bodies such as the Canadian Association of Occupational Therapists and the College of Occupational Therapists of Ontario. Specifically, the concept of occupational therapists working within a dual role format, combining case manager generalist and occupational therapy specialist duties, is distinctly missing from standards, guidelines and position statements. While the Canadian Association of Occupational Therapists released a position statement on *Occupational Therapy and Mental Health* (2008), the document is brief and vague, with no mention of the dual role experienced by occupational therapists who also serve as case managers, or reference to community specific factors. This impoverished state created an environment in which occupational therapists working on community mental health teams formulate individual interpretations of the roles. While some personalization is expected from workplace to workplace, the current landscape has

created much variability in role definition, leaving occupational therapists on community mental health teams wanting formal guidance and reassurance that they are fulfilling their occupational therapy roles suitably in the assessment of their governing bodies.

Some participants expressed feeling that their scopes of practice were extremely wide, even branching out into other specialist domains:

I can do whatever is required in that moment with the client, so if they have an [occupational therapy] need, I can do that, if their need is more like you know social work-y or you know educational related or substance use related I have the skills to do that and I think that it's really nice that I've been able to develop those skills, and can you know flip between roles as needed. (Martha).

Other participants felt they carried out smaller, more focused roles on their teams: "We have vocational counsellor as well as rec therapies, so when looking at the whole person I don't have to look at the leisure or productivity parts so much." (Barbara). Nova echoed this sentiment in her hesitation to address equipment needs and tendency to refer to the Community Care Access Centre occupational therapy services with an aim to focus on being a "... mental health [occupational therapist]". Viewpoints continued to be varied in relation to whether occupational therapists sought out a wide scope of practice, or rather felt that the nature of the job demanded an expansive set of skills.

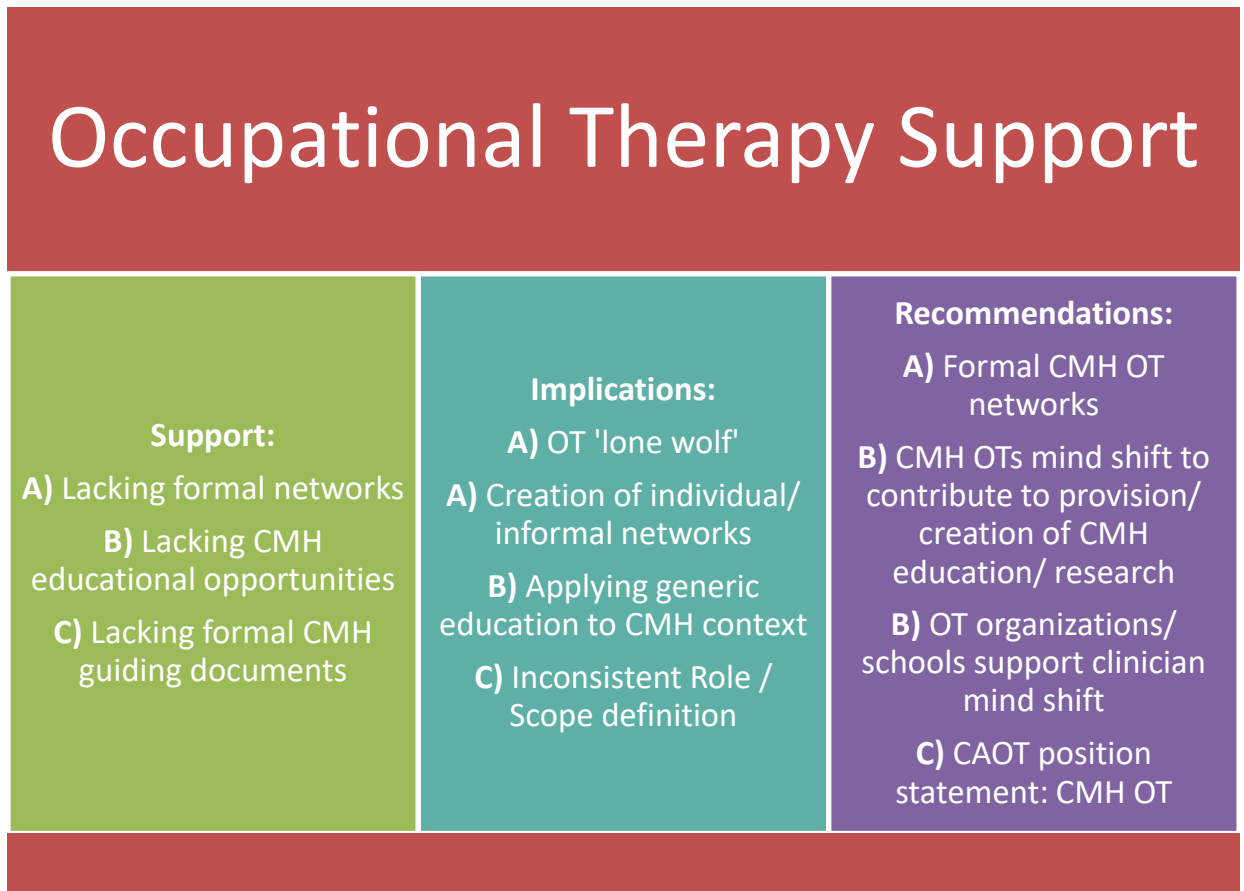
In speaking with occupational therapists, a united message came through. Part one was the participants' recognition that "It's not as easy to find documentation or information to support your practice for community occupational therapists..." (Taylor). This reality

was consistent with the lack of community mental health specific research and educational opportunities. Guiding documents followed much the same tone and tended to apply more generically to occupational therapy, without specifically addressing the community mental health context. Part two was hearing participants respond to the paucity of guiding documents with a:

... wish [that] there was a tool or a guideline that actually said, like laid out, what an [occupational therapist] on a [community mental health team] should do {laughs}... I wish there was something like that. Not to say that guidelines are the only thing we should follow, but just to have a general sort of look at 'this is the general role of an [occupational therapist] on a [community mental health team]'. (Nova).

The documents coming from various government bodies echo the need for increased clarity in relation to roles, responsibilities and competencies. Multiple sources highlighted this need in their recommendations, linking role clarity to streamlined service delivery, improved consistency across services and job retention (Every Door is the Right Door, 2009; Respect, Recovery and Resilience, 2010; Open Minds, Healthy Minds, 2011; and Changing Directions, Changing Lives, 2012).

Figure 4 Occupational therapy support



5.5.5 Supports Summary

The discussion around the theme of support highlighted the united front from the viewpoints of the role on paper and the role in practice. Government documents outlined the present state of supports as one that is lacking, and cite the need for more targeted personal development opportunities for those working on community mental health teams. Participants echoed this state of underwhelming supports. They took the discussion one step further and outlined their desires for discipline-specific supports, professional development opportunities and formal networking systems. Additionally, as

brought up in the previous section, paper and practice were also in agreement in relation to the room for improvement around role clarity.

5.6 COMMUNITY MENTAL HEALTH OCCUPATIONAL THERAPY PRACTICE AND CLINICAL STUDENT PLACEMENTS

5.6.1 The Impact of Clinical Student Placements on Community Mental Health Teams

Fieldwork is an essential component to each student occupational therapist's training. Students require experiences with a variety of client groups and practice settings, with efforts made to provide students with exposure to occupational therapy in mental health (Canadian Association of Occupational Therapists Academic Accreditation Standards and Self-Study Guide, 2011). Positive experiences during fieldwork have been observed to impact new graduates' job searches (Aiken et al., 2001) (e.g., pursuing a specific population and/or setting). In examining attitudes in students before and after clinical placements in mental health settings, students were found to possess largely neutral to negative attitudes regarding working with mental health clientele pre-placement. Students described clients as being different, having deficits, as well as commenting on their own fear around the work (Beltran et al., 2007). Upon completion of fieldwork placements in a mental health settings, students' attitudes were generally observed to have remained neutral or changed from negative to neutral, with new attitudinal themes centering around students viewing clients as ordinary, students

understanding the clients, and focused on an enabling approach to care as opposed to deficit-based view (Beltran et al., 2007).

Participants corroborated this phenomenon, recollecting the changes they underwent on student placements themselves: “I tell all my students that I had no desire to do mental health [occupational therapy]... and my first placement was mental health... at the end of my placement he said ‘you’re going to do mental health, you’re meant for mental health’.” (Barbara). Barbara continued, “...a lot of students that come here it’s their first experience with mental health, or they have some interest but weren’t really sure and I’ve been successful in getting people interested in mental health.”

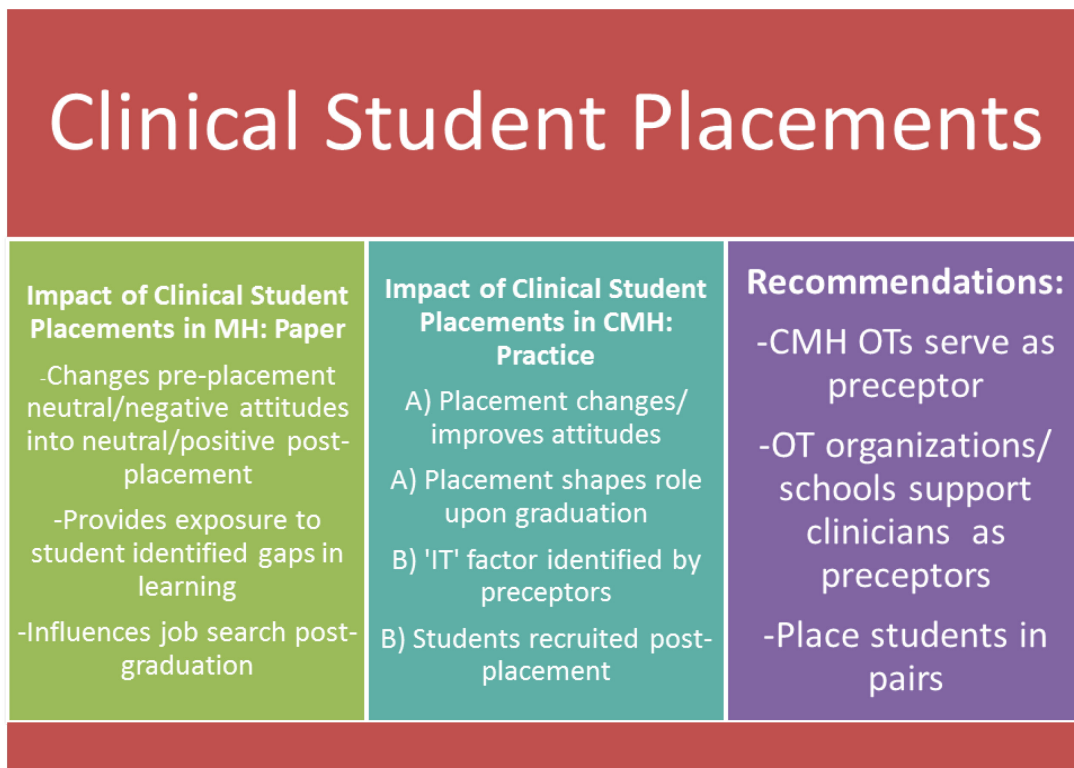
Student placements developed interest in working in mental health upon graduation and served as a foundation for shaping the occupational therapist role once employed: “I think for me personally, it’s been my experience, having done my placement in [occupational therapy] school... some of the things that we did there as an [occupational therapist], it is what I’m doing here... so I look at my experience as a tool to guide me and what I’m doing.” (Nova)

Many participants (four of seven) expressed their ability to see the ‘it factor’ in students: “certainly some people, you probably can agree, who work in mental health just have a sort of ‘je ne sais quoi’... you just have it. You just have the skills required for the job” (Martha). Once the ‘it factor’ had been identified, participants took the next steps required towards transitioning these students into colleagues upon graduation.

I was a preceptor for almost all [the student occupational therapists we were able to recruit upon graduation]... I think it was an opportunity to put [community mental health] on the student radar within [the occupational therapy school] and promote the role of [occupational therapist] as a case manager and in a mental health clinic and I'm very excited that we were able to recruit some of those graduates to come and work here. (Peggy).

This reinforces the pivotal role that clinical student placements play in generating interest in working in the field of community mental health upon graduation. See Figure 5 Clinical student placement, results from existing literature & current interviews, with recommendations for future.

Figure 5 Clinical student placements, results from existing literature and current interviews, with recommendations for future



5.6.2 What is the 'it' factor, and is the 'it' factor a good thing?

Made clear by the participants was that an 'it' factor could be seen by occupational therapists on community mental health teams, and that those with the 'it' factor were sought out as desirable future colleagues. The next step in examining this result is to ask: Can the 'it' factor be measured, and if so, is the 'it' factor a good thing? Given that the 'it' factor has yet to be quantified, and no substantiation of what intangible personality traits make one a good or bad therapist exist, can one truly say that certain types of therapists are, or are not, cut out for working in community mental health? Therapists working on community mental health teams felt they possessed the 'it' factor, and were able to see 'it' in student occupational therapists. In reality, they may have seen intangible personality similarities between themselves and the student. 'Seeing' and placing such heavy value on the 'it' factor can be another way occupational therapists avoid actively seeking more formal guidance (eg. Occupational therapy documents, government documents, job descriptions) in shaping the occupational therapy role on community mental health teams. This phenomenon of valuing like-minded individuals breeds an environmental conformity, not the desired dynamic and ever-advancing environment that community mental health needs, to provide cutting edge quality care. Post et al. (2009) studied teams looking for factors that bred innovation. They found that teams with a high level of shared mindset were less innovative, while higher levels of "thought diversity in a team (diversity in perspectives and in approaches to problem solving)..." (p. 15) generated more alternatives and ultimately more innovative outcomes. Post et al. (2009) asserted that teams with a shared mindset, while cohesive,

deter members from expressing unique points of view. Building on Post et al.'s (2009) insights, Disis & Slattery (2010) further explained how shared mind-set teams function within sequential thinking and not surprisingly, get standard results. The alternative presented was diverse teams, who share material with each other via a connective thinking model where members made connections between multiple varying ideas. This process was “more likely to develop radical innovations.” (p. 22).

So while embracing the student occupational therapist with a shared mindset may be comfortable, giving more thought and credence to a student that goes a bit against the grain may be worth the time and efforts, in the name of innovation.

5.6.3 Clinical Student Placements Summary

The theme that emerged around the impact and importance of student clinical placements is not derived from governing documents, rather from a strong united voice of occupational therapists. Experiencing a student clinical placement in a mental health setting has the power to change attitudes and influence the job search after graduation. In addition, the occupational therapy specialist role is largely learned via placement, and whether positive or negative, preceptors see the ‘it factor’ in students and pass down their practice knowledge through the experiential learning process.

5.7 ADDRESSING AGREEMENT, DISCORD AND GAPS IN PAPER

VERSUS PRACTICE SUMMARY

The research question guiding this phase of the study set out to find areas of agreement and discord between 'paper' and 'practice'. In reality, the themes highlighted by participants included areas of agreement, discord and general gaps. As a result, phase three took a new direction and expanded beyond the original intent, to also explore how 'practice' themes fit in with existing literature.

Occupational therapists clearly expressed situations that cause discomfort, mainly different perceived lack of understanding from team members, and demonstrated the use of laughter as a coping mechanism. The discord is that while 'paper' outlined the need for mutual understanding of roles, 'practice' demonstrated a significant lack of understanding as the norm.

A united front was found when exploring support for occupational therapists on community mental health teams. Both 'paper' and 'practice' acknowledged that supports were lacking and that more opportunities for professional development (e.g., evidence-informed practice) and increased role clarity were needed.

Finally, while participants were extremely vocal about the 'it' factor, and the role that clinical student placements play in the education and recruitment of occupational therapists working in community mental health, 'paper' failed to recognize this practise altogether.

The following chapter will highlight how areas of clear discord and identified gaps can be addressed to improve the landscape for occupational therapists working on community mental health teams.

CHAPTER 6 RECOMMENDATIONS & CONCLUSIONS

6.1 INTRODUCTION

After analyzing provincial and national documents that inform the role of occupational therapy in community mental health from the perspectives of government and professional governing bodies, as well as speaking to occupational therapists working in community mental health, four main areas for improvement emerged: 1) Applying an occupational therapy lens to the dual role; 2) evidence informed practice; 3) role clarity; and 4) clinical student placements in community mental health. The government documents frequently listed areas two and three as ‘goal’ areas for future attention in strategy and recommendation documents. Profession-specific documents set out expectations for engagement in evidence informed practice and contributions to student development. Finally, participants actively working in this sector spoke about their concerns in relation to all four areas, and how these impact their day to day moving with a focus on what individual occupational therapists and their supporting organizations can do to make notable improvements across these areas.

6.2 APPLYING AN OCCUPATIONAL THERAPY LENS TO THE DUAL ROLE: RECOMMENDATIONS FOR IMPROVEMENT

In hearing occupational therapists on community mental health teams talk about their daily practice, it was evident that regardless of the job title, occupational therapists view their role through an occupational therapy lens at all times. Incorporating occupational

therapy principles such as partnering with clients, adapting to individual client needs, skill building, advocating for clients and generally enabling participation are ways that occupational therapists can successfully navigate the dual role. Occupational therapists on community mental health teams need to put conscious thought into the application of their 'OT lens' on their seemingly generalist duties.

6.3 PROVIDING FORMAL SUPPORT NETWORKS FOR OCCUPATIONAL THERAPISTS ON COMMUNITY MENTAL HEALTH TEAMS: RECOMMENDATIONS FOR IMPROVEMENT

Occupational therapy organizations (e.g., Ontario Society of Occupational Therapists, Canadian Association of Occupational Therapists) are well-positioned to provide centralized structures that facilitate networking for occupational therapists working in community mental health. Given the heavy caseloads, variable work hours, limited resources, and modest subset of occupational therapists within this practice setting, special thought should be given to designing user-friendly network structures. Ideally, a support network would require only a small time commitment, be offered at little or no cost, and be easily accessible across the province. Options for achieving this include an online, monthly video chat session, providing a platform for a community of occupational therapists to discuss current topics, and share experiences and strategies. In turn, these supports and resources can contribute to improved job satisfaction and retention of occupational therapists in their community mental health roles.

6.4 CONTRIBUTING TO & CONSUMING COMMUNITY MENTAL HEALTH TEAM OCCUPATIONAL THERAPY KNOWLEDGE: RECOMMENDATIONS FOR ADVANCEMENT

Occupational therapists are capable of moving beyond the act of finding generic educational opportunities that they can tailor to their individual practice contexts.

Occupational therapists working in community mental health have a wide scope of skills and expertise. As a result, a mind shift from 'learner' to 'educator/ presenter/ expert' is essential for occupational therapists to embrace so they may begin sharing the knowledge they have at events such as conferences, symposiums, lunch and learns, etc.

While not an explicit requirement of the ACOTRO Essential Competencies (2011), contributing to occupational therapy-specific community mental health research can be viewed as an element of 'Engaging in Professional Development' (Competency #6), specifically, point 6.2 'Demonstrates Commitment to Continuing Competence' (p.25). In the Canadian Association of Occupational Therapist's position statement: *Occupational Therapy and Mental Health Care* (2008), participating in research activities is listed clearly in the recommendations for occupational therapists. This document however, is extremely dated and requires significant updating to reflect current practice.

Occupational therapy organizations such as the Canadian Association of Occupational Therapists and the Ontario Society of Occupational Therapists can support this endeavor by offering increased resources and funding to enable clinical therapists to expand into the research realm. University-based occupational therapy researchers are also well-

positioned to recruit and partner with occupational therapists working in community mental health to form well-rounded research teams that focus on the creation of new occupational therapy community mental health evidence. Generating peer reviewed journal articles are just one way to contribute to the occupational therapy evidence base. Options for sharing expertise and opinions include outlets such as professional magazines like *OT Now*, writing up case studies, presenting posters or workshops at conferences, conducting lunch & learn sessions for colleagues, getting engaged in professional committees and participating in the development of position statements. In addition to these traditional formats for disseminating knowledge to groups, occupational therapists should consider active multi-component knowledge translation interventions (e.g., outreach visits, working groups, problem based learning, networking, etc.), as some research suggests these active formats could generate improved knowledge and implementation of practice behaviours in comparison to passive interventions (e.g., delivery of written documents) (Menon et al., 2009). Documents outlining the vision for mental health care provincially and nationally emphasize the importance of continued research to generate evidence and fill existing gaps in knowledge. Occupational therapists are well suited to apply for management positions, where they can become change agents for operationalizing the occupational therapy lens in a broader context. In light of the findings of this project, future research to develop user-friendly practice guidelines and standards is recommended (Toward Recovery, 2009; Every Door is the Right Door, 2009; Navigating the Journey to Wellness, 2010; Respect, Recovery, Resilience, 2010; Open Minds, Healthy Minds, 2011; and

Changing Directions, Changing Lives, 2012). The progression from vision and strategic style documents to more action-oriented 'how to' documents that possess the ability to bring further clarity to work roles, will ultimately provide improved consistency of occupational therapy practice across community mental health teams.

6.5 CREATION OF NATIONAL POSITION STATEMENT ON OCCUPATIONAL THERAPY IN COMMUNITY MENTAL HEALTH TEAMS: RECOMMENDATIONS FOR INCREASING ROLE CLARITY

As the national governing body for occupational therapy in Canada, the Canadian Association of Occupational Therapists has a responsibility to acknowledge the approach that community mental health is taking with regards to the case manager/ specialist role (dual role). Creating a position paper which outlines how occupational therapists are equipped to handle these roles is due. Such a document should provide guidance in balancing generalist duties while maintaining an occupational therapy lens. A position statement can contribute to further role clarity and confidence that occupational therapists on community mental health teams are supported by their professional organizations. Ideally the position statement would be co-created with frontline occupational therapists working on community mental health teams (practice informing paper) and would move away from generic strategic, to provide an actionable and accessible resource to inform daily practice. The position statement could help shape occupational therapy in community mental health in aligning with the larger overarching vision for occupational therapy in Canada (paper informing practice). Such a partnership

would reflect a dynamic and fluid process respecting and valuing all stakeholders' viewpoints, generating an informed and realistic vision for community mental health occupational therapy practice in Canada.

The development of a relevant message is extremely important, however if the message is not delivered in a relatable and accessible fashion, then the likelihood of wide-spread acknowledgement and acceptance is limited. A knowledge translation strategy beyond that of posting a written document on a website is needed. Occupational therapists involved in the development can also disseminate the message through in-person presentations, lunch and learns, and online forums.

6.6 CREATING POSITIVE EXPERIENCES FOR PRECEPTOR & OCCUPATIONAL THERAPY STUDENT: RECOMMENDATIONS TO IMPROVE & INCREASE OPPORTUNITIES FOR CLINICAL STUDENT PLACEMENTS ON COMMUNITY MENTAL HEALTH TEAMS

Clinical student placements are an area where both students and preceptors can benefit. Occupational therapists on community mental health teams are encouraged to take on the role of preceptor and provide clinical learning opportunities for student occupational therapists. Occupational therapists have a “professional responsibility to engage and support entry level occupational therapy fieldwork education where possible” (Position Statement: Fieldwork Education & Occupational Therapy, Canadian Association of Occupational Therapists, 2012). This statement is echoed in the Canadian

Association of Occupational Therapists' position paper: *Continuing Professional Education* (2011), where mentoring and supervising students are recommended actions for occupational therapists to fulfill their responsibility to continuing education standards. The College of Occupational Therapists of Ontario's *Essential Competencies for Occupational Therapists in Canada* also addresses this role, in Competency #7: *Manages Own Practice & Advocates Within Systems*. Specifically, point 7.2.3 refers to the occupational therapist's duty to: "Supports effectiveness and safety through monitoring, preceptorship, supervision, mentoring, teaching, and coaching" (p. 28, 2011). Clearly, the governing bodies of occupational therapy within Canada are united on highlighting the duty and importance of practising clinicians regularly engaging in student fieldwork education. The Canadian Model of Client-Centred Enablement (Townsend et al., 2007) also mentions the role of occupational therapists in contributing to the education of students, within the enablement skill of 'educate'. Community mental health teams have the capacity to fill perceived gaps in student learning through exposure to, and collaboration with, other health professionals (e.g., social workers, nurses, psychiatrists, recreation therapists, vocational counsellors), developing coping strategies in the workplace, navigating the health system, as well as managing interpersonal conflicts, and seeking consultations and collaboration with colleagues. Clinical placements have a significant impact on new graduates' job searches and placements in mental health have shown the ability to change attitudes to be more positive about working in this area of practice (Beltran et al., 2007). Many participants echoed this sentiment, expressing how pivotal their own student clinical placements

were in their decision to pursue employment in mental health upon graduation. Serving as a preceptor is one way to generate interest in community mental health occupational therapy as well as actively recruit new team members.

In order to enable occupational therapists working on community mental health teams to serve as preceptors, they need to be properly supported with helpful resources to generate confidence and competence taking on the clinical mentor role. Occupational therapy organizations (associations, societies, colleges, university programs) in particular are well-positioned to develop supports and resources that help preceptors manage student anxiety and reflection while modeling professional socialization, confidence and application of theory to practice (Aiken et al., 2001; Beltran et al., 2007). Finally, consideration of partnering student occupational therapists on community mental health occupational therapy placements should be given, as it can benefit both the students and the preceptor. The creation of a peer learning environment can foster increased sharing of knowledge and reflection, allow the students to benefit from questions posed by their classmates, foster independent thinking and decrease reliance on the preceptor (Aiken et al., 2001).

6.7 SUMMARY OF RECOMMENDATIONS

To summarize, both individual occupational therapists, and larger occupational therapy organizations have steps they should take to improve the state of occupational therapy in community mental health: See Table 9 and Table 10

Table 9 Steps individual occupational therapists can take to improve the state of occupational therapy in community mental health

Goal	Steps to take
Successfully navigate dual role	Apply OT lens to both generalist & specialist duties.
Advance evidence-based practice	Change mindset from 'learner' to 'educator/presenter/expert'. Partner with University programs and share your information (e.g., conferences, symposiums, lunch 'n' learns, OT Now, journals).
Maintain duties to Professional College	Serve as a preceptor for student occupational therapists.

Table 10 Steps occupational therapy organizations can take to improve the state of occupational therapy in community mental health

Goal	Steps to take
Successfully navigate dual role	Create position statement on occupational therapy in community mental health (CAOT) recognizing the goof fit between occupational therapy and the dual role
Generate supportive community	Facilitate networks for occupational therapists in community mental health to discuss/share experiences /strategies (OSOT).
Increase occupational therapy role clarity	Acknowledge the dual role in community mental health to align with National mental health strategy and develop position statement on occupational therapy in community mental health (CAOT).
Support and encourage preceptorship	Develop new, and promote existing preceptor resources (CAOT, COTO, OSOT, and University OT Programs).

6.8 CONCLUSION

Working as an occupational therapist on a community mental health team is a complex and challenging role to undertake. This study set out ultimately to answer the question: How do occupational therapists working on community mental health teams understand their professional role in relation to existing governing texts?

In short, it is evident that few formal texts or documents are consulted by occupational therapists working in community mental health on a daily basis. The occupational therapy documents that do exist tend to be more general in nature, not community mental health specific. While many of the occupational therapy specific documents are written at a level outlining straight forward expectations, the government documents are largely still at a level describing overarching strategy and desired outcomes in the future, leaving more practical and tangible 'how to' types of readings still lacking.

As a result, many occupational therapists' practices are informed via experiences from clinical placements as student occupational therapists to shaping one's role over time on the community mental health team, all the while collaborating and consulting with a wide variety of co-workers with diverse outlooks.

Both government and occupational therapy professional documents expect service providers to practice from a recovery-based perspective while collaborating with others to best meet client's needs. This requires occupational therapists to demonstrate a wide variety of competencies, both case manager generic and occupational therapist specific, on a daily basis. Advocating for clients' needs while actively changing attitudes towards mental illness and mental health is expected. Finally, practising from a strong evidence

base and doing so in a professional manner, while also managing significant administrative demands are key expectations for every occupational therapist on a community mental health team.

In actuality, occupational therapists find themselves often experiencing two ends of a spectrum in their daily practices. Occupational therapists express they have the best job, and then in the same breath discuss the significant challenges that can contribute to job stress and burn out. Similarly, occupational therapists express that their roles require them to meet their clients' needs as best they can independently, yet they also strongly endorse close team work. It is evident that an occupational therapist's outlook on work makes a large impact on how the role is viewed. While most occupational therapists describe completing similar tasks on a daily basis, some feel they have a wide scope of practice, while others feel it is narrower. Similarly, some occupational therapists feel that almost everything they do in their job can be classified as occupational therapy, while others feel they get to practice occupational therapy only a small percentage of the time. Although all occupational therapists work on multidisciplinary teams, they often feel isolated. When they do find a confidante on their teams, occupational therapists are most likely to find common ground with other regulated professionals such as nurses and social workers.

As evidenced by the results of the role on paper, there are not many documents guiding practice for occupational therapists on community mental health teams. However, occupational therapists are not distressed by this, but would welcome further role

clarity from their professional bodies to generate greater unity and strengthen the profession's stance within community mental health on the whole. Finally, occupational therapists on community mental health teams find that they have the ability to influence their roles over time and shape the role to suit their clients' needs. This often involves incorporating a recovery-based approach which has many commonalities with both psychosocial rehabilitation and occupational therapy principles of practice. These uniquely skilled and passionate occupational therapists possess a certain 'it' factor that was discovered when they were students on clinical placement and now, as practising occupational therapists they can see the same 'it' factor in students whom they mentor when serving as clinical preceptors.

In reflecting back on my personal experiences working in this area of practice, I found it comforting to see so many of the perspectives I myself held expressed by the participants. Some experiences I understood explicitly prior to taking on the study (e.g., lack of community mental health specific documents) while others emerged during the process of hearing individual experiences from the occupational therapists interviewed (e.g., registered vs. non-registered differences, the importance that student clinical placements play in job hunting). As the study comes to an end, I am grateful for having had an opportunity to reflect on my experiences in such depth and breadth to fully appreciate and better understand the intricacies and challenges of working on a community mental health team. I have now come full circle in a sense: from first finding my passion and interest in community mental health via a clinical student placement, to working on a community mental health team as a new graduate and experiencing all the

challenges and rewards the role has to offer, then returning to school to explore the practice through research training. I have undergone a journey from outsider to insider to researcher and am now positioned to share my knowledge and insights to ultimately improve the practice of occupational therapy on community mental health teams. At the time of this writing, I am pleased to say that the first steps of sharing knowledge with my colleagues is underway as I prepare to present at an upcoming provincial occupational therapy conference.

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Appendix A: Content Analysis Tool

Title of Document:

Source of Document: e.g., Organization, governing body, etc.

Date Document was produced:

Date Document was retrieved:

Reference/ Online address of Document (if applicable):

Intended Audience: e.g., OTs, Mental Health Workers, General public, etc.

Type of Document: e.g., Job description, mission, vision, value statement, position statement, guideline/standard of practice, strategic report, policy document

Nature of Document: e.g., Mandated, informative, suggestive, related to CMHT or OT profession, etc.

Issues Addressed: e.g., Service provision, professional role, team role, etc.

Summary: i.e. outline of main points

Key Words: i.e. Use of specific language, reference to specific legislation, other important documents, buzz words, etc.

Interpretation: Researcher's notes about how this document fits in relation to other documents and to different roles



Dear Occupational Therapist,

This letter is an invitation to participate in a research study. As a Post-Professional Masters student in the School of Occupational Therapy at Dalhousie University, I am currently conducting research under the supervision of Dr. Crystal Dieleman on the experiences of occupational therapists working within community mental health teams.

Study Overview

Occupational therapists working within community mental health teams (CMHTs) often find themselves holding a dual role of occupational therapy specialist as well as general case coordinator. Two roles can represent two differing sets of expectations. One way expectations are expressed is through governing texts (e.g., Job descriptions, mission, vision, value statements, position statements, guidelines/standards for practice, strategic reports, and policy documents). The purpose of this study is to explore the role(s) being held by occupational therapists working on CMHTs along with the source and impact of role expectations.

Learning more about the role(s) being held by occupational therapists on CMHTs and the influence of governing texts can aid in strengthening the position of occupational therapy in community mental health. It may also serve to identify areas of discord that require attention, directing future efforts towards building a stronger and more unified position of occupational therapy in community mental health. Ultimately, through the strengthening of the profession of occupational therapy in community mental health, clients reap the rewards long-term.

The research will be carried out in three parts. First, a document review will be conducted to identify and examine existing governing texts on occupational therapy and mental health care. Second, interviews will take place with occupational therapists, hearing about their experiences working within a CMHT. Thirdly, participants will be asked to read over initial analysis of their interview as well as the summary of the group of interviews and share their thoughts around the initial conclusions brought forth by the researcher.

Your Involvement

Participants are being asked to take part in the second and third parts of the research study specifically. If you agree to participate, I will follow up with you to arrange an interview. Interviews are expected to take approximately 45 minutes to one hour and will be conducted in person when possible, arranged at a time convenient to your schedule. To ensure the accuracy of your input, I would ask your permission to audio record the interview. The review of the initial analysis from your individual interview is expected to be of a similar time commitment and documents would be sent via secure encrypted file transfer. For review of the initial analysis of the group results, you may choose to do so via e-mail, telephone, in person or as a part of a participant focus group. Review of both individual and group analysis is optional and it should be noted that confidentiality will be maintained in all cases except if participation in a focus group occurs. Focus group participation would involve your identity being known to the other group members. All group members participating in a focus group will be required to sign a confidentiality agreement prior to focus group participation.

Participation in the study is entirely voluntary and there are no known anticipated risks to taking part. Further, you may decide to withdraw at any time from the study, or decline to answer any of the questions you do not wish to answer.

This study has been reviewed and received ethics clearance through Dalhousie University Research Ethics Committee and is in compliance with the Tri-Council ethics

standards for conducting research involving humans. All information you provide will be considered confidential unless otherwise agreed to, and the data collected will be kept in a secure location and confidentially disposed of in five years' time.

Contact Information

If you have any questions regarding this study, or would like additional information about participation, please do not hesitate to contact me or my supervisor, Dr. Crystal Dieleman, using the information provided below.

--

Jennifer Michetti, OT Reg., (Ont.)

OT Post-Professional Masters Candidate, BSc Human Kinetics, MSc Occupational Therapy

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Crystal Dieleman, PhD, OT Reg., (NS)

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Appendix C: Participant Screening Questionnaire

Hello. [If by phone: May I please speak with {insert potential participant's name here}?] My name is Jennifer Michetti and I'm leading the research study titled: Occupational therapy in community mental health: Paper vs. practice. I received your email/phone call expressing interest in participating. [If by phone: Is this a good time for you to discuss this? If yes, continue. If no, arrange a time to call back.]

Right now I am recruiting participants for the study and have a few criteria that must be met for participation. [If by phone: May I ask you a few questions to ensure your eligibility for participation? If yes, continue. If no, thank for their time and end call.]

Do you speak English fluently? [If by phone: If yes, continue. If no, thank for their time, and end call.]

Are you a registered occupational therapist in the province of Ontario? [If by phone: If yes, continue. If no, thank for their time and end call.]

Do you currently work on a community mental health team in Ontario? [If by phone: If yes, continue. If no, thank for their time and end call.]

[If meets inclusion criteria: You are invited to participate in the study. Would you like to schedule your interview now? Or should I call back at another time? If yes, schedule interview. If no, arrange a time to call back.]



Title

Occupational Therapy in Community Mental Health: Paper vs. Practice

Introduction

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require attention, directing future efforts towards building a stronger and more unified position of occupational therapy in community mental health. Ultimately, through the strengthening of the profession of occupational therapy in community mental health, clients reap the rewards long-term.

The research will be carried out in three parts. First, a document review will be conducted to identify and examine existing governing texts on occupational therapy and mental health care. Second, interviews and a focus group will take place with occupational therapists, hearing about their experiences working within a CMHT. Thirdly, participants will be asked to read over initial analysis of their interview as well as the summary of the group of interviews and share their thoughts around the initial conclusions brought forth by the researcher.

Your Involvement

Participants are being asked to take part in the second and third parts of the research study specifically. If you agree to participate, I will follow up with you to arrange an interview. Interviews are expected to take approximately 45 minutes to one hour and will be conducted in person when possible, arranged at a time and location convenient to your schedule. To ensure the accuracy of your input, I would ask your permission to audio record the interview. You will be asked to review the initial analysis of your interview. This review of initial analysis is expected to take between 1-2 hours and documents would be sent via secure encrypted file transfer. For review of the initial analysis of the group results, you may choose to do so via e-mail, telephone, in person or as a part of a participant focus group. Review of both individual and group analysis is optional.

Confidentiality

Your name will not be used in anything that is written or presented about this research. The researcher will not tell anyone your name. An identification number was assigned to you when you first contacted the researcher about possible interest in the study. The file

that links your ID number and your name will be kept in a locked drawer in the researcher's office.

The digital recording of your interview will be stored on the researcher's password protected computer. It will be deleted after the interview is typed up by a transcriptionist who has also signed a confidentiality agreement. The typed up version of your interview will also be stored on the computer, and password protected. Your name will not be in it, and anything that identifies you will be changed or taken out to preserve your confidentiality.

Should you wish to participate in the participant focus group, confidentiality may not be maintained. Focus group participation would involve your identity being known to the other group members. All group members participating in a focus group will be required to sign a confidentiality agreement prior to focus group participation.

All data collected during this study will be securely stored at Dalhousie University for five years after the last publication is complete. The researcher will keep everything you say in the interview private.

Possible Risks and Withdrawal Process

Participation in the study is entirely voluntary and there are no known anticipated risks to taking part. Further, you may decide to withdraw at any time from the study, or decline to answer any of the questions you do not wish to answer. You may request that any information gathered up until the end of data collection be removed should you wish.

If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact Patricia Lindley, Dalhousie University's Office of Human Research Ethics Administration at (902)-494-1462.

I have read the consent form about this study. All of my questions have been answered at this time and I agree to be part of this study. I know that I am free to stop being part of this study at any time. I have been given a copy of this signed consent form.

____ I consent to having interview recorded

____ I consent to interview recording being transcribed by transcriptionist who has signed confidentiality agreement

____ I consent to the research including anonymous quotations from my interview and initial analysis review in publications and presentations from this study. I understand I have the right to view such material in context and can refuse its inclusion prior to publication.

Participant's Signature

Date

Researcher's Signature

Date

____ I would like a copy of the final report from this study

Your preferred contact information:

Contact Information

If you have any questions regarding this study, or would like additional information about participation, please do not hesitate to contact me or my supervisor, Dr. Crystal Dieleman, using the information provided below.

--

Jennifer Michetti, OT Reg., (Ont.)

OT Post-Professional Masters Candidate, BSc Human Kinetics, MSc Occupational Therapy

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Crystal Dieleman, PhD, OT Reg., (NS)

T: 902-494-1982 F: 902-494-1229 E: crystal.dieleman@dal.ca

Appendix E: Script for Reviewing Consent- Individual Interview

Researcher: Hello, before we begin I wanted to remind you about the Consent Form you signed.

You're aware that: The researcher will make efforts to maintain your anonymity and confidentiality by not sharing your name with anyone. You can choose not to answer any

question that is asked. You can take a break at any time. You can stop participation at any time.

You have agreed to have your interview recorded and that I can use anonymous quotes from the interview or initial analysis review in publications from the study. Do you agree to proceed?

[Wait for confirmation] Okay, do you have any questions or concerns before we start?

Appendix F: Semi-Structured Interview Guide

Can you start off by telling me more about your current role on the ACT Team?

What sort of things do you do on a day to day basis that you see as specifically OT and things that you see as not really OT, but more generalist?

What sort of advantages do you see in being able to wear multiple hats? What disadvantages are there to having those multiple hats?

In terms of having the skills to help with all those different sort of areas- do you feel like that's something that all OTs have, that you've learned over time , or?

Any challenges that you face in your role, day-to-day or bigger picture that you see as issues or concerns?

What's limiting your time with OT specific work?

How do you feel about those issues taking priority over OT related goals?

Given the multidisciplinary team, can you tell me about how much or how little you other disciplines in to work with a client, or consult with them- what does that look like?

Assessing for independent living and helping to make the plan towards that goal sounds like something that you see as being a distinctly OT role- is that correct?

Any other specific topics or areas that you feel are owned by OT?

Are there any documents that you wish existed, to help delineate the role and what OTs should be doing in Mental Health and what OTs could be doing in Mental Health?

The concept that OTs on multidisciplinary teams aren't boxed into one area and have lots of variety- where did this concept come from? (School, Written materials, Experience, Unknown, Mixed)

Tell me about any conflicts or dilemmas that you run into as the OT on the ACT Team?

Being the one who's assessing for independent living- how do you feel with what tools out there and what's available to you to? Does it allow you to be confident in making recommendations supporting or bringing up concerns?

What would this role look like ideally for you? Magic wand time. What would this role look like ideally? What would you change, what would you keep? What would you throw away, add in?

Can you tell me about any opportunities to working with others outside of the team?

With the great opportunities for working with different community partners, are there any barriers to working with others either inside or outside of the Mental Health sector?

Any strategies that you employ in those situations where there are barriers, or there's been bridges that have been burned?

Keeping on the same topic about advocacy- tell me about your experiences in dealing with stigma and discrimination. Working with your clients, in different situations.

Do you see any difference in attitudes within the mental health sector, versus outside of the mental health sector?

How do you find others' knowledge of OT? How do you find that the knowledge level of those that are around you in the team, outside of the team?

When you're working with your clients, how do you select which sort of interventions you're going to use? What's some of your decision making process?

Any certain models or principles that you base your practice on? You had mentioned recovery earlier.

What does recovery mean to you? What is psychosocial rehab?

Do you get the sense, that that goal is shared amongst the entire Team?

Moving into the non-clinical responsibilities, tell me about your responsibilities that are not face to face with clients.

Is your site also one that does the OCAN? How do you find the OCAN as a tool, for goal setting?

What does it mean to you, that OT is a profession, so as opposed to say someone who works as a bank teller- that that's a job, that OT being a profession.

Any overlaps or differences you see with the professional expectations placed on OT and the others on your team?

Please tell me about the role of family in your day-to-day work.

How do you feel in terms of support from the profession, whether that be the COTO, CAOT, OSOT, other OTs in regards to working in Mental Health.

Can supports you wish existed for OTs in Mental Health- formal or informal?

Is there anything else that you think is important for me to know around your role and work here on the ACT Team?

Appendix F: Semi-Structured Interview Guide

This is a guide, not a script. Questions will be adapted throughout interview process as this guide is a living document

1. Tell me about your current role.

Probes to keep in mind:

- a. What do you see as specifically 'OT' and 'not OT'?
- b. What advantages do you see in the dual role?
- c. What disadvantages do you see in the dual role?
- d. What (if any) challenges do you face in your work role? (OTs, Manager, Organization, Co-workers, etc.)

Info I'm aiming to hear about: How they view their individual role duality. Are certain things viewed as positive or negative, right or wrong?

2. Are there any document or texts that guide or influence your practice?

Probes to keep in mind:

- a. Tell me about the document, how do you interpret the message?
- b. What value does it bring you?
- c. How does the document fit into your daily practice?
- d. If no, what do you wish existed, and why?
- e. If no, where do you receive direction from?

Info I'm aiming to hear about: Are they OT specific? Mental Health specific? National, Provincial, Organizational? Want to see if OTs consciously seek guidance and direction from any existing texts

3. Tell me about the type of conflicts or dilemmas you run into, given your work role.

Probes to keep in mind:

- a. How often do these issues arise?
- b. What are the impacts of these issues?
- c. How do governing texts influence these situations?

Info I'm aiming to hear about: Types of conflicts, how often do these situations occur. Are conflicts expected, bring how much/little stress? Patterns to common dilemmas?

4. What would this role look like ideally, & why?
5. Is there anything else you would like to add?
 - a. Do you feel there is a gap/conflict/discord between paper & practice?

Info I'm aiming to hear about: Having now given the participant the opportunity to work through the above questions, looking to hear about potential recommendations for changes from the individual occupational therapist's perspective. Will serve to highlight what individuals feel are most important to maintain within the role and their rationale for their thoughts.