Engaging the hard to engage, what specific contribution could occupational therapy make to an interdisciplinary approach?

Practice-based paper

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Introduction

How best to engage individuals who find it hard to engage in mental health services is an ongoing complex interdisciplinary issue. A number of client groups are of particular concern, including those with severe and enduring mental health problems; specifically those with schizophrenia, psychosis and early psychosis (NICE, 2014). Engagement, although assumed as beneficial, remains poorly understood; lacking clear definition (Wright, Callaghan and Bartlett, 2011), precision, and consistency in its use (Cole et al, 2016). Hitch (2009) helpfully conceptualises it as attracting an individual's attention or interest, with emphasis on the desire of the engaged individual to participate, be involved, or connect. Furthermore she illuminates the concept of both engagement in mental health services and engagement in occupation, as two separate but interrelated issues. Additionally there is significant concern, that once engaged in a service, individuals can become over engaged, with dependency, a non - proactive approach to recovery (West and Savage Grainge, 2012) and a reluctance to be discharged from more intensive services (Rana and Commander, 2010). This practice based paper considers whether use of occupational therapy core skills and philosophy, alongside the skills of the wider interdisciplinary team, could help clarify the potential role of occupational therapy with clients labelled as hard to engage.

Background

Perceived reasons for lack of engagement are varied, including loss of autonomy and identity, undesirable side-effects associated with medication and poor therapeutic relationships (Priebe et al., 2005). Nationally and internationally there have been varied attempts to develop whole services to address concerns around engagement, for example long standing assertive outreach/assertive community treatment teams within America and Australia (Issakidis et al., 1999) and internationally early intervention psychosis teams (Alameda et al., 2016). Others have focused on this issue through specific aspects of wider service delivery, for example the flexible assertive community treatment model (FACT) as part of a wider community mental health team (CMHT) within the Netherlands (van-Veldhuizen, 2007) and more recently within the UK (Firn et al., 2013). Juxtaposed Fieldhouse (2012) raises whether individuals are hard to engage, or is it more that services are 'un-engaging'.

It is acknowledged that the whole team approach within a traditional assertive outreach model, emphasises involvement of the whole team with each individual, however this approach also calls for differentiation between distinct contributions of different professionals. West and Savage Grainge (2012) advocate the need for flexibility in approach to allow different disciplines to be involved, according to the focus of the work required and Brugha et al (2012) identified use of more specialist skills may improve outcomes in assertive outreach, focusing on cognitive behavioural therapy. However with the exception of Hitch (2009), Fieldhouse (2012) and Newberry and Terrington (2016) there has been relatively little published consideration of the contribution occupational therapy can or does make in relation engagement. Regardless of type of service provision, engagement focussed research either does not contain any specific reference to occupational therapy (Priebe et al., 2005; Rana and Commander, 2010; Wright, Callaghan and Bartlett, 2011; Cole et al., 2016), is ambiguous about the mix of professions involved in service delivery (Brugha et al., 2012; Firn et al., 2013; Alameda et al., 2016), or states occupational therapy involvement, but does not specify any occupational therapy specific role or use of occupational therapy specific skills (Hussain, Thirkell and Taher, 2011; West and Savage Grainge, 2012).

Therapeutic use of self to enable service and occupational engagement

In a large scale study of American occupational therapists, working across varied areas of service delivery, the majority considered therapeutic use of self to be the most important skill in occupational therapy practice (Taylor et al., 2009). Interestingly Burns (2004) also identified that structured and reflective thinking around therapeutic use of self was a strength of occupational therapy within assertive outreach. Arguably many professions consider concepts similar to therapeutic use of self, such as the importance of a deep understanding of each individual's interpersonal skills and preferences, and the need to then proactively vary responses according to interpersonal needs of each individual (Taylor, 2008). Indeed, therapeutic use of self in its own right may be an interdisciplinary skills set effective in facilitating service engagement with individuals who have previously had negative experiences with staff. However the Intentional Relationship Model (IRM) (Taylor, 2008), may further clarify why Burns considered therapeutic use of self as a specific strength of occupational therapy. The IRM aligns the therapeutic relationship and occupational engagemen,t focussing on conscious use of varied interpersonal response modes, but in contrast to other professions the ultimate end goal is always occupational engagement. Burns (2004) highlights the importance of occupational therapists enabling people to do things, eve n in the midst of crisis, as a healthy counterbalance to other team members' professional perspectives. This goal of occupational engagement can directly begin to address reasons for non-engagement identified by Priebe et al (2005) such as loss of autonomy.

Hitch (2009), as part of her assertive outreach based exploratory study, considered both staff and client perceptions of the concept of engagement. Of note clients spontaneously focussed on engagement in occupation, whereas staff, including one occupational therapist, focussed on service engagement. Additionally Fieldhouse (2012) identified that it was relationships with assertive outreach team members, based on occupations, that facilitated renewed engagement in community resources, and that this was something individuals valued. Priebe et al (2005) also highlights a supporting factor of engagement within assertive outreach as the team showing an interest in people's lives. Viewed collectively these studies indicate a potentially important lesson; those individuals considered as hard to engage, appear to be more focussed on engaging in doing things of meaning and value to them as part of their real lives, rather than on considering whether they are engaged with service provision. Enabling this through occupational engagement, is an area of professional expertise occupational therapists could lead on within services. Addis and Gamble (2004) highlight the need to spend time with individuals, repeatedly returning to see individuals who have previously declined contact. This labour intensive, interdisciplinary engagement can be challenged by occupational therapy colleagues and managers, especially when occupational therapists can be viewed as a scarce resource (Newberry and Terrington, 2016). However by embracing the IRM focus of therapeutic use of self being in order to facilitate long term occupational engagement, a clearer, profession specific contribution can be identified within the wider interdisciplinary service engagement.

'Doing for'; is this really an occupational therapy role?

Particularly in initial service engagement, individuals can have extensive and diverse practical needs, for example related to housing, food shopping and meal preparation, managing bills, laundry or cleaning. It is not uncommon for practical resources to meet such needs, to be provided as an effective part of service engagement (Hitch, 2009; Wright, Callaghan and Bartlett, 2011; West and Savage Grainge, 2012). Priebe et al (2005) indicated for the majority of participants in their study, practical help was an important aspect of engagement. At the route of many of the practical resources provided are familiar occupations that form the basis of many occupational therapy specific interventions in wider CMHT's, such as meal preparation sessions. Traditionally occupational

therapists would not be involved in directly meeting these needs by 'doing for' the individual in CMHT work (Newberry and Terrington, 2016), focusing on problem solving to promote independence in occupational performance. In contrast within services that actively set out to engage individuals, this 'doing for' is seen as an interdisciplinary role, hence occupational therapists are quite rightly involved.

As an occupational therapist 'doing for' can be both a personal and professional challenge, seeming at odds with widely held beliefs and definitions of occupational therapy. Indeed critics of this approach may suggest 'doing for' is both costly and in the long term promotes the dependency levelled as being encouraged by assertive outreach (West and Savage Grainge, 2012; Firn et al., 2013). However without such initial engagement via 'doing for', in the longer term there may not be opportunity to move to the next steps of 'doing with' and finally 'doing independently' (Newberry and Terrington, 2016). Priebe et al (2005) identified a key reason for disengagement is that services conflict with the individuals desire to be an independent and able person, hence supporting the notion that this continuum of moving towards 'doing independently' must underpin the initial 'doing for' if disengagement is to be avoided. Wilcock (1995) in her seminal work identified the need to 'do' as integral to human life. Some may view 'doing for' as directly opposing this, indeed if 'doing for' has no essence of leading to 'doing with' or 'doing independently', and worse still if the 'doing for' is not meaningful and purposeful for the individual, then it is unsurprising that disengagement occurs. By an occupational therapist taking an active role in the planning and/or delivery of 'doing for', a focus of the individual fulfilling their need to be an occupational being may mediate against the potential of service dependency or disengagement.

The value of occupational identity

One of the first challenges as an occupational therapist when working with people labelled as difficult to engage, is determining occupational goals on which to centre 'doing for', 'doing with' and 'doing independently'. Priebe et al (2005) assert identity as a real issue of concern within engagement, as the individual strives to regain their old identity. Occupational goals should therefore be closely linked with this concept. Kielhofner (2008) considers occupational identity; combining who one is and who one wishes to become, based on previous occupations undertaken. It is not uncommon for individuals at the point of engagement to have been undertaking very few healthy occupations, and for previously aspirations to have been disrespected and ignored by services, or abandoned by the individual themselves (Newberry and Terrington, 2016). However considering occupational identity when establishing occupational goals, may increase the likelihood of the individual remaining engaged. The encouraging response mode of the IRM is essential in instilling hope and courage to engage or re-engage with desired occupations (Taylor, 2008). Intertwining this encouragement mode with the interdisciplinary recovery focus, based on hope, optimism and realism (Shepherd et al., 2008) is central. Frequent reiteration of informal goals and discussion around their current priority ensures that even as an individual's circumstances quickly change, longer term goals are not lost. They should merely be temporarily reprioritised to be refocussed on, hence maintaining long term engagement (Newberry and Terrington, 2016) and continuing to work towards maintaining or even reimagining a new occupational identity.

'Doing with'; activity analysis and a graded approach

Initially many individuals long term goals can appear unrealistic; occupational therapy specific skills of activity analysis are vital to interpret how work towards these goals can begin. Kielhofner and Forsyth (2009) consider activity analysis as finding the fit between the characteristics and needs of the individual and the desired occupational goal. Maintaining the interdisciplinary team recovery focus that includes realism is integral to finding this potential fit. Large goals may require breaking

down into smaller goals so that the fit is more apparent. This graded approach (Creek and Bullock, 2008) is integral to many areas of occupational therapy practice, and conceptualising some initial 'doing for', before then moving towards 'doing with', as part of this grading can be valuable. Fieldhouse (2012) advocates the importance of being a travel companion on the recovery journey, as opposed to a travel agent who would provide information and let the individual go alone. In essence this 'doing with' is about providing support in a form that equates to collaboration. Taylor (2008) identifies key aspects of the collaborative response mode of the IRM being around making joint decisions and active participation, leading to individuals taking ownership. It is interesting to note that a lack of active participation can be a key reason for disengagement (Priebe et al 2005), further supporting use of the IRM collaborative mode.

Hitch (2009) identified that the structure of occupations being organised for individuals by the assertive outreach team was valued. A useful metaphor for this structure in relation to 'doing with' is the concept of scaffolding; working towards the goal is facilitated by temporarily constructed support. Scaffolding is a common concept within educational theory and philosophy, often attributed to the ideas of Vygotsky (1978), indeed Fieldhouse (2012) details aspects of this in relation to assertive outreach work. Within a graded approach the scaffolding is gradually dismantled as the individual's independence is increased.

'Doing independently'; issues of external and internal motivation

When moving from 'doing with' to 'doing independently', maintaining motivation and volition for the occupational goal is vital; symptomology, side effects of medication, chaotic lifestyles, and limited social support and encouragement may all impact on volition (Newberry and Terrington, 2016). The IRM therapeutic response modes of encouraging and instructing can be valuable as by providing verbal positive reinforcement, alongside direction, positive elements of occupational performance can be reinforced with the aim of them being repeated (Taylor, 2008). Fieldhouse (2012) discusses providing external motivation, advocating creation of an affirming environment in which to provide graded empathetic and non-judgemental support. In the period of moving between 'doing with' and towards to 'doing independently' the level of this support is gradually reduced as the individual gains independence; grading of this requires careful planning and skilled delivery. A key aspect of the IRM is the intentional and planned use of response modes and it is vital that all those involved have a shared understanding and adherence to such plans.

Ideally the individual experiences internal reinforcement from completing the occupation or a particular aspect of the occupation, as this will increase the likelihood of long term 'doing independently'. If a true occupational goal without due consideration for occupational identity was not determined at the start of the 'doing for' process, it is less likely internal reinforcement will occur. Additionally symptoms such as blunting of affect, anhedonia, delusional thoughts and medication side effects may negate this internal reinforcement. Use of the IRM collaborating mode (Taylor, 2008) can prove useful in addressing these issues, as the mode encourages individuals to give on-going feedback. This in itself may help the individual to develop self-awareness of internally reinforcing feelings such as pleasure, enjoyment, satisfaction and increased self-esteem.

Over engagement or dependency versus adaptation

Returning to the scaffolding metaphor, scaffolding by its very nature is temporary; at some point it is either removed or has to be replaced with a more permanent support. Many of the criticisms of costly over dependency in teams such as assertive outreach, subjectively appear to occur due to long term use of scaffolding; the initial engagement process has occurred, however after a lengthy process of 'doing with' the individual appears not to be able to progress to 'doing independently'.

The core occupational therapy principle of occupational adaptation (Kielhofner, 2008) may be useful at this point. The individual still has the desired occupational identity, but their occupational competence doesn't enable them to 'do independently', hence scaffolding is still required to support the desired occupation. For example for some aspects of an occupation the individual may still require someone to 'do with' or even to 'do for'. Adaptation focuses on finding a new way to achieve the same or similar outcome, for example by the permanent support of a friend, relative, volunteer, or paid support worker, who can 'do with' or 'do for' in the long term. Alameda et al (2016) identify a small proportion of early intervention caseloads have less potential for recovery, hence these individuals may well need a long term adaptive approach to follow on from service and occupational engagement. This will require gradual introduction to replace the existing scaffolding and sustainable support to meet the end occupational goal and maintain occupational identity for many years to come.

At this point disengagement from the occupational goal and potential overall service disengagement as a result, are arguably significant risks. However it is suggested encouraging dependency through continued use of a scaffolding approach is a bigger risk, in terms of unsustainable long term support. Addis and Gamble (2004) highlight the anxiety associated with working in services such as assertive outreach, and question whether factors such as anxiety impact on team members not considering discharge of individuals. Planned and carefully implemented adaptation, could serve to both reduce team anxiety and more importantly facilitate long term adapted occupational engagement. Rana and Commander (2011) noted benefits of assertive outreach plateaued after the first two years, raising whether the benefits could be sustained by other services. Adaptation, led by occupational therapists, may provide a theoretical underpinning to the clinical reasoning for replacing 'doing with' scaffolding, by a planned, implemented and monitored alternative.

The challenge ahead

Whilst there seems little uncertainty that a group of individuals will always exist that are labelled as hard to engage, much ambiguity remains about the future of services that best meet there needs. Indeed Brugha et al (2012) identified that current characteristics of assertive outreach do not explain long term patient outcomes; advocating new models are developed and researched. The current paucity of robust evidence for occupational therapy in this area is of concern, however this paper has identified ways in which occupational therapy core skills and philosophy could be utilised as part of these new models through wider consideration of not only service engagement, but also occupational engagement. Carefully planned and executed implementation of 'doing for', 'doing with' and 'doing independently', or 'doing with' sustained by long term support through occupational adaptation are advocated. Indeed they may help facilitate interdisciplinary services in being more engaging and potentially support the engagement of those who find it hard to engage. Further research into this potential role is essential to determine what added value occupational therapy can bring.

References

Addis J, Gamble C (2004) Assertive outreach nurses experience of engagement. J Psychiatr Ment Health Nurs 11(4): 452–60

Alameda L, Gloay P, Baumann P, et al (2016) Assertive outreach for "difficult to engage" patients: A useful tool for a subgroup of patients in specialized early psychosis intervention programs. Psychiatry Res 239: 212-9

Brugha TS, Taub N, Smith J, et al (2012) Predicting outcome of assertive outreach across England. Soc Psychiatry Psychiatr Epidemiol 47(2): 313-22

Burns T (2004) Community mental health teams, a guide to current practice. Oxford University Press, Oxford

Creek J, Bullock A (2008) Planning and implementation. In Creek J, Lougher L (eds) Occupational therapy in mental health, fourth edition. Churchill Livingston, Edinburgh: 109-30

Cole A, Kim H, Lotz K, Munson M (2016) Exploring the perceptions of workers on young adult mental health service (dis)engagement. Soc Work Ment Health 14(2): 133-48

Fieldhouse J (2012) Community participation and recovery for mental health service users: an action research inquiry. Br J Occup Ther 75(9): 419–28

Firn M, Hindhaugh K, Hubbeling D, Davies G, Jones B, White SJ (2013) A dismantling study of assertive outreach services: comparing activity and outcomes following replacement with the FACT model. Soc Psychiatry Psychiatr Epidemiol 48(6): 997–1003

Hitch D (2009) Experiences of engagement in occupations and assertive outreach services. Br J Occup Ther 72(11): 482–90

Hussaine A, Thirkell T, Taher A (2011) Enhancing the effectiveness of an assertive outreach team: case study. Psychiatrist 35: 266-68

Issakidis C, Sanderson K, Teeson M, Johnston S, Bucrich N (1999) Intensive Case Management in Australia, a randomised control trial. Acta Psychiatr Scand 99: 360-367

Kielhofner G (2008) Model of human occupation: theory and application, fourth edition. Lippincott Williams and Wilkins, Baltimore

Kielhofner G, Forsyth K (2009) Activity analysis. In Duncan EAS (eds) Skills for practice in occupational therapy. Churchill Livingstone, London: 91-103

National Institute for Health and Care Excellence (2014) Psychosis and schizophrenia in adults: prevention and management guideline. https://www.nice.org.uk/guidance/cg178 (accessed 2 June 2017)

Newberry K, Terrington C (2016) Occupational therapists and assertive outreach. In Clewes J, Kirkwood R (eds) Diverse roles for occupational therapists. M and K publishing, Keswick: 19- 36

Priebe S, Watts J, Chase M, Matanov A (2005) Processes of disengagement and engagement in assertive outreach patients: qualitative study. Br J Psychiatry 187: 438-43

Rana T, Commander M (2010) Long term follow up of individuals on assertive outreach teams. Psychiatrist 34: 88-91

Shepherd G, Boardman J, Slade M (2008) Making recovery a reality. Sainsbury Centre for Mental Health, London

Taylor RR, Lee SW, Kielhofner G, Ketkar M (2009) Therapeutic use of self: A nationwide survey of practitioners' attitudes and experiences. Am J Occup Ther 63:198–207

Taylor RR (2008) The intentional relationship; occupational therapy and use of self. FA Davis Company, Philadelphia

van-Veldhuizen JR (2007) FACT: a Dutch version of ACT. Community Ment Health J 43(4): 421–33

Vgotsky LS (1978) Mind in Society. Harvard University Press, Cambridge

West R, Savage Grainge A (2012) A team approach to promoting recovery in assertive outreach. Mental Health Practice 15(9): 20-24

Wilcock A (1995) The occupational brain: a theory of human nature. J Occup Sci 2(2): 68–72

Wright N, Callaghan P, Bartlett P (2011) Mental health service users' and practitioners' experiences of engagement in assertive outreach: a qualitative study. J Psychiatr Ment Health Nurs 18(9): 822-32

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