Survey Questions and Submission Results
Part one: Self-injurious Behaviors

Question #1
Do you work with people who engage in self-injurious behaviors (SIB)?

Answers:
8/9 say: Yes
1/9 say: No

Question #2
If so, what were there age ranges and general diagnostic categories?

Answers:
1. Ages 64 to 89 with general diagnostic categories of bipolar, MDD, and schizoaffective disorder.

2. Ages 18 to 50 with borderline personality disorder.

3. Ages 18 to 65 with depression and personality disorder.

4. As an OTR working with adolescents I encounted significant amounts of SIB in teens. I changed jobs last year and am now working with adults in a state mental health facility. Although we continue to see this occasionally it is a small percentage. We get individuals who "used" to cut but have gotten this behavior under control.

5. Age 30 borderline personality disorder.

6. Ages 25 to 45.

7. Ageing from 25 to 60 years old. Most of them diagnosed with schizophrenia.

8. Adolescents 10 to19 years old. Conduct disorder, autism, asbergers, ADHD, Borderline, PDD, MR, and others.
9. N/A

Question #3
What are the primary types of SIB your population engages in?

Answers:
1. Refusal to eat or drink, knife wounds, gun shot, and overdose.

2. Over doses, cutting, increase in alcohol and drugs, ongoing cutting at infectious wounds.

3. Self harm, overdose and cutting.

4. Typically cutting is primary.

5. Cutting and overdose.

6. Biting, scratching, cutting ones self, head banging, hitting walls/doors, break windows/light fixtures, throw beds/chairs.

7. Burns, using knife.

8. Cutting self, burning self.

9. N/A

Question #4

What do you think are the general functions of these behaviors?

Answers:

1. Attention seeking, frustration with life changes, grief, despair.

2. As a coping mechanism to deal with distress- to help the person cope that can't cope with emotions, and to change the focus from internal to and external focus. Also to stop the ongoing feelings of depersonalization i.e. proof that I exist.

3. Relief, increase in arousal state.
4. As per the teens I worked with they used cutting to relieve internal pain. Some reported that taking the pain out on themselves was better than taking the pain out on some one else.

5. Coping, avoiding unpleasant memories and feelings.

6. To get attention, release anger (cope with negative news)

7. Seeking attention.

8. Attention from others, self release.

9. N/A

Question #5

What kind of assessment tools do you use with those who engage in SIB?

Answers:
1. COPM, Kohlman evaluation of living skills for safety knowledge, Katz index of act of daily living, leisure expansion testing.

2. Questionnaires- at present not standardized

3. - No answer

4. We do not use any structured assessment tools. We had clients complete a goal sheet, a daily functioning assessment/daily schedule, a collage, and an interview.

5. MOHOST, OCAIRS..

6. None specific to SIB.

7. BAFPE, COTE, clinical observations.

8. Sensory profile, same as everyone else. Nothing specifically geared towards SIB.

9. N/A

Question #6
What kinds of treatment approaches do you use with people who engage in SIB?

Answers:
1. Self expansion activities and discussions, group dynamics, reminiscent activities that focus on coping skills, problem solving skills, support system expansion, ---verbal, group, individual and written.

2. Menatlisation based treatment, gestalt psychotherapy practical based activities initially to promote a period of grounding and stabilization before group work and psychotherapy.

3. CBT

4. Exploring alternate ways to cope without use of self harm. CBT if able to comprehend. Behavior modifications.

5. Motivational interviewing, CBT, joint problem solving, damage limitation, family interventions.

6. PT maybe 1;1 with staff, make a list of what they enjoy, have them choose something from that list. Sometimes isolation.

7. Cognitive behavioral approach.

8. Sensory integrative, Cognitive behavioral.

9. N/A

Question #7
What areas do you feel are in need of further exploration for this population?

Answers:
1. Education of the disease process per patient need. Resources for geriatric activity.

2. On going support and long term treatment based programs. More research into the value of OT programs with this client group. More support for care takers and respite for short periods in supported accommodation in the community.

3. Sensory integration theory, abuse/ support networks.

4. Why this appears to help individuals and alternatives (sensorimotor) that may effect the same outcome.

5. Service response. Especially in emergency departments and general ward, dbt, family work.

6. Many.

7. Family history regarding the violence and early ages abuse.

8. Adolescent Mental Health population in general (Non acute)

9. N/A

Question #8
Do you believe there is a relationship between trauma history and engagement in SIB with your specific population?

Answers:
8/9 say yes
1/9 I don't know

Question #9
Has your facility engaged in trauma-informed staff educational projects?

Answers:
6/9 say No
3/9 say Yes

Question #10
Do you believe there is a link between sensory modulation and trauma informed care approaches?

Answers:
5/9 I don't know
4/9 Say Yes

Question #11
If so what?

Answers:
1. For self expression and emotional release.

2. N/A

3. Sensory seeking behavior.

4. N/A

5. N/A

6. N/A

7. N/A

8. I believe there is a link, but am unsure what you mean when you referring to trauma informed care approaches.

9. N/A

Question #12
Do you believe that your administrators recognize the OT role in trauma-informed care?

Answers:
7/9 say No
2/9 I don't know

Question #13
What country or US state do you participate in?

Answers:
1. Texas

2. Northern Ireland

3. Devon, UK

4. Ohio

5. UK

6. TX

7. Jordan

8. Minnesota

9. Washington

Part two: Occupational Therapy in the US

Question #1
Why do you think that as recent as 2006, various OT circulations in the US continue to report that there are few OT positions in mental health?

Answers:
1. Lack of education about disease process and lack of education about occupational therapy process and scope.

2. I am not sure as to why because in Ireland we have a larger number of OT's in mental health than we do social workers.

3. N/A

4. Because there are! I have worked in OT mental health for approx. 17 years and have recognized the decline. Obviously managed care that had a role in this as well as limited reimbursement for mental health services. Insurance companies are not covering OT per say, we typically are "per diem". I also feel our AOTA has lost sight of OT in mental health and have gone with the more reimbursable area of care. I currently am in college for a master's in counseling as I feel OT in mental health will not be around much longer.

5. People still don't understand the full scope of OT, less OT's means fewer services have personal experience of OT and so the cycle continues.

6. TX state requirements for state mental hospitals does not include OT specifically, just psychiatrist, social worker, nursing and psychology. A functional skills assessment is to be done but TX does not state by whom. Each TX state hospital is independent and chooses if and how many OT's there are. To my knowledge, the community mental health do not employ OT's.

7. I believe most OT's are working with the cases that they will see some hard evidences and achievements of there works. Working with mentally ill people is not easy and you are working with intangible problems but it's effects are seen.

8. Funding sources don't like to pay OT to do Mental Health, they think it is the job of the mental health therapist. Lack of knowledge of OT's role in mental health.

9. I believe funding for positions is inadequate. I think that our government has not funded for long term treatment for mental health disorders. It has become a band aid approach. For example, now day treatment services are defined as TX for two weeks. During the 1970's, day treatment services for persons with chronic disabilities was at least six months to one year of out patient, skill building/therapy services.

Question #2

What are the current roadblocks you face in your practice?

Answers:

1. Money, staffing for additional services.

2. Funding for more staff and not to become blurred with other staffs roles in mental health.

3. N/A

4. Ignorance about what OT is and does. Administration seems to want "cheaper" staff to complete "activities". They don't comprehend "therapy" vs. recreation. I know this is partially my fault but I have only been with this facility a short time and there is a long reputation here of poor OT services.

5. Lack of money, increasing case loads, burn out, misunderstanding of value of OT. Forced to take many additional roles as well as OT, generic work load pressure.

6. Trying to incorporate the OTPF and ACL into a concise, meaningful mental health evolution and report. Better understanding of medicare requirements and how to mesh with electronic records.

7. The psychiatrists and nurses don't believe that the purposeful and active engagement in activities will make any difference or changes with clients.

8. Payer paying for services. Lack of knowledge. Poor documentation and not well

developed plan of treatments.

9. I am in a private practice, Aging Welles, LLC. We work with persons in the community who can pay for our service. Persons with chronic psychological disabilities do not have an economic base from which to demand for service that meets there needs.

Question #3

In your opinion what kinds of things can be done to help the road blocks you have listed?

Answers:

1. Education of the benefits of our patients. Marketing the service. Community education of our geriatric population and there needs.

2. Promoting the role of OT clearly at any opportunity given.

3. N/A

4. Obviously educate staff on OT and our "therapeutic" value.

5. Leaflet explaining OT, more money allocated to Manchester - so there is less crisis intervention work and more rehab to exit services and prevent relapse.

6. I read articles, SIS, listservs, documentation book. I think that I have come closer. I am still working on it.

7. Get the psychiatrists involved in the therapeutic sessions and attend more lectures and work shops about OT and mental health.

8. EDUCATION! EDUCATION! EDUCATION! At all levels and research.

9. Re-define day treatment service to include ongoing treatment which is focused on maintaining ability to function on daily community life. Pay for it and appreciate that the growth may be incremental. If one looks at the bottom line it appears to be less expensive than to pay for out patient ongoing skill building services than to pay for ER for crises. Also take back mental health from the criminal justice system.

Question #4

What kinds of educational and/or supportive projects would be useful to you in your practice?

Answers:

1. Education of operation and set up of sensory motor program. Marketing tools for community awareness. How to session to make own tools.

2. N/A

3. N/A

4. Networking with our OT's in mental health, more OT mental health seminars/educational activities.

5. OT related MSCS and further post grad study – mostly OT study is re-generic courses.

6. We are getting the 2000 ACL information book. Discussion with others how they incorporate OTPF into notes. What is the "standard of care"that others use in mental health (children to geriatric)?

7. Get the psychiatrists and nurses into the sessions and maybe making some joint therapy together.

8. Funded research and better assessment tools.

9. Actual resources where I can refer clients to for a sense of community and skill enhancement. I am trying to find resources for a young man in Portland, OR area about two months ago, I could find nothing that was considered to be ongoing support. Day treatment was two weeks and the referral seemed to be vague "Well, I am not sure there is anything for this young man to participate in to help him learn how to live with his mental disability."

Question #5

What are your area's of expertise?

Answers:

1. Inpatient rehab, geriatric population, neuro reeducation with CVA

2. Vocational rehabilitation and working with clients with B.P.D

3. Adult acute inpatient psychiatry

4. Currently I am working with forensic mental health and in patient acute care. Also I have 8 years experience with adolescents. Limited experience is geriatric psychiatry.

5. Mental health, Self neglect, difficulty engaging, complex issues, CBT.

6. ACL/ADM, mental health, in past-community adaptation-home visits; some research experience.

7. Mental health. Mainly the mood and thought disorders.

8. Outpatient and residential adolescent physical and mental health.

9. Aging, mental health, ergonomics, injured working, teaching.

Question #6
Would you be interested in participating in an international support project for OT's practicing in mental health in the future?

Answers:
6/9 say Yes
3/9 say Maybe

Question #7
If yes, what capacity?

Answers:
1. If COTA can participate.

2. N/A

3. Could add updates of current practice in my area.

4. I would need more information before I could determine what role I could take.

5. N/A

6. Researching info, computer skills, presentations.

7. Gathering info from my country and sharing my own experiences.

8. Funded research, training opportunities, open to ideas.

9. Resource for program development in the community for folks that need a place to be that provides structure, support, education, and skill building.

Question #8
If no, why not?

Answers:
9/9 N/A

Survey Participant Demographics
Each number corresponds with his or her responses.

1. KM, COTA
Senior care- Gero Phych
Palestine Regional Rehabilitation Hospital
Serving population of 55 or older
Texas, USA

2. MO, Mental Health
North Belfast
Co Antrim Northern Ireland

3. LS, Head OT
Adult Acute Psychiatry
Devon, England

4.B R-B, OTR/L
Mental Health
Heartland Behavioral Healthcare
Inpatient acute care and long term forensic
Ohio,USA

5. N/A

6. KW, MOT/OTR
Acute Chronic adult mental ill
San Antonio State Hospital
Texas, USA

7. MA, Mental Health
Hampshire University
Adults with thought and mood disorders
Jordan

8. CS MA OTR/L
Focus on adolescent mental health in outpatient basis
Life-Balance private practice whom contracts with resid TX f
Child and adolescent physical and mental health
Minnesota, USA

9. CDS, MA OTR/L
Private Practice
Aging Welles, LLC.
Serving Seniors
Washington, USA