

Opportunities for Occupational Therapy Behavioral Health: A Call to Action

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The Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) provides a window of opportunity for occupational therapy to reengage in serving people with serious mental illness (SMI) and substance use challenges using contemporary community-based and person-centered, recovery-oriented services and supports. As implementation of the law moves forward, occupational therapy practitioners must respond to this call for action to ensure that the essential benefits in products offered by state-based purchasing exchanges fully include rehabilitation, habilitation, mental health, substance abuse, and behavioral treatment services for all covered persons with behavioral health conditions. Each benefit category is required to be covered under the exchange-based offerings. Occupational therapy's goal must be that occupational therapy is recognized in all of them.

In addition, availability of chronic care management and care coordination services for people with SMI and disabling substance use disorders provide additional areas in which occupational therapy expertise can add to the consistency and quality of recovery outcomes. Medication management and wellness and prevention programs are consistent with areas covered by the ACA and with recovery-oriented outcomes. With the growing movement toward recovery and the emerging definitions of *recovery*, *recovery services*, and *recovery supports*, the goodness of fit between these constructs and the unique skills of occupational

therapy practitioners supports a growing role for occupational therapy in the behavioral health marketplace.

The June 28, 2012, U.S. Supreme Court decision concerning constitutional challenges to the ACA (*National Federation of Independent Business, et al. v. Sebelius, Secretary of Health and Human Services, et al.*, 567 U.S. 2012, Case No. 11–393) and the recent presidential election outcome bode well for optimum implementation of the law. The Supreme Court upheld the minimum coverage provision (the “individual mandate”) considered central to the law. By a 6 to 3 vote, the justices found that the individual mandate was permissible under the power of Congress's tax authority. Other provisions, such as providing family coverage for children up to age 26, coverage of preexisting conditions, and the strengthening of health centers in urban and rural communities across the nation, remain in force.

Although the Supreme Court decision on the 2014 Medicaid expansion kept the expansion program intact, federal penalties for states choosing not to undertake the Medicaid expansion were removed, essentially making this expansion an option for states (Manderscheid, 2012). Although the political process will continue around response to the Medicaid expansion, at this time, 26 states have indicated some opposition to the expansion. The major implication of this action is that people who are currently uninsured in states rejecting the expansion may remain

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uninsured, undercutting another primary goal of the ACA (Manderscheid, 2012). “In states that opt out of the Medicaid expansion, poor people with mental illness may find themselves in a terrible predicament: They earn too much to qualify for Medicaid, yet not enough to get the federal subsidy to pay for insurance” (Friedman, 2012, para. 13).

President Barack Obama’s reelection in November 2012 would indicate that the federal government will move to fully implement the law.

Advocacy With Other Coalitions at the State Level

One call to action for occupational therapy practitioners is to join with other health and human services coalitions to advocate for use of the Medicaid expansion so that the social injustice of being poor and disabled might be balanced by this portion of the ACA, which during the first 3 years is fully funded by the federal government and then funded at 90% in the years beyond. The American Occupational Therapy Association (AOTA) has a team of experts who lead in advocating for important system-level change; however, the scope of potential changes requires full participation by every occupational therapy practitioner in many groups that are organized around similar values.

One such group that I have recently become a member of is ACMHA: The College for Behavioral Health Leadership, an organization focused on cultivating leaders and fostering innovations in behavioral health environments in the United States (see www.acmha.org). ACMHA members include senior and emerging leaders concerned with mental health and substance use across all systems of care. As a new ACMHA member in 2012 representing AOTA, I attended the annual summit and receive about 20 emails weekly, each containing up-to-date information and links to documents and potential policy ideas that might affect treatment and prevention behavioral health services. AOTA’s support of this advocacy will further our mission considerably.

Other advocacy groups that I have found to be strong advocates around

behavioral health and that are open to occupational therapy practitioners include the National Alliance on Mental Illness (see www.nami.org) and Mental Health America (see www.mha.org). Both organizations have leadership from many stakeholders, from people with the lived experience of mental health and substance abuse conditions to family members, friends, behavioral health professionals, peer mentors, policy experts, and the public. Because individual states will decide important aspects of the scope and nature of coverage under the ACA’s essential benefits categories and because states must decide whether to opt in or out with regard to the Medicaid expansion, the state chapters of these organizations will be important partners with occupational therapy state associations in advocacy efforts.

Essential Benefits as Applied to Behavioral Health Treatment

Metzler, Tomlinson, Nanof, and Hitchon (2012) have discussed the 10 categories of essential benefits required of all private insurance products that participate in state-based health insurance purchasing exchanges beginning in 2014. One category is specific to mental health and substance use disorder services, which is seen as an effort to strengthen the impact of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110–343, mandating that psychiatric conditions be covered at the same level as other medical illnesses; Friedman, 2012).

In addition, many other categories of essential benefits are likely to apply to mental health and substance use disorders, depending on the level of acuity, debilitation, and co-occurring health issues, including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, pediatric services, and preventive and wellness services and chronic disease management. These benefit categories reflect many of the locations and program foci where occupational therapy practitioners are currently practicing, albeit in small numbers, and are actively working to promote recovery. The ACA is viewed as paving the way to care

access and to reducing problems with service fragmentation, which often stand in the way of people struggling with their mental health and substance use disorders fully using prevention, crisis intervention, treatment, and support services (Barry & Huskamp, 2011): “Lack of integration between primary care and specialty behavioral health care and poor coordination for patients with coexisting mental health and addiction disorders are endemic to our delivery systems and are exacerbated by the prevailing payment methods” (p. 973).

This perspective further raises another call to action for occupational therapy practitioners to determinedly and consistently create working relationships with primary health care providers to serve in key primary health positions offering client-centered integrated care.

During 2012, as members of the AOTA Board of Directors set budget priorities, they highlighted a need for development of primary health care roles for the profession. Some models have already been demonstrated in health systems with involvement of occupational therapy faculty, staff, and students, including at the University of Southern California (Prestwich, 2012) and St. Louis University (Karen Barney, personal communication, June 2012). By the time of publication of this column, I expect that many more ideas about how to integrate occupational therapy into first-contact, continuing, and coordinated care will have emerged. These programs and others will help shape working relationships and innovations, including engagement in Medicare accountable care organizations, health homes for enrollees with chronic conditions (can be a combination of conditions such as mental disorders, substance abuse disorders, asthma, diabetes, heart disease, obesity; Buck, 2011; Kaiser Commission on Medicaid and the Uninsured, 2012) and other ways to achieve better care, better outcomes, and better control of costs (Berwick, Nolan, & Whittington, 2008).

Increased Need for Behavioral Health Services Providers

The number of people in the United States who will be eligible for insurance coverage

and care under the ACA is considerable. Even with variable involvement of all states in the Medicaid expansion, the Congressional Budget Office (CBO) immediately after the Supreme Court decision estimated that at least 28 million new people will be covered by 2017 (CBO, 2012). As such, there will be a significant need for professionals who will deliver services to the newly insured, including those in need of behavioral health care and integrated care management, which incorporates occupational therapy services.

It has been estimated that 3.7 million more adults with SMIs needing care would gain coverage once the ACA is fully implemented in 2019 (Garfield, Zuvekas, Lave, & Donohue, 2011; Mechanic, 2012). In addition, the aging population creates another area of need. A recent Institute of Medicine (IOM; 2012a) report conservatively estimated that between 5.6 million and 8 million older Americans (14%–20% of all older adults in the United States) have a mental health condition or a problem related to substance misuse or abuse, including depression, dementias, accidental and intentional misuse of prescriptions, and illicit drug use.

Rising needs also are occurring among children and adolescents with autism spectrum disorders (ASD). It has been estimated that 2.8% of such youths are uninsured (Metzler et al., 2012), yet with the prohibition on lifetime caps, annual limits, and denial of coverage afforded by the ACA, as well as extension of coverage to age 26 under a parent's insurance plan, the number of adults with ASD who will be insured will be even higher. Moreover, the need for mental and behavioral health services directed to returning veterans and their families is also on the rise, with an expected sixfold increase from 2004 to 2008 in the rate of veterans affected by posttraumatic stress disorder (IOM, 2012b; Keyes, 2010).

New Opportunities for Occupational Therapy in Mental and Behavioral Health

Reforming health care also affects where and how services will be rendered. For example, under the ACA, the philosophy

and the design of the benefits package promotes a positive change. Physical health issues will be integrated with substance abuse and mental health services in a whole-person orientation to care, and care coordinators will help patients access subspecialties more effectively (Buck, 2011). Community mental health centers may expand their services so as to allow for more integrated care. Health centers in the community and in schools also may expand their behavioral health services to achieve the same level of integrated care.

New technology may have an influence. Cason (2012) suggested that occupational therapy practitioners may use telehealth to offer school-based wellness programs such as violence prevention programs, healthy lifestyle to combat obesity, and other health promotion programs.

The growing need for occupational therapy practitioners who can meet the service demands attributed to the ACA places a new level of demand on the profession (IOM, 2012a, 2012b; Keyes, 2010). Educational programs preparing occupational therapists and occupational therapy assistants must teach the competencies needed to deliver highly skilled interventions, emphasizing recovery and optimum well-being as outcomes. Emphasis on comprehensive, coordinated care is consistent with the traditional domain of occupational therapy (AOTA, 2008), and the skills of occupational therapy from this perspective will be much needed as the system moves in this direction, especially as it relates to integration of mental and physical health services.

Recommendations have been generated from several sources to meet these needs. For example, the IOM (2012a) recommended that the Secretary of the U.S. Department of Health and Human Services ensure that its agencies (including the Agency for Healthcare Research and Quality, Administration on Aging, National Institute on Mental Health, and Substance Abuse and Mental Health Services Administration [SAMHSA]), among others, take responsibility for building the capacity of the mental health and substance use workforce needed by older Americans. In addition, they recommend modification of accreditation and

professional certification examinations to require competence in the special issues related to geriatric mental health and substance use for all levels of personnel serving older adults. In addition, the IOM (2012a) suggested that Congress appropriate funds to support training, scholarships, and loan forgiveness programs for persons working with or preparing to work with older adults with mental health or substance use problems.

In late 2011 and early 2012, AOTA led efforts to amend the Public Health Service Act of 1944 (Pub. L. 78–410) to include occupational therapists as behavioral and mental health professionals for the purposes of the National Health Service Corps (H.R. 3742), and in March 2012 the association held a congressional briefing to ensure that congressional staffers were aware of the rich history and current practice associated with occupational therapy professionals meeting the mental health and behavioral needs of children, adolescents, adults, and seniors. Should this initiative be passed, scholarships and loan forgiveness programs would be in place for occupational therapists working in targeted geographic areas requiring such services, both urban and rural. These programs would help meet the expanded needs created by ACA's approach.

Focus on Recovery

During the past 20 years, the vision of "recovery" has been shaped and explored by people with the lived experience of mental health and substance use challenges as well as by families, communities, educators, employers, churches, researchers, and the behavioral health workforce. SAMHSA has promoted programs supporting a dynamic vision of recovery. A previous view was that SMIs were "a never-ending life sentence of disability, with little or no hope of regaining a full and happy life" (SAMHSA, 2012a, p. 4). With the emergence of the principle of *positive recovery*, SAMHSA now has a working definition of *recovery* that reflects both a positive view of possibilities and shares the long-held perspective of occupational therapy: "A process of change through

which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (p. 5).

This perspective of recovery shares the perspective that occupational therapy holds for clients, as evidenced by the most recent occupational therapy brand from AOTA: “Occupational Therapy: Living Life To Its Fullest.” A revised SAMHSA definition also shows the link to the occupational therapy perspective: “*Recovery* is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized” (SAMHSA, 2012b, italics added).

Four major dimensions considered to be essential to living in recovery were further delineated by SAMHSA, including

health (overcoming or managing one’s disease as well as living in a physically and emotionally healthy way), home (a stable and safe place to live), purpose (meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society), and community (relationships and social networks that provide support, friendship, love and hope). (SAMHSA, 2011a, p. 1)

These concepts of *health*, *home*, *purpose*, and *community* can be closely linked to the Person–Environment–Occupation (PEO) Model, first articulated by a group of Canadian occupational therapists (Law et al., 1996). Applied to mental and behavioral health, the PEO Model embodies a client-centered approach to helping people with the lived experience of mental illness or substance use disorders fully participate in everyday life doing what is important and meaningful, in environments of their choosing, and with others who support them (Stoffel, 2011; Strong & Gruhl, 2011). The SAMHSA perspective on health and purpose connects with the PEO person and occupation concepts, and the SAMHSA home and community aspects highlight the PEO environment concepts in the occupational therapy literature. This alignment positions occupa-

tional therapy practitioners to contribute their knowledge and skills to facilitating the path to recovery as a key member of the behavioral health team.

Recovery-Oriented Systems of Care

In the past 2 years, SAMHSA has provided grant funding to promote programs that are built on the recovery model, including peer-to-peer recovery support (SAMHSA, 2011c) and addressing homelessness as a critical component of recovery (SAMHSA, 2010). At a meeting in April 2012, AOTA was invited to engage in a recovery-to-practice discussion with the professions of psychiatry, psychology, nursing, social work, peer specialists, addictions counselors, psychiatric rehabilitation practitioners, and advocates to share what each group has done or is doing to embrace a recovery philosophy and prepare curricula for their respective professions. The inclusion of occupational therapy in this meeting was significant, and the occupational therapy voice was heard.

SAMHSA brought together this group to promote relationships and collaborations across and among these professions to yield new models and programs that can most effectively meet the needs of persons with or at risk for behavioral health conditions and their families. Bringing together these professions—and including occupational therapy—was a step toward the achievement of

a transformed system of care . . . based on the core beliefs that prevention works, that services and supports can be effective, that people can and do recover, and that communities benefit from including and valuing the contributions of all their members. (SAMHSA, 2011b, para. 1)

As a result of the ACA, SAMHSA has established the SAMHSA Center for Integrated Health Care Solutions to bring the recovery model to people in need throughout the entire health care system (SAMHSA, n.d.-a). This development links recovery to changing system design and emphasizes that

primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general health care needs. . . . The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. (SAMHSA, n.d.-b, para. 2–3)

SAMHSA’s work is aligned with efforts by AOTA and others to integrate occupational therapy into these systems for people with any problems that can be addressed or improved by occupational therapy intervention. Integration is critical for mental and behavioral health as well as for the maximum utilization of what the profession of occupational therapy has to offer for achieving true health for everyone.

Recovery Services and Supports

Some principles must be recognized as these integrated systems are developed. Some needs may go beyond the health care system or even the existing behavioral health service system. Davidson and Tondora (2011) have suggested that recovery-oriented systems offer both recovery services and recovery supports, with the differentiation between services and supports often based on time, needs, and medical necessity. *Recovery services* are often time limited and based on specific needs, including acute situation care, crisis intervention, various psychological and other therapies, and services often available through psychiatric or addictions programs. *Recovery supports* exist to support people with ongoing challenges in their lived environment:

These support activities are rooted in community settings and may include supported housing, employment, education, socially inclusive activities, spirituality, and parenting as well as recovery coaching or mentoring, peer support, and the use of self-care tools such as Wellness Recovery Action Plan (WRAP), Pathways to Recovery, psychiatric medications,

and psychiatric advance directives. (Davidson & Tondora, 2011, para. 6)

Davidson (2012) framed such supports as building strengths and “*recovery capital*—the sum of social, emotional, informational, instrumental, and ‘affiliational’ support a person can use to initiate and sustain recovery” (para. 2, italics added)—and posited that those with stronger recovery capital (who have a safe place to live; meaningful work; and strong support from family, friends, and peers) are more likely to be able to live a full life in the community and pursue recovery supports and services as needed. Those with low recovery capital (who are homeless, unemployed, and isolated from family and friends) are likely to be challenged in pursuing recovery, needing recovery services (treatment aimed at decreasing distress) and supports (increasing recovery capital) to place them on a path toward success (Davidson, 2012). Under the ACA, these services and supports fit the overall intent of getting and keeping people with complex chronic conditions as healthy as possible. Occupational therapy practitioners, whether currently employed in settings that provide recovery services and supports or in other settings, can be a bridge to link all of these services together. It is an opportunity the profession must seize.

Strengthening the Links Between Peer Specialists and Occupational Therapy Practitioners

Another aspect of building a recovery-sensitive environment is the support for peer specialists’ involvement. Two organizations are at the forefront in helping to formally prepare and recognize the contributions of peer specialists: the National Association of Peer Specialists (NAPS; see www.naops.org) and the Faces and Voices of Recovery. NAPS provides the following definition of peer specialists:

In general, a *peer specialist* is an individual who has made a personal commitment to his or her own recovery, has maintained that recovery over a period of time, has

taken special training to work with others, and is willing to share what he or she has learned about recovery in an inspirational way. In many states, there is an official certification process (training and test) to become a qualified peer specialist. Not all states certify peers, but most organizations require peer specialists to complete training that is specific to the expected responsibilities of the job (or volunteer work). Often, a peer specialist has extra incentive to stay well because he or she is a role model for others. (NAPS, n.d., para. 2, italics added)

The mission of NAPS is to promote the use of peer specialists throughout the mental health system of care, create a community of peer specialists, and offer high-quality curricula for training peer specialists.

Faces and Voices of Recovery (see www.facesandvoicesofrecovery.org) seeks to influence private and public policies to support addiction recovery and is establishing a system to accredit organizations and programs (as opposed to individual practitioner credentialing) using peer support models of addictions recovery.

Peer support specialists trained in mental health and addictions are increasingly being recognized in recovery-oriented systems of care. Peer specialists offer day-to-day support for persons coping with the challenging aspects of their mental illness or substance use disorder while pursuing recovery. Occupational therapy practitioners have the expertise to join with peer specialists to offer consultation and, where needed, supervision, when day-to-day challenges are outside the peer specialist’s knowledge and expertise, thereby bridging recovery services and recovery supports.

Occupational therapy practitioners who work in behavioral health treatment programs as well as in the community can offer recovery services and supports in collaboration with peer specialists. Such an integration of clinical and community care—multiple practitioners addressing the complex issues of daily living and

recovery—is essential with the challenges present in the lived experience of mental illness and addictions. Models for such partnerships need to be pursued and researched to ensure that improved quality, lower costs, and better outcomes are achieved when considering peer services (Edmondson, 2012).

Conclusion

Occupational therapy practitioners have much to offer recovery-oriented systems of care given their expertise in helping people live meaningful lives and pursue healthy daily routines. The profession must recognize these ongoing changes as a true call to action and a tremendous opportunity to promote occupational therapy’s critical role in meeting mental health needs. Occupational therapy must collaborate closely with behavioral health professions, advocacy groups, and the community to ensure that quality essential services include the expertise of occupational therapy practitioners. Providing recovery services and supports in all appropriate settings under the ACA is a significant change in policy and perspective that offers the profession an open door to restore our contributions to this important population. We must walk boldly forward to achieve this goal. ▲

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