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**Improving functional outcomes for children and adolescents with anxiety related disorders through occupational therapy : a narrative review ; Perceptions of the role of occupational therapy in community Child and Adolescent Mental Health Services (CAMHS)**

Paula J. Anderson  
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Improving functional outcomes for children and adolescents with anxiety related disorders through occupational therapy: A narrative review

Perceptions of the role of Occupational Therapy in community Child and Adolescent Mental Health Services (CAMHS)

Paula J. Anderson

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of Occupational Therapy, Honours, Faculty of Health Engineering and Sciences, School of Exercise and Health Science

Edith Cowan University

October, 2013

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## **Literature Review**

Improving functional outcomes for children and adolescents with anxiety related disorders through occupational therapy: A narrative review

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Improving functional outcomes for children and adolescents with anxiety related disorders through occupational therapy: A narrative review

**Background/Aim:** Children and adolescents experiencing anxiety find it challenging to maintain optimal occupational performance, thus the specific role of occupational therapy in the management of anxiety requires investigation. This narrative review examines the current available literature surrounding the use of occupational therapy approaches for children and adolescents experiencing anxiety.

**Methods:** Academic journals as well as a variety of sources were considered, due to the paucity of literature surrounding this topic. Articles were included if they discussed the occupational therapy role in treatment of children experiencing anxiety symptoms, including anxiety related disorders such as post traumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD).

**Results:** A total of eight articles that satisfied the inclusion and exclusion criteria were included, in addition to other publications that referred to occupational therapy approaches with children or adolescents with a co-morbidity of anxiety. The findings are presented in the format of the Person Environment Occupation (PEO) model.

**Conclusions:** Occupational therapy approaches include sensory based interventions, the use of creative activity within a counselling context and occupation based group therapy programs. Psycho-education as well as family and caregiver involvement during the therapy process was identified as an important occupational therapy role.

**Significance of the study:** Further rigorous research regarding specific occupational therapy approaches is warranted to provide best practice guidelines for therapists involved in the treatment of anxiety for this population group.

**Keywords:** Adolescent, Anxiety Disorders, Child, Mental Disorders Diagnosed in Childhood, Occupational Therapy

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11<sup>th</sup> October 2013

## Improving functional outcomes for children and adolescents with anxiety related disorders through occupational therapy: A narrative review

Anxiety is an emotion experienced during childhood and adolescence and it is during this time that coping strategies are developed (Lougher, 2001). However when a child cannot navigate an effective way for dealing with anxiety, these worries and fears can affect occupational performance in a variety of contexts (Downing, 2011; Lougher, 2001; Maid, Smokowski, & Bacallao, 2008). Anxiety can potentially affect functioning in a number of areas, inhibiting involvement in roles and routines (Davis, 2011; Downing, 2011). This review aims to identify what occupational therapy approaches are documented for children and adolescents with anxiety problems.

Evidence suggests that mental health and anxiety related disorders in childhood can persist and contribute to ongoing mental health problems in adulthood (Davis, 1999; Kjorstad, O'hare, Soseman, Spellman, & Thomas, 2005). Despite the lack of recent data providing information on the prevalence of specific mental health conditions in Australian children, a survey of Australian general practitioners in 2007-08 found that depression/anxiety disorder accounted for 13% of mental health problems managed at this level (Australian Institute of Health and Welfare, 2009). Similarly within the adolescent and youth age group of 16 to 24 years, the 2007 National Survey of Mental Health and Wellbeing estimated that anxiety disorders accounted for 15% of the most common mental health conditions in Australia (Australian Institute of Health and Welfare, 2011). Of these, the most common anxiety related disorders reported were post traumatic stress disorder (PTSD) at 50% and social phobia at 35% (Australian Institute of Health and Welfare, 2011). These figures clearly indicate that anxiety is a common problem amongst Australian children and youth, and health professionals

working with this population need to be skilled to address anxiety issues in young people.

Some common types of anxiety related disorders experienced during childhood include phobias, separation anxiety, generalised anxiety disorder, PTSD and obsessive compulsive disorder (OCD) (Commonwealth of Australia, 2012-13). Anxiety in children may present as a co-morbidity with other mental health problems like depression or attention deficit hyperactivity disorder (ADHD) (Commonwealth of Australia, 2012-13) and developmental conditions such as autism (Lane, Reynolds, & Dumenci, 2012). Anxiety in children can manifest as physical symptoms such as headaches and/or nausea and can also be seen in the form of school refusal and panic attacks (Commonwealth of Australia, 2012-13; Lougher, 2001), all of which can have adverse effects on a child's ability to participate in their regular occupations and roles (Downing, 2011).

The management of anxiety in childhood and adolescence commonly involves psychological support from a range of sources and professionals, including occupational therapists as part of a multidisciplinary team (Lougher, 2001). However, the specific role of occupational therapy in the management of anxiety for children is less well known (Tokolahi, Em-Chhour, Barkwill, & Stanley, 2013). The purpose of this review was to examine the current available literature addressing occupational therapy approaches for anxiety in childhood and adolescence. Literature was analysed using framework of the Person Environment Occupation (PEO) model (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996).

## **Methods**

### **Search strategy**

Databases searched included EBSCO- CINAHL Plus with full text, MEDLINE and PsychINFO. The most frequently used search terms related to the areas of occupational therapy (occupational therap\*, intervention\*, occupation\*), the applicable population group (child\*, adolescen\*, youth), mental health; specifically anxiety related disorders (mental health services, mental health, anxiety, childhood anxiety) and relevant theories (attachment\*). The words were truncated and synonyms were used as appropriate. Combinations of keywords were searched; in addition all reference lists were manually searched for further relevant papers. Papers written by specialist authors were purposely sought. The search was run from the earliest available literature to 22<sup>nd</sup> July 2013. An extended search of grey literature was also conducted.

### **Inclusion and exclusion criteria**

Articles specifically discussing anxiety as a co-morbid condition with autism were excluded due to the vast body of existing research covering this topic. Literature was included if a direct reference was made to the occupational therapy role and treatment of anxiety symptoms in childhood or adolescence within the broader community context. This included anxiety related disorders such as PTSD or OCD. Due to the limited resources available for review, other professional publications and literature in addition to peer reviewed journals were considered. Criteria for inclusion were that such publications were industry specific, professional in nature and provided a greater insight into the occupational therapy approaches of anxiety related disorders within this particular population group. This included literature from occupational

therapy magazines which specifically discussed occupational therapy approaches for children or youth with anxiety problems. Other articles outlining general occupational therapy approaches targeted at child and adolescent mental health including anxiety were incorporated as supporting evidence. All levels of evidence including relevant quantitative and qualitative research studies were considered. Only articles available in full text and in the English language were included for evaluation.

### **The Person Environment Occupation (PEO) model**

The findings from this review will be presented in the Person Environment Occupation (PEO) format (Law et al., 1996), outlining the occupational therapy approaches for anxiety with children and adolescents in relation to person, environment and occupation elements. The nature of the relationship of these three elements is represented by three interlinking circles, with some degree of overlap (Law et al., 1996). The occupational therapy approaches discussed in this review have been presented in the three principal elements; however it is important to note that some of the occupational therapy approaches share characteristics that transcend more than one category.

### **Results**

Eight studies were included for review (see table 1). Further publications discussing occupational therapy approaches for children or adolescents with a co-morbid problem of anxiety were also included as supplementary evidence.

### **Methodological quality of studies**

Table 1 provides a summary of articles reviewed. Three quantitative studies were reviewed, one using a survey design distributed to professionals in contact with children with a PTSD diagnosis (Kjorstad et al., 2005) and two others examining a group program for children with anxiety (Tokolahi et al., 2013) and adolescents with OCD (Söchting & Third, 2011). The survey design had a small sample size and relied on other professionals' observations and evaluations of the children involved in the study; therefore some confounding factors may have impacted the results. In contrast, the two group programs were repeated measures designs and explored a variety of outcome measures, general mental health evaluations (Söchting & Third, 2011) and one that used occupational therapy specific assessments appropriate to the child/adolescent population (Tokolahi et al., 2013).

Due to the lack of current available research papers on this topic, a number of case studies and opinion pieces were also included for review. Two opinion pieces described occupational therapy approaches used for children with anxiety as a primary diagnosis or a co-morbid issue, one within a group setting and another as an individual therapy approach (Champagne, 2012; Feldman, 2012b). Case studies documenting occupational therapy intervention for children experiencing anxiety symptoms and trauma were also reviewed (Christie, 2007; Davis, 1999; Feldman, 2012a). Despite the low level of evidence, these case studies were included to provide insight into the current forms of occupational therapy intervention. The lack of available studies indicates the need for greater research into occupational therapy interventions for children with anxiety problems.



## Person

**The sensing/regulating self.** An occupational therapy approach to assist children to manage their anxiety and develop effective coping strategies involves implementing emotional self regulation tools (Champagne, 2012; Davis, 1999; Feldman, 2012a, 2012b). An example of this involves teaching children to recognise and rate their own anxious feelings (Champagne, 2012; Feldman, 2012a, 2012b). Furthermore, individualised strategies based on Cognitive Behavioural Therapy (CBT) principles have been described with the pre-adolescent age group to help reduce anxiety when it arises (Feldman, 2012a, 2012b). These strategies often take the form of sensory approaches, using scales and analogies to rate the need for sensory adjustment (Feldman, 2012a, 2012b). Through practice and guidance, the child can then begin to identify and name anxious feelings and adopt self regulatory techniques before such feelings escalate (Feldman, 2012b).

Relaxation strategies are used in occupational therapy as a method of coping with anxiety symptoms for children and adolescents (Christie, 2007; Tokolahi et al., 2013). Relaxation time is reported as an activity that is incorporated in a weekly occupation based group therapy program for children with anxiety (Tokolahi et al., 2013). A single case study example (Christie, 2007) illustrates the teaching of relaxation techniques in combination with calming sensory input as part of the therapy process for a child experiencing anxiety symptoms.

Both Champagne (2012) and Feldman (2012a, 2012b) employ strategies to help manage anxiety through empowering children to control their anxious feelings, with the aim of improving occupational functioning. Both examples incorporate learning to

identify and rate anxious feelings as an intervention with the pre-adolescent age group. Within a group setting, children were taught to recognise feelings within themselves and others, in addition to developing important skills such as social interaction and the perceived consequences of their behaviour (Champagne, 2012). Learning to self rate emotions is also documented in the older adolescent group, where incorporating strategies to de-escalate feelings is explored (Champagne, 2012).

The use of sensory approaches with children to help address emotional and behavioural concerns has been well documented in the literature. The development of an individualised sensory diet is an occupational therapy approach that has been used with anxious children (Champagne, 2011; Champagne, Koomar, & Olson, 2010). This type of intervention aims to accommodate sensory preferences and offers individualised sensory techniques that calm and relax (Champagne, 2011; Champagne et al., 2010). In addition to understanding what approaches may have a calming effect, it is equally important to recognise what sensory strategies may result in a negative consequence, especially for children that may have experienced trauma (Koomar, 2009).

Occupational therapists utilise a variety of sensory processing assessments that are appropriate to the child and adolescent population, which inform these interventions (Champagne & Koomar, 2012). The concept of a sensory diet is explored in a number of case studies involving young children with anxiety symptoms, emotional self regulation (Champagne, 2011) and sensory defensiveness issues (Kinnealey, 1998; Weatherston, Ribaud, & Glovak, 2002). Although these are individual examples, each treating therapist uses a sensory diet to incorporate activities that provide tolerance to the surrounding environment and a sense of calm (Champagne, 2011; Kinnealey, 1998; Weatherston et al., 2002).

Research suggests that sensory processing problems in children can manifest as anxiety (American Academy of Pediatrics, 2012; Champagne & Koomar, 2012). Part of the occupational therapy role in anxiety management has been to determine whether anxiety is the primary diagnosis or whether the overabundance of sensory stimuli produces a heightened arousal resulting in anxious feelings (Pfeiffer, 2012). Research suggests an apparent association between sensory hypersensitivity and ritualistic behaviour in children (Dar, Kahn, & Carmeli, 2012). A survey of psychologists and occupational therapists reported that it was more probable for occupational therapists to identify sensory processing issues in toddlers as opposed to symptoms of anxiety (Ben-Sasson, Cermak, Orsmond, Carter, & Fogg, 2007). As the relationship between sensory processing issues and anxiety symptoms often appear very similar clinically, this can make diagnosis difficult (Ben-Sasson et al., 2007).

**The expressing self.** The use of creative expression is reported as an appropriate approach to use with children experiencing anxiety within a counselling context (Davis, 1999; Kjorstad et al., 2005). Creative activities such as drawing (Kjorstad et al., 2005), writing or dance can provide children with an alternative means of describing events or feelings that may be too confronting to discuss verbally with the therapist (Davis, 1999). It has been suggested that drawing may be a comfortable means of expression for children as it is often a common and familiar activity (Kjorstad et al., 2005).

Through participating in the creative process together, the use of expressive activity can be used as a rapport building tool, and a means to developing a trusting therapeutic relationship (Davis, 1999). Creative mediums provide opportunities to explore problem solving and identifying coping strategies within a supportive environment for children who have experienced trauma (Davis, 1999). A number of

case studies portray the use of creative activities throughout the occupational therapy process. Drawing has been used as a medium to reduce distress (Christie, 2007) and to express traumatic events in a less threatening, non-verbal way. This leads to safe expression, managing and expressing emotions and ultimately benefits the child's mental health (Christie, 2007; Davis, 1999). An example of this included the use of a sand tray for creative expression in a case study as an activity to safely explore thoughts and feelings (Christie, 2007). Two authors explored the use of creative mediums and provided examples of occupational therapists using creative activity within the child-therapist relationship (Christie, 2007; Davis, 1999), allowing safe expression of potentially confronting feelings (Christie, 2007; Davis, 1999).

**The understanding self.** Psycho-education has been documented as a tool that occupational therapists can use when working with children who have anxiety symptoms (Christie, 2007; Feldman, 2012a, 2012b; Söchting & Third, 2011; Tokolahi et al., 2013). Educating the child about anxiety assists them to recognise anxious feelings. Validation of a child's anxious feelings and fostering hope for improvement is important (Christie, 2007; Feldman, 2012a, 2012b). In addition, making children with anxiety aware that they are not alone in experiencing their symptoms can hold therapeutic value (Christie, 2007; Feldman, 2012a). Occupational therapists can provide hope and assist children to address emotional problems through focusing on existing strengths of the child and family (Champagne, 2012; Christie, 2007).

## **Environment**

**The familial environment.** Occupational therapists work with families of children experiencing anxiety (Christie, 2007; Feldman, 2012a, 2012b). This involves

incorporating the child's family background and history, and family sessions into the intervention approach (Christie, 2007). Occupational therapists work with caregivers and siblings to enable them to support the child with anxiety in establishing positive emotional regulation habits in non therapy environments (Feldman, 2012a, 2012b). Through this approach family members are educated to recognise signs and triggers of the child's anxiety, thereby assisting the child to recognise their own anxiety symptoms (Feldman, 2012a). This supports the child in self-assessment and modifying the environment accordingly. Others report working alongside families through a parental psycho-educational support group run alongside a child's occupation based anxiety group, although this parental group was not formally evaluated as part of the study (Tokolahi et al. (2013).

Developing a secure attachment pattern has been linked to the quality of a child's relationships with caregivers within the familial environment (Meredith, 2009). Poor attachment to a primary caregiver in childhood can have a negative impact on mental health and lead to an insecure attachment style (Champagne, 2011; Meredith, 2009). Similarly, childhood trauma can often occur within the confines of the care giving setting (Champagne, 2011). Therefore it is important that occupational therapists are aware of possible attachment issues when treating children who have experienced trauma (Champagne, 2011; Meredith, 2009). As a consequence many children referred to occupational therapy services have a variety of mental health concerns which can occur concomitantly with attachment issues (Champagne, 2012). Attachment theory can assist occupational therapists in understanding behaviours and relationships, provide insight into the developing client-therapist relationship and contribute to the planning of appropriate interventions (Meredith, 2009).

Additionally as trauma can take many different forms, occupational therapists should take into account the child's current environment and the possibility that the source of trauma may still exist throughout the therapy process (Champagne, 2012). Likewise there is evidence to suggest that the emotional consequence of experiencing trauma in childhood can result in anxiety symptoms (Champagne, 2012; Hyter, Atchison, Henry, Sloane, & Black-Pond, 2001). Furthermore it is important that occupational therapists are able to recognise signs of trauma in children so that these symptoms are not misinterpreted, for example as being primarily a sensory issue (Koomar, 2009).

Christie (2007) exemplifies how the occupational therapist can utilise attachment theory and an understanding of the impact of trauma to assist the child with anxiety. An example of this is the occupational therapist that recognised the need for a trusted female attachment figure and was successfully able to introduce this female caregiver into the therapy process in combination with narrative therapy sessions (Christie, 2007). Similarly, other authors expound an occupational therapy role involving caregivers participating in sensory activities with their children as a way of facilitating attachment (Bagatell & Pollard, 2010; Koomar, 2009). Another example involving a 5 year old girl with PTSD and ADHD residing in foster care demonstrates the inclusion of a caregiver in the therapy process (Champagne, 2011). The occupational therapist supported the child's foster mother to participate in activities to encourage development of attachment through demonstrating safe interaction behaviours throughout therapy sessions (Champagne, 2011).

**The peer group environment.** Peer group environments may provide a source of support and a mechanism for learning new coping skills (Christie, 2007; Davis,

1999). Davis (1999) and Christie (2007) describe working alongside adolescent girls experiencing anxiety, with both authors referring these clients to stress management groups as a source of peer support. Whilst work by occupational therapists utilising group work for anxiety management with adults is well documented (Prior, 1998; Rosier, Williams, & Ryrie, 1998) there is little occupational therapy literature documenting group approaches for children or adolescents experiencing anxiety.

**The sensory environment.** The use of sensory approaches in relation to person factors such as self regulation has been discussed, however an additional sensory approach involves modifying the surrounding environment to reduce or eliminate stimuli that may be anxiety provoking (Champagne, 2011; Davis, 1999). Occupational therapists can assist with identifying scenarios that could lead to a child experiencing an overload of sensory stimuli which can impact on function, particularly within the surroundings of home and school (Gutman, McCreedy, & Heisler, 2004). Researchers discuss modifying a child's sensory environment as part of the occupational therapy approach (Champagne, 2011; Davis, 1999; Koomar, 2009). Examples of this include modifying the classroom environment so the surrounds are less overwhelming for a child that has experienced trauma (Koomar, 2009) or an anxiety related condition such as PTSD (Davis, 1999). A further case study example (Champagne, 2011) of a five year old child with a co-morbid issue of PTSD and ADHD illustrates the use of providing sensory supports at home which are tailored to the sensory preferences of the child, such as the use of a weighted blanket or aromatherapy to encourage sensory stabilisation.

## Occupation

**Occupation based approaches.** The use of activity in a group format is an occupational therapy approach for children experiencing mental health concerns such as anxiety (Champagne, 2012; Tokolahi et al., 2013). A recent study (Tokolahi et al., 2013) described an occupation based group therapy program incorporating CBT principles. A weekly outline of topics were covered with one example of a group activity provided, however details of specific group activities were not discussed. The study reports some improvement in anxiety symptoms from pre-test to post-test, though a number of confounding factors exist that may have had an impact on the results (Tokolahi et al., 2013). One of the outcome measures used included the Occupational Questionnaire which some of the children found difficult to complete (Tokolahi et al., 2013). There was also the potential for rater bias as the same clinicians conducting the groups also measured the outcomes (Tokolahi et al., 2013). Additionally, another CBT group program co-run by an occupational therapist targeting treatment for OCD in adolescents has been described with some success (Söchting & Third, 2011). However like Tokolahi et al. (2013) examples of activities were discussed but further details of weekly group outlines would be beneficial for repeating the study, as well as details of other factors such as specific homework tasks (Söchting & Third, 2011).

An activity based community occupational therapy group program for children with mental health concerns (including anxiety) has been investigated (Champagne, 2012). This program also utilised activities as the basis for each group, however unlike the work undertaken by Tokolahi et al. (2013) the tasks aimed to remain child focused through accounting for each participant's sensory preferences and interests to allow the activities presented to be relevant and engaging (Champagne, 2012). Activities



encouraging the development of social skills, emotional regulation and sensory processing were common objectives for each group. Examples of activities included the creation of an age appropriate sensory kit for older children, tailored to suit the developmental level of the group (Champagne, 2012). Although no formal outcome measures were used, interviews with parents were conducted to ensure each child's suitability for the group and as a source of feedback both throughout the course and at the conclusion of the program (Champagne, 2012).

### **Discussion**

Anxiety is a common problem within the Australian child and adolescent population, as both a primary and co-morbid diagnosis (Australian Institute of Health and Welfare, 2009, 2011; Commonwealth of Australia, 2012-13). This is an issue that can significantly impact a child's occupational performance (Downing, 2011; Lougher, 2001). Due to the often complex nature of psychosocial problems in children (Gutman et al., 2004), there are several aspects that occupational therapists should consider when planning appropriate intervention approaches for this population.

One important aspect of providing occupational therapy services are identifying the boundaries of professional practice and recognising when to refer on to other professions for specialised support, particularly for children who have experienced trauma (Davis, 1999; Kjorstad et al., 2005). Part of this process involves familiarity and understanding of other roles within the multidisciplinary team and the broader mental health services within the community. Baseline occupational therapy training includes working with individuals and groups; however often specific training for areas such as

family therapy is required to work in this specialised area (Dutton; 2006; Lougher, 2001; Lougher, Hutton, Guest, & Evans, 2008).

Group programs (Champagne, 2012; Söchting & Third, 2011; Tokolahi et al., 2013) demonstrate that coping strategies for anxiety in children and adolescents may be learned within a group format, though further research is needed to enhance the validity of each approach. Söchting and Third (2011) documented a CBT approach which involved activities that encouraged sharing and graded exposure within the group, in addition to learning alternative behaviours for distraction of obsessive thoughts for adolescents suffering OCD. In contrast, Tokolahi et al. (2013) focused on activity and time scheduling, whereas Champagne (2012) documented the use of sensory regulation techniques to teach children how to self-regulate their emotional responses. These groups have adopted some aspects of a CBT framework to support participants to exercise some control over their emotional responses, with the aim to enhance occupational functioning in a supportive peer group setting (Söchting & Third, 2011; Tokolahi et al., 2013).

Occupational therapy has taken a leadership role in the area of applied sensory approaches (Champagne & Koomar, 2012); however some argue that its effectiveness must be subject to further rigorous research (American Academy of Pediatrics, 2012; Bream, 2013; Rodger, Ashburner, & Hinder, 2012). The level of evidence for sensory approaches as an intervention with children has been questioned (American Academy of Pediatrics, 2012; Rodger et al., 2012). One suggestion is that occupational therapists consider sensory approaches as one perspective to explore, rather than a single solution to address behavioural problems in children (Rodger et al., 2012). It is however, important that occupational therapists explore the possible links between a child

presenting with anxiety symptoms and the possibility of sensory processing issues (Feldman, 2012b) so that informed clinical decisions relating to the development of appropriate sensory strategies can be made (Pfeiffer, 2012).

Awareness of transference and the ability to reflect on one's practice, is also raised in the occupational therapy literature in relation to therapists; particularly those working with anxious and traumatised children (Christie, 2007). Cultural awareness must also be considered, as cultural factors may impact what a child feels they can disclose during therapy (Davis, 1999). The selection of interventions must therefore take cultural aspects into consideration, in addition to other factors such as the developmental age of the child and individual values and aspirations (Champagne, 2011).

When working with children who have anxiety symptoms, an important part of the rapport building process is to eliminate pressure to perform during the therapy sessions (Feldman, 2012b; Kinnealey, 1998) and to provide a safe environment in which to convey their anxious feelings (Gutman et al., 2004). This is particularly important if the occupational therapist suspects emotional regulation difficulties and sensory defensiveness, as the child may need to initially feel a sense of control in order to engage with the therapist and build a trusting relationship (Kinnealey, 1998).

The occupational therapy literature surrounding interventions for children who are anxious has come from a variety of sources within the mental health and/or paediatric fields. This raises the question of whether occupational therapy involvement in cases of anxiety in children are being recorded and subsequently published. There are few studies that document occupational therapy work with traumatised children

(Davis, 1999; Kjorstad et al., 2005), despite literature outlining the potential benefits occupational therapy could contribute to this age group, particularly within the school setting (Driver & Beltran, 1998). Evidence suggests that anxiety is often a co-morbid problem that presents in general paediatric settings (Feldman, 2012a, 2012b), the broader community (Champagne, 2012; Söchting & Third, 2011) and within Child and Adolescent Mental Health Services (CAMHS) (Christie, 2007; Tokolahi et al., 2013).

The role of occupational therapy particularly within CAMHS is not clearly defined in the literature. In addition a lack of literature surrounding the definitive role of occupational therapy within paediatric mental health (Dennis & Rebeiro, 2000), youth mental health (Hardaker, Halcomb, Griffiths, Bolzan, & Arblaster, 2007) and more specifically within CAMHS (Harrison & Forsyth, 2005; Tokolahi et al., 2013) remains an ongoing problem. Published research specifically discussing occupational therapy approaches and anxiety in children within CAMHS appears to be predominantly from New Zealand based studies (Christie, 2007; Tokolahi et al., 2013). Australian based research is therefore recommended. Further research into this area of practice has the potential to enhance the professional standing of occupational therapy within CAMHS (Harrison & Forsyth, 2005).

Each of the varied occupational therapy approaches presented in this review aims to address the way in which anxiety affects a child's ability to participate successfully in occupations and roles; however there is a need for more literature to add to the body of evidence in this field. Occupational therapy intervention has been documented to assist children with anxiety to regain optimal occupational functioning through a variety of approaches such as teaching relaxation techniques (Christie, 2007; Tokolahi et al., 2013) and evaluating current habits and routines (Downing, 2011).

Through viewing the child holistically, it has been suggested that occupational therapy approaches consider attachment issues (Meredith, 2009) and the impact of any past experiences of trauma on the presentation of a child's anxiety symptoms (Champagne, 2011, 2012).

Equally, psycho-education and practicing coping strategies outside of the therapy setting appears to be an important factor (Feldman, 2012a, 2012b). Working with an anxious child's caregivers (Christie, 2007; Feldman, 2012a, 2012b; Tokolahi et al., 2013) and providing advice regarding environment modification (Champagne, 2011; Davis, 1999; Koomar, 2009) has been identified as being part of the occupational therapy role. Literature suggests that occupational therapists utilise sensory approaches such as teaching children strategies of how to self regulate (Champagne, 2012; Davis, 1999; Feldman, 2012a, 2012b), as well as creative expression activities with children as a rapport building tool and to encourage facilitation of problem solving (Christie, 2007; Davis, 1999; Kjorstad et al., 2005), however further research regarding how occupational therapists use this approach with children experiencing anxiety is needed. Recent literature documents the use of occupation based groups with children as an occupational therapy approach for addressing emotional and behavioural problems such as anxiety with some positive results (Champagne, 2012; Tokolahi et al., 2013). However detailed descriptions of the activities used along with further rigorous research would be beneficial to support these findings.

### **Conclusion**

Occupational therapists have the potential to intervene early to prevent ongoing and long term mental health problems during the transition into adulthood; however

there appears to be sparse literature surrounding occupational therapy and children's mental health services. The current paucity of literature detailing the occupational therapy approaches for young people with anxiety related disorders needs to be addressed. Due to the limited literature currently available, the studies included for this review focused on case studies and professional opinion with some articles dating back 15 years. This demonstrates the lack of evidence based approach and the need for further investigation into how occupational therapists are working with this population group. Occupational therapists working with children or youth in a variety of settings would benefit from sharing and formally evaluating their current work practices used to address anxiety based problems. Current research with larger sample sizes and standardised outcome measures is necessary to provide greater evidence of the effectiveness of the occupational therapy approaches described. This would inform evidence based practice for the occupational therapists currently working with children and youth experiencing anxiety and provide opportunity for the advancement of occupational therapy in the child and adolescent mental health field. Consequently further research would ultimately benefit the many children and adolescents experiencing anxiety in the broader community that could potentially access the services of occupational therapists.

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Table 1: Summary of articles discussing occupational therapy approaches for children and adolescents experiencing anxiety

Authors	Title	Type of study	Aim	Participants	Main outcomes/ Occupational therapy approach documented	Other comments
Champagne, T. (2012).	Creating occupational therapy groups for children and youth in community-based mental health practice	Opinion piece	Use of community based occupational therapy groups for children experiencing a range of mental health problems, including anxiety. Aim of each group was to increase participation and enhance occupational functioning.	3 occupational therapy groups were developed for various ages from 4 years of age to 18 years of age. Each group consisted of up to 8 participants, 1 OT, 1 OT assistant or OT student. Each group ran once a week for approximately 50 to 60 minutes over an eight week period.	A variety of models and theories were incorporated throughout the development of the groups, such as Sensory Modulation Program (SMP), 3 phrase trauma model, attachment theory, strengths based model, psychodynamic theory and cognitive behavioural therapy (CBT) approach. Group activities were developed in accordance with age and developmental appropriateness.	Screening of participants completed before suitability for group determined via an initial interview with primary caregiver, with a range of assessments completed. No formal outcome measure was used to gauge effectiveness; however a part two of the program was established following feedback from those involved.
Christie, A. (2007).	Childhood anxiety: Occupational disruption	Case study example	To illustrate treatment approaches for childhood anxiety through an occupational therapy perspective.	Single case study of a 12 year old girl experiencing anxiety symptoms.	Occupational therapy assessments utilised within a child adolescent and family mental health clinic, impact on occupational functioning and roles explored. Various counselling techniques and frameworks were utilised throughout the therapy process including: CBT, family therapy, narrative therapy, attachment theory, the use of creative activity.	This study provides one case study example, therefore difficult to generalise findings however does offer a detailed insight into the therapy process with the case discussed, from an occupational therapist point of view.

Davis, J. (1999).	Effects of trauma on children: Occupational therapy to support recovery	Opinion piece with case studies	To inform occupational therapists working with children to help recognise possible signs of Post Traumatic Stress Disorder (PTSD) and impact on a child's functioning, occupations and roles. Provides explanation of possible OT treatment through 2 case studies.	Focus on 2 case studies, an 8 year old girl and a 14 year old adolescent. Outlines a brief history of trauma and subsequent options for occupational therapy intervention.	CBT, stress management, coping frame of reference, discussion of creative expression activities Focus on the impact of PTSD on functional ability, assisting with recognition of problem solving and coping strategies. Highlights importance of when to refer on to other services and the need for further OT research into this area.	Although some of the information may be outdated, this article does provide some insight into possible occupational therapy approaches for children and adolescents experiencing PTSD.
Feldman, J. S. (2012a).	Treating pre-adolescents with anxiety disorders: A case study using sensory-motor interventions to teach 10-year-old Courtney to regulate her anxiety	Case study example	To explain the use of occupational therapy techniques utilised to help with anxiety symptoms experienced.	A singular case study of Courtney, a ten year old girl with anxiety	Documents the transition and OT treatment process of an anxious child. Self regulation is encouraged through sensory integration techniques and sensory-motor activities. Involvement of family members throughout the therapy process, OT helped Courtney to transfer the skills she acquired to manage her anxiety outside of the therapy environment.	Documents one case study therefore difficult to generalise, however does provide insight into an occupational therapy approaches used to successfully treat anxiety from an occupational therapist drawing on personal clinical experience.
Feldman, J. S. (2012b).	Treating pre-adolescents with anxiety disorders: Using cognitive-behavioural and sensory-integrative approaches for	Opinion piece	To explain occupational therapy treatment approach for pre-adolescents experiencing anxiety as a primary diagnosis.	No formal participants, explanation of current treatment used by one OT practitioner	CBT techniques Sensory integration, use of sensory-motor tasks. Associated case study by the same author featured above.	Provides an explanation and overview of occupational therapy approaches, however is from the point of view of one therapist.

	self regulation.					
Kjorstad, M., O'hare, S., Soseman, K., Spellman, C., & Thomas, P. (2005).	The effects of Post-Traumatic Stress Disorder on children's social skills and occupation of play.	Quantitative study, survey design	To increase awareness of the psychosocial effects of PTSD, particularly on play and social occupations of children. Aims to help OTs recognise possible play and social skill behaviours of children experiencing PTSD in order to plan appropriate interventions.	Professionals working with school aged children with a diagnosis of PTSD (e.g. OTs, social workers, teachers, psychologists, etc), were chosen at random from telephone book. These participants were contacted via phone for informed consent and asked for names and details of those that work directly with children of school age with PTSD. Surveys were sent to supervisors of the practitioners identified to distribute at their workplace. 30 children were assessed. A pilot study conducted by authors to increase reliability and validity.	Survey found that generally there was no significant impact on play skills and PTSD had no effect on structured games, a difference was more likely to be seen with social behaviours. Discusses a range of possible OT interventions with this population group, including expressive therapies and other considerations for OTs when working with children that have experienced trauma; however the survey did not directly address these aspects.	8 of the children had a developmental delay, possibly affecting the skills assessed. Survey had a low response rate, 37 out of 200 surveys returned, researchers unsure how many surveys reached professionals involved. Surveys relied on other professionals' assessment of the children, with many having worked with the children identified for less than 12 months.
Söchting, I. & Third, B. (2011).	Behavioral group treatment for obsessive-compulsive disorder in adolescence: A pilot study	Quantitative study, repeated measures design (self reported)	Pilot study to examine the effectiveness of a CBT based group program for adolescents with OCD in an outpatient setting The group was co-run by an occupational therapist and a clinical psychologist	7 adolescents aged 14 to 17; group ran for 2 hours per week over a period of 10 sessions. Only those with OCD as a primary diagnosis were considered suitable, 4 participants also had co-diagnoses. Some participants were taking medication in addition to	Integration of approaches included externalising through detachment, Exposure and Response Prevention (ERP) and refocusing on other behaviours. Some support for this group approach was found—5 out of 7 participants showed an improvement in symptoms on one of the outcome	Small sample size. There was no control group and other variables such as medication use and completion of homework tasks were not taken into account.

				group attendance. Assessments were conducted prior to the group, after the last session and at 12 months post treatment.	measures; however other measures indicated a decline or were not statistically significant, making results difficult to generalise.	
Tokolahi, E., Em-Chhour, C., Barkwill, L., & Stanley, S. (2013).	An occupation-based group for children with anxiety	Quantitative study, repeated measures design (no randomisation)	Assessed effectiveness of a group based approach on the reduction of anxiety symptoms and the increase in occupational functioning for the participants. Acceptability of the program was measured in part by attendance levels.	34 participants aged between 10 to 14 years, with a number of inclusion and exclusion criteria. Participants must have presented with some anxiety symptoms. 6 to 8 children per group, each group ran for 1.5 hours over a 9 week period. Data collection included a total of 5 groups over 14 months.	Variety of models and theories utilised in development of the program including CBT, effects of mental illness on daily activities from an occupational therapy perspective, solution-focused brief therapy and clinical experience of the researchers. All participants allocated to a group completed the program. Use of occupation in a group format to teach and consolidate skills learnt. An improvement in anxiety symptoms seen from pre-test to post-test as rated by the parents of participants and the clinicians running the groups.	Small sample size. Parents reported improvement in anxiety symptoms more than the children. Difficult to determine participants motivation for attending the group, although attendance was high considering the children were offered a range of intervention options. Groups run by the researchers also involved in assessment of outcome measures.

**Abbreviations:** OT: Occupational Therapy, CBT: Cognitive Behavioural Therapy, ERP: Exposure and Response Prevention, OCD: Obsessive-Compulsive Disorder, PTSD: Post Traumatic Stress Disorder, SMP: Sensory Modulation Program.



**Research Report**

Perceptions of the role of Occupational Therapy in community Child and Adolescent  
Mental Health Services (CAMHS)

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Perceptions of the role of Occupational Therapy in community Child and Adolescent  
Mental Health Services (CAMHS)

**Abstract**

The role of occupational therapy in community child and adolescent mental health services (CAMHS) multidisciplinary teams is not well documented. This ethnographic investigation involved the perception of occupational therapy within community CAMHS in the Perth metropolitan region. The occupational therapy role was explored in relation to collaborative work practices and team dynamics. Eight mental health community CAMHS professionals took part in semi-structured interviews. Three themes emerged: team membership, nature of the work and the team and occupational therapy. Findings suggest a limited understanding of the scope of occupational therapy practice. Further research is needed regarding occupational therapy in this field.

**Keywords:** Child and Adolescent Mental Health Services, multidisciplinary team, Occupational Therapy, professional role

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## Perceptions of the role of Occupational Therapy in community Child and Adolescent Mental Health Services (CAMHS)

In Australia, it has been estimated that approximately 25% of those with a mental illness will have experienced their first episode by 12 years of age (Roxon, Macklin, & Butler, 2011). The importance of early intervention in child and adolescent mental health difficulties cannot be overstated, as disorders originating during this developmental stage can contribute to ongoing mental health problems in adulthood (Australian Institute of Health and Welfare, 2009, 2011). This highlights the importance of mental health services in the community that specifically target the child and adolescent population.

Within Western Australia, Child and Adolescent Mental Health Services (CAMHS) are available to children and youth up to the age of 18 years (Commissioner for Children and Young People Western Australia, 2011). CAMHS is distributed in a tiered service delivery model (Commissioner for Children and Young People Western Australia, 2011). Community CAMHS sits within tier three, which provides a specialist service for children and adolescents needing assistance for multifaceted and ongoing mental health problems (Commissioner for Children and Young People Western Australia, 2011). There is a small community of CAMHS workforce in Perth, with a number of sites servicing the greater metropolitan area. A Western Australian government document has suggested that intervention at this level be multidisciplinary (Department of Health Government of Western Australia, 2001), however there is a lack of evidence that provides specific data on the type and number of professionals employed. The multidisciplinary team commonly working in child and adolescent

mental health services includes clinical psychology, mental health nursing, psychiatry and social work (Department of Health Government of Western Australia, 2004).

Children and adolescents accessing CAMHS often present with a range of difficulties, and commonly this can be seen in the form of learning disabilities (Department of Health Government of Western Australia, 2004). A Western Australian government document has suggested that occupational therapy and speech pathology could complement the existing professions working in this sector and would benefit this client group (Department of Health Government of Western Australia, 2004). The inclusion of occupational therapy services could help address the dual developmental and psychosocial problems of children and adolescents presenting in CAMHS through a range of assessments and interventions, including sensory motor approaches (Department of Health Government of Western Australia, 2004). Additionally occupational therapists are also equipped to address function and participation (Lougher, 2001). From an international perspective, literature documents occupational therapy practice in CAMHS within the United Kingdom and the United States (Lougher, 2001); with some recent studies from New Zealand outlining occupational therapy intervention approaches (Christie, 2007; Tokolahi, Em-Chhour, Barkwill, & Stanley, 2013).

Within the field of mental health practice, occupational therapy has a longstanding history (Kloczko & Ikiugu, 2006) both in the inpatient setting and within the broader community (Peters, 2011). The literature reflects an established role for occupational therapists within adult community based mental health services (Culverhouse & Bibby, 2008; Hughes, 2001; Parker, 2001; Pettican & Bryant, 2007; Yau, 1995) as well as a history of working alongside adolescents with mental health

problems in a variety of environments (Bream, 2013). The work of occupational therapists in inpatient settings with children and youth has also been documented, such as the role of occupational therapy within inpatient settings for the treatment for eating disorders (Kane, Robinson, & Leicht, 2005; Kloczko & Ikiugu, 2006). Despite evidence supporting the role of occupational therapy within mental health teams there appears to be a paucity of literature surrounding the perception of occupational therapy in community CAMHS.

Mental health multidisciplinary teams face a number of challenges and evidence suggests that health professionals can experience a sense of role confusion or blurring when working within a multidisciplinary mental health team (Filson & Kendrick, 1997; Hardaker, Halcomb, Griffiths, Bolzan, & Arblaster, 2007, 2011; Harries & Gilhooly, 2003; Harrison & Forsyth, 2005; Kaur, Seager, & Orrell, 1996; Lankshear, 2003; Lloyd, Bassett, & King, 2002; Lougher, 2001; O'Connell & McKay, 2010; Parker, 2001; Pottebaum & Svinarich, 2005; Smith & Mackenzie, 2011; Yau, 1995). Occupational therapists place value on occupation based intervention approaches (Aguilar, Stupans, Scutter, & King, 2012; Gardiner & Brown, 2010; Harrison & Forsyth, 2005; Pettican & Bryant, 2007) and describe their work within multidisciplinary mental health teams as a combination of generic and specific occupational therapy based tasks. The ability to define and separate occupational therapy work from that of generic mental health tasks within a multidisciplinary team is important for occupational therapists working with youth in the mental health sector (Hardaker et al., 2007). Further research is warranted to explore the generic and specific contributions occupational therapists can bring to community CAMHS teams.

The perception of occupational therapy within mental health services is discussed most often in the form of opinion pieces. The evidence that exists is limited as the studies have few participants, making the results difficult to generalise to wider populations. One exception exists in the study by Hardaker et al. (2011) which involved a survey of 63 Australian occupational therapists identified as having a youth specific caseload. This highlights the need for further research into the occupational therapy role within CAMHS in Australia, particularly from a community perspective.

Occupational therapists have much to offer in the developing area of CAMHS in the community (Lougher, 2001). This qualitative study involved semi-structured interviews with health professionals currently working in community CAMHS in Perth, Western Australia. This study was conducted in order to investigate the perceived role and value of occupational therapy from the viewpoint of team members within this service. Objectives of the research included being able to identify collaborative work practices amongst the community CAMHS multidisciplinary team, to explore personal attributes considered important for work in this setting, to investigate the participants understanding of occupational therapy practice and the potential role of an occupational therapist within the community CAMHS team. Additionally an objective of this research was to describe the type of work undertaken by the community CAMHS multidisciplinary team as it related to CAMHS teams who have experience with an occupational therapist as a team member.

## **Methods**

### **Methodology**

An ethnographic approach was selected for this study to explore insiders' views and patterns within a particular culture (Holloway & Wheeler, 2010; Luborsky &

Lysack, 2006) which in this case was community CAMHS. Central to the study was the CAMHS multidisciplinary team's perceptions of the potential contribution of occupational therapy.

### **Procedure**

A purposive sample of eight community based CAMHS professionals involved in direct client-services or managing service delivery informed the study. This included the professions of social work, psychology, psychiatry and nursing. Cross-site sampling involving participants who had a minimum of six months clinical experience were recruited from six separate worksites to strengthen reliability. Occupational therapists were excluded from the sample as the aim of the study was to explore the perceptions of the current and potential contribution of occupational therapy to community CAMHS from the perspectives of other professionals. Due to the limited workforce available for sampling in the Perth region, eight participants from community CAMHS were considered adequate in providing data for analysis. As a result of time limitations and sample size data saturation was not reached. Prior to the commencement of data collection, ethics approval was obtained from the Human Research Ethics Committee at Edith Cowan University, Perth, Western Australia and informed consent was obtained through a signed consent form prior to interviews.

### **Data collection**

The Person Environment Occupation (PEO) model (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996) was used as theoretical framework for the study. The model was considered appropriate as it encompasses the causal relationships between the person, their environment and their occupations (Law et al., 1996). An interview guide was developed with questions around the three elements of the PEO model,

however, as is the nature of semi-structured interviews, probes were used to further explore and discuss matters considered relevant by participants (Hansen, 2006; Holloway & Wheeler, 2010). Interviews averaging 40 minutes were conducted at the participants' worksite over a period of approximately five weeks. Reflective journal notes recorded the researcher's thoughts and observations (DePoy & Gitlin, 2011) around the interview experience, adding to the richness of the interview data. Each semi-structured interview was recorded using an audio recording device with prior permission of each participant. Each interview was transcribed verbatim (Holloway & Wheeler, 2010).

### **Data analysis**

Data collection and analysis was an iterative process. This allowed interview questions to be refined according to what was beginning to emerge from previous interviews (Hansen, 2006).

Using a coding system, which involved creating sections of the informative data that was found to be of particular relevance and significance across interviews, patterns in data emerged (Polgar & Thomas, 2008). Key words or significant statements consistently emerging from data were clustered into categories which were then further grouped into themes. Triangulation was achieved by co-coding with supervisors and member checks were conducted with a number (N=3) of research participants to enhance trustworthiness (Holloway & Wheeler, 2010). An audit trail was used as a method of managing data procedures to enhance dependability (Holloway & Wheeler, 2010; Lysack, Luborsky, & Dillaway, 2006). Previous research related to the findings was explored and compared with the findings of this study.



## **Findings and Discussion**

Three themes emerged from the interview data. These were: team membership, the nature of the work, and the team and occupational therapy. These findings will be discussed within the PEO model framework (Law et al., 1996) (See figure 1).

### **Person Factors: Theme One: Team membership**

“...one person can’t make a difference, so it has to be a team effort if you want good outcomes...”

A major theme emerging from the data was CAMHS workers’ identification as team members and their strongly held views on the importance of belonging to a team. This sense of belonging was seen to have a direct impact on team functioning. Many participants could identify benefits of working within a team, highly valuing the support that this provides. Due to the particular type of work and the complexity of cases, the support of the team was seen as an integral component to managing clinical work and crucial to problem solving and generation of ideas. The support of the team was particularly important in managing clinical risk. As one team member stated:

“...if you’ve got healthy people in a healthy MDT [multidisciplinary team] you’re going to be running into that MDT saying please help me, give me the support, can you share the therapeutic burden here...”

Valuing the support of others and sharing the load in managing risk was stated as highly important:

“...and plus doing that [consulting with the team] you share the load, rather than having all that bear down on you”.

In addition to managing risk, the importance of supervision was highlighted. Having the opportunity to problem solve within a supportive team environment and obtaining the contribution of another clinician's viewpoint assisted in sharing the burden of the clinical work particularly when involved with difficult or complex cases. In discussing the value of supervision and having additional insight into issues related to clinical work a team member stated:

“...get someone else's opinion in, which I found so helpful...a lot of the time there's always another thing...I'll get stuck with something, why isn't this working?...then my supervisor is like well have you thought about it like this...it's a really nice process”.

Team members described occasions when collaboration was highly important including instances when it was deemed appropriate for more than one clinician to co-manage a case. When discussing collaborative work practices, many participants identified team meetings as the main opportunity to discuss cases in a group format in order to provide input and seek contributions from other team members regarding clinical work. This team meeting approach was described by one participant as a way of consulting with others:

“...we all... come together...talk about the cases so all of them are reviewed at different times of course. Or if you've got a priority case or a high risk case, or...something like that, then you can come along for the support of the team and you know, some ideas and sort of share it around a bit”.

Having a diverse mix of disciplines was considered beneficial as a means of accessing a range of perspectives. One participant explained this in terms of the way different team members viewed aspects of the work from an alternative outlook:

“...good healthy input from the others, because we each have our own view because we come from slightly different way of viewing the world”.

Also having a range of staff with particular areas of expertise was viewed as an advantage of belonging to a diverse team. Having the opportunity to consult with team members that had specialist skills was seen as a benefit of team membership, as one participant reported:

“...there’s a lot of experiences, a lot of expertise that you can um call upon, not too many areas you can get that”.

In relation to personal attributes, many participants were able to identify desirable qualities of community CAMHS team members. This quality of honesty was mentioned in regards to being authentic in communication style and having a therapeutic approach with children. Honesty was described by one participant as being an important aspect to protect oneself and the child and was articulated in relation to being honest with oneself regarding boundaries of practice:

“Honesty is good...one thing really I think is very clear boundaries about who you are and what you will and won’t do”.

Other desirable attributes included the ability to be empathetic, well grounded, respectful and to enjoy working with children. Empathy was considered important as key to understanding each child’s unique situation. Participants described having the ability to reflect and be self-aware as a particularly important quality:

“I think you have to like children; you have to be able to be in the head of a child and understand their world. You have to be reasonably grounded...that comes with the ability to reflect, but understand what you’re bringing to the work”.

Respect was considered an important characteristic in interpersonal team collaboration.

Desired personal attributes and having respect for one another as team members was explained:

“...you’ve got to be flexible...courageous enough to confront things when they’re not right, but humble enough to pull back when you think...intervening will cause more harm to the collegial relationship”.

Due to the challenges of the therapeutic work, the importance of resilience was recognised by a number of participants. It appeared that resilience was imperative to therapeutic work, as well as being a healthy aspect of belonging to a team. One participant mentioned resilience as an important factor to role longevity and another described being able to manage critique and voice an opinion as critical to team functioning.

Previous research relating to the findings of this study were investigated and compared. The sense of belonging to a CAMHS team and the support of others is an important aspect of team membership (Walker, 2003). A study exploring interprofessional dynamics within CAMHS teams found that team members appreciated the opportunity to share ideas amongst colleagues (Walker, 2003). The level of cooperation between team members of various professions can lead to better outcomes for those accessing CAMHS services (Hill-Smith, Taverner, Greensmith, & Parsons,

2012; Walker, 2003). Supervision allowed discussion and reflection which was important in order to implement optimal treatment options for children assessing the service (Walker, 2003).

Studies of multidisciplinary teams in mental health settings suggest that a range of varying perspectives (Lankshear, 2003) can be an advantage of team membership (Lloyd, King, & McKenna, 2004). Interprofessional relationships and the feeling of belonging to a team are important factors for effective team work (Onyett, 1997). Opportunities for collaboration such as team meetings (Duffy & Nolan, 2005) allowed discussion and sharing of ideas regarding clinical work (Christofides, Johnstone, & Musa, 2012; Miller, Charles-Jones, Barry, & Saunders, 2005). Risk management remains an issue for community mental health teams (Larkin & Callaghan, 2005); however the support of a team allows responsible sharing of risk for mental health professionals and clients (Duffy & Nolan, 2005). Mutual respect is a central aspect of effective collaboration amongst multidisciplinary team members (Chong, Aslani, & Chen, 2013; Fox, 2013).

The findings of this research reflect the literature about qualities related to team membership. The support of team members and gaining perspective of others appeared to be an important aspect of belonging to a team. Although current studies discuss interprofessional working within mental health teams, there appears to be less literature regarding community CAMHS multidisciplinary teams and the desired qualities considered important to undertake work in this setting.

**Environment Factors: Theme Two: Nature of the work**

“...we work with those presentations of moderate to severe mental health...problems...we tend to...to see more the pointy end I think of...presentations”.

During the course of the interviews, participants described the characteristics of the service that community CAMHS provides, and the nature of the working environment. The level of severity of the cases presented was discussed. Due to the often complex nature of the therapeutic work, risk management was emphasised as one important aspect. The type of therapeutic services offered within the community CAMHS environment was explained:

“...risk assessments...the formulation of...management plans, and also...providing psychotherapy, counselling services, either long term or short term”.

Participants discussed the types of skills they considered a requirement to work within the community CAMHS team. A number of generic mental health tasks were mentioned as a core aspect of the type of work involved. Tasks common to multidisciplinary team members were case management, completing assessments and providing therapeutic interventions. Generic work common to all CAMHS workers was explained:

“...we all have cases in common, we all do counselling, therapy...we all formulate the case in the right –in the common way, we all have to review the case in the common way, we all have...similar case loads”.

In addition to generic tasks, a number of participants mentioned specialist skills as a point of difference in regards to team member contributions. Specialist expertise appeared to add another dimension to the range of skills and therapeutic interventions that the team could provide. This seemed to depend on the training of each individual within the team:

“...maybe you know the nurse working with the psychologist, the social worker...even though there sort of different professions... each profession has its own expertise there’s a lot of commonality as well”.

Working alongside families also featured regularly throughout the interview process as one core aspect of clinical work. Family work appeared to be an important part of providing a holistic approach, as described by one participant:

“...sometimes we work with the whole family, family therapy...we’d get to see the whole family for a few sessions...if it’s appropriate. Otherwise it’ll just be a one to one”.

The work was conducted mostly onsite with some team members undertaking home and school visits as appropriate and when resources allowed. One team member described this facet of their work:

“With CAMHS, you have to work wider...so we work wide so we do go out into the community frequently for the school angle”.

Due to the nature of the service, several participants spoke about some of the challenges that come with working in this setting. The type of work and issues presented were described as being of a sensitive nature and confronting at times. One of the challenges

of working within the community CAMHS environment was the demands of the therapeutic work. One participant explained this quite simply in a brief statement:

“...you hear some tricky things, you know... some days”.

Helping others appeared to bring meaning and significance to the therapeutic work, with a number of participants expressing their belief in the importance of early intervention.

One participant explained the value of the contribution they were making in their clinical role and the sense of personal gratification this gave them:

“...for me personally yeah it’s nice, it’s a nice thing to be doing with my life...”

It seemed that even though there were challenges associated with the work, those within the team found personal meaning in their involvement of providing what they believed was an important service to children who required their assistance.

There is some evidence to suggest that the cases seen by CAMHS clinicians can be complex in nature (Walker, 2003). CAMHS work has been documented to include work with families and schools (Lougher, 2001). Specifically tier three CAMHS services in the United Kingdom health system offer family work and family therapy (Davies & Lowes, 2006). A government document outlining the type of tier three CAMHS work in Western Australia includes services such as group and individual counselling, family psycho-education and specific psychiatric approaches (Commissioner for Children and Young People Western Australia, 2011). Other literature discusses CAMHS work within the community extending to settings including schools and homes (Walker, 2003). This appears to be congruent with the findings of this study, as participants described aspects of community work and working closely alongside families of children accessing the service. There is a paucity of literature



regarding the challenges and personal value of community CAMHS work, as participants described in this study. This could potentially be an area of future research.

### **Occupation Factors: Theme Three: The team and occupational therapy**

As part of the research process, participants were asked about particular skills they thought an occupational therapist could bring to their team. The experiences of occupational therapy varied, from those that had limited or no knowledge to those that had worked alongside an occupational therapist in CAMHS. Generally there was a limited understanding of occupational therapy, some ideas of occupational therapy work included addressing motor skills, group work and sensory based approaches. Generic skills were emphasised as being an important factor to fitting into the multidisciplinary team. Due to limited knowledge, some participants felt they didn't know enough about occupational therapy to make comments about the profession:

“I don't know enough about OT's [occupational therapists] and I don't know enough about CAMHS and OT's”.

This was also illustrated by some participants reflecting questions to the researcher about what occupational therapists do:

“Um... but anyway so...I don't know, where do most OT's end up? In which field do they end up?”

A number of participants had not worked with an occupational therapist before within the community CAMHS context and were therefore unsure about what occupational therapy could potentially offer. Having past experience of working alongside an occupational therapist, whether it was within the CAMHS service or another clinical area, appeared to influence the kinds of skills they thought occupational therapists could bring to the team. One participant explained their past experiences:

“...one or two occupational therapists would sort of run activities...that provided...an opportunity not only...for a bit of a?... to get out and do something and maybe, and learn something practical...”

Another reflected on a past experience and the perceived benefit an occupational therapist could bring to the team:

“...that was quite useful...to think a little bit more about... I think the sensory-motor, developmental difficulties, for the children”.

Although generally there was a limited understanding of occupational therapy, there were some commonalities in the perceptions of the skill set specific to occupational therapy. These ideas included group work and motor skills. One team member articulated this in terms of the physical aspects of occupational therapy assessment:

“...OT assessment around...looking at kids...physical capacity, fine motor skills and balance and all of that sort of stuff...”

Within the CAMHS environment, it appeared that colleagues were valued for their work and the skills they brought to the team rather than the professional background of the CAMHS worker. It seemed that being able to complete generic tasks was an important part of fitting into the team, as a participant explained:

“...we need you [occupational therapists] like everybody else to be able to pick up a case, carry the risk, do a mental health... comprehensive assessment...do a broad formulation that would go beyond my understanding of an OT skill base...I have worked with OT in the past who did struggle with that...there was a bit of

tension in the team...who can do it and who can't do it...so I guess...it depends on the OT”.

It was suggested that when occupational therapists had limited experience or knowledge of generic skills they could be supported by others in the team to carry out these tasks, and that occupational therapists have been able to share generic team responsibilities such as case management. In addition, undertaking further training in specific therapeutic approaches was discussed in relation to the occupational therapy role. Extra training and professional development appeared to be an important aspect to keep up to date with treatment methods. Level of clinical experience was also mentioned as being significant, due to the challenges of the working environment. One team member discussed this in terms of the complexity of clinical work:

“They’re very complex kids and we don’t get taught complex ways of being able to work, that comes with other up-skilling and other years on the floor...”

The perception of occupational therapy differed between those who did not have an occupational therapist as a team member and those who did. One aspect of occupational therapy work mentioned by both groups was sensory based intervention approaches. The value of viewing children from a sensory perspective was discussed. One participant currently working alongside an occupational therapist explained that this involved occupational therapy working closely with the child’s family and school to incorporate regulatory techniques in a range of environments:

“...given that this is the profile they have, to reduce that and then involving the parent, the parents to help with that and school to help with that”.

Viewing the child from a developmental perspective was seen as a benefit of having an occupational therapist as a team member, as children accessing the service could also present with other problems as was discussed:

“...they come with various developmental limitations sometimes, which needs to be looked at from the developmental perspective and OT's obviously are very important part of that assessment and treatment”.

Generally, participants could see value in involving a range of professions within the community CAMHS team and this could potentially include occupational therapy. It appeared that a range of different perspectives from which to view clinical work would be useful as was explained:

“...I think with...OT and other specialities you're just going to get more comprehensive...view of...a child and how they see the world. How they interpret the world”.

Where occupational therapists were already an existing member of the multidisciplinary team, they were considered integral to team outcomes. The discrepancy of occupational therapist employment between worksites was discussed and it appeared that the long established mix of disciplines employed within each community CAMHS worksite had some influence into the current team structure. As some worksites have historically had occupational therapists in the service, this seemed to relate to the perceived value of occupational therapy within the team as one participant explained:

“...this team traditionally has had occupational therapy...therapists within the team for a long time so they have a

very healthy attitude and very...what do you say... (pause) trust,  
in what the OT's and value in what the OT's can bring".

Participants discussed the possible benefits of the integration of services within the community. This included collaboration with child development services, as it was mentioned that children accessing community CAMHS can have dual developmental and mental health problems. One team member discussed the benefit of this approach:

"...hopefully one day they broaden...the staffing profile a bit...  
and then people don't have to go to maybe here and then go to  
child development centre...It'd be nice if they could sort of  
amalgamate and you'd have a range of professions you could  
call upon".

Where occupational therapy was already an established part of the team, the potential difficulty of having to outsource occupational therapy was discussed:

"...if you don't have OT within CAMHS you would actually be  
outsourcing that which is quite difficult in the community".

Literature suggests there are a variety of generic tasks team members are expected to complete as part of their role within general mental health settings (Lloyd, Kanowski, & Samra, 1998) and community mental health teams (Lloyd, King, & Bassett, 2002). A study of the nursing role in out-patient CAMHS found that all team members regardless of the discipline spent considerable time completing generic work, which included assessment and addressing the needs of children and their families (Baldwin, 2002).

This was also discussed by participants, as the ability to complete generic tasks contributed to team cohesiveness and was an important aspect of fitting into the team.

Literature documents the need for occupational therapists within community mental

health teams to develop generic skills in addition to specific occupational therapy skills in order to adapt to this work setting (Harries & Gilhooly, 2003; Lloyd, Bassett, et al., 2002). There is evidence to suggest that occupational therapists working in mental health have been able to complete generic tasks, including case management (Craik, Austin, & Schell, 1999; Hardaker et al., 2011; Harrison, 2003) and there is an expectation that occupational therapists contribute in this way and complete discipline specific work (Greaves, King, Yellowlees, Spence, & Lloyd, 2002; Lloyd et al., 2004). This supports the finding of this study that the ability of occupational therapists to partake in generic tasks could influence the way they are perceived by others within the community CAMHS team.

Studies suggest that there is a limited understanding of occupational therapy amongst other mental health professionals (Kaur et al., 1996; O'Connell & McKay, 2010; Pottebaum & Svinarich, 2005). This is reiterated by the findings in this study that CAMHS team members have limited knowledge of occupational therapy. Occupational therapists are recognised as undertaking group work within the mental health field (Duffy & Nolan, 2005; Lloyd, King, et al., 2002; Lloyd & Williams, 2010; O'Connell & McKay, 2010), and working in groups with children or youth in mental health settings (Champagne, 2012; Hardaker et al., 2011; Lougher, 2001; Olson, 2011; Söchting & Third, 2011; Tokolahi et al., 2013). Therefore it is understandable that participants that had past experience of working alongside an occupational therapist in another mental health area, could perceive group work as part of an occupational therapists role. A study involving psychiatrists in the United States found that the perception of occupational therapy involved addressing motor skills, and that they would refer children to occupational therapy services for sensory integration problems (Pottebaum

& Svinarich, 2005). Other authors are of the opinion that collaborative working across a range of occupational therapy services including CAMHS and paediatric services could be of benefit to this client group (Harrison & Forsyth, 2005). This was identified by participants in this study as a possibility for providing a more holistic service.

### **Conclusion**

This study aimed to investigate the perception of occupational therapy within community CAMHS multidisciplinary teams in Perth, Western Australia. The PEO model was utilised to explore topics around the three factors of person, environment and occupation as related to the community CAMHS context. Three themes emerged from the data which included team membership, the nature of the work and the team and occupational therapy.

Factors relating to 'person' revealed that a sense of belonging to the team was valued, particularly regarding management of risk and there were a number of examples in which team members worked collaboratively. Personal attributes such as honesty, respect and resilience were seen as important qualities to have within a team in addition to a range of perspectives and expertise from which to draw upon. Factors relating to 'environment' included the type of CAMHS work completed, which participants described as being challenging in nature, however personally very meaningful. Generic tasks as well as specialist skills were described in relation to team contributions and aspects of family and community work were identified. Factors associated with 'occupation' related to how the profession of occupational therapy was regarded amongst team members. Generally there appeared to be a limited understanding of the skills occupational therapy could potentially bring to the team. Participant's past or current experience of working alongside occupational therapy seemed to influence

perceptions of the type of work occupational therapists complete and the perceived value of occupational therapy within this setting. It appeared that team members were valued for the work and skills they could bring to the team, rather than a focus on professional identity.

Limitations of this study included the small sample size and that saturation was not reached due to time restrictions. This study reflects the thoughts and opinions of a group of community CAMHS professionals in the Perth metropolitan region at a particular point in time, therefore generalising the findings outside of this context must be applied with caution.

The current role of occupational therapy within community CAMHS multidisciplinary teams requires further research. The findings of this exploratory study suggest that a range of different professional perspectives within a team are valued, and this could potentially include occupational therapy in a broader CAMHS context. Generally the limited knowledge of occupational therapy highlights the need for occupational therapists currently working in community CAMHS to inform other multidisciplinary team members about the skills occupational therapists can provide. This is particularly important in regards to their work with children or adolescents experiencing mental health problems. In addition to this it is imperative that occupational therapists currently working in this service publish their intervention approaches and work practices so more is known about the potential role of occupational therapy in this setting. This could help advance the occupational therapy profession within community CAMHS and assist children and adolescents/youth accessing these services through the provision of a more comprehensive service delivery approach.



Educating other CAMHS professionals about the occupational therapy profession may challenge preconceived ideas regarding the structure of multidisciplinary community CAMHS teams and contribute to strengthened interprofessional relationships. A multidisciplinary approach which includes occupational therapy within both inpatient and community settings may assist in providing integration of services for children and adolescents experiencing mental health problems as they move from one setting to another. Occupational therapists are well placed to provide this gap in service, given their core skills and training in both mental health and paediatrics. Further research regarding the occupational therapy role in community CAMHS would be beneficial to support these recommendations in clinical practice.

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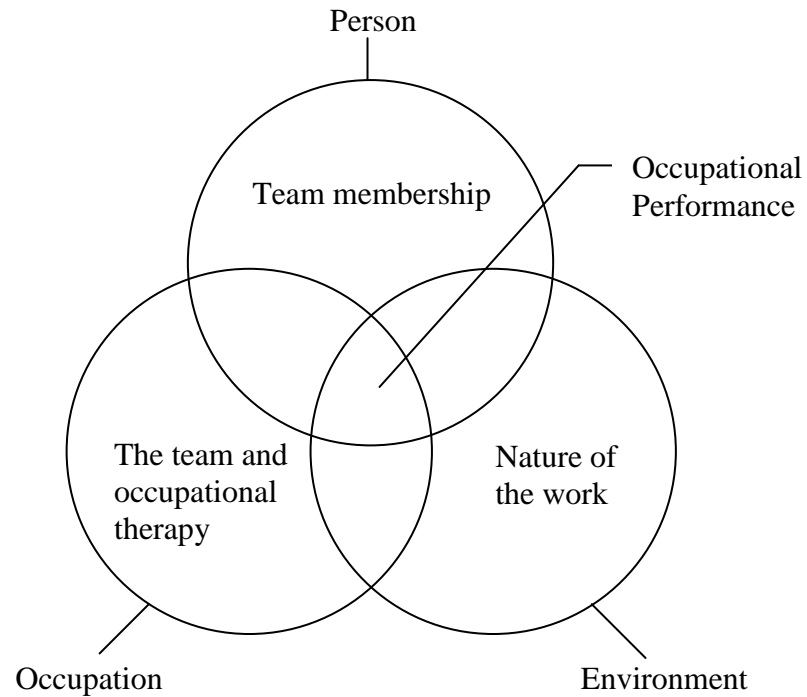
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Figure 1.

Person Environment Occupation (PEO) Model



An adaptation of the PEO Model used with permission of: (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996)