Supporting Veteran Mental Health Through Metacognitive Reflection and Insight Therapy for the Occupational Therapist (MERIT-OT): A Quality Improvement Doctoral Capstone Project Report

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Author Note

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Abstract

Background: Veterans are at over 50% higher risk of experiencing mental health crises compared to the general population, negatively impacting occupational engagement and quality of life. With roots in mental health practice, OT is primed to meet these uniquely complex healthcare needs. Research shows improving factors of metacognition through interventions like MERIT-OT can improve self-agency and recovery from mental health crises. However, OT at the IN VA has not yet been utilized within the mental health care teams. For MERIT-OT research to move forward at the IN VA, the barriers and facilitators to implementation at this site needed to be understood. **Methods:** A DCE student completed a 14-week quality improvement project to support the role of OT in mental health services within the IN VA, eliciting appropriate patient populations to implement MERIT-OT research in the future. Program implementation included OT staff training and advocacy, MERIT-OT resource building, and clinical skills building through mental health group interventions. Data was collected through activity analysis of staff workflow, informal discussion, staff survey, self-assessment journalling of MERIT-OT integration, and pre/post assessment of domiciliary groups. **Results:** Increased knowledge, access, and the likelihood of OT staff implementation of mental health resources. New OT integration into existing suicide prevention follow-up programs. Deeper understanding of MERIT-OT principles, barriers/ facilitators, and appropriate opportunities for future research. **Conclusion:** Integration of MERIT-OT within OT's newly established and growing roles in mental health services at the IN VA healthcare system will improve the quality of care, meet the growing need for mental health professionals, and support rigor and fidelity within the field of mental health OT.

Keywords: metacognition, mental health, quality improvement, Veteran

Contents

Introduction

With a growing need for mental health services in all populations, OT practitioners are already uniquely positioned to help improve access to effective mental health treatment options within the current scope of practice. As occupational therapy holds improved client function as a core outcome measure, mental health interventions can be approached through a functional lens by addressing both physical and mental health through the routines and occupations that support the various activities of life. This can be done respective of, yet distinctly different from other fields of psychotherapy as described by the American Occupational Therapy Association (AOTA) "the aim of occupational therapy services in mental health is to help all individuals develop and maintain positive mental health, prevent mental ill health, and recover from mental health challenges in order to live full and productive lives" (2016, p.1). For example, when someone loses a limb, there is a clear physical client factor for OT to address in order to promote a successful return to the community. Additionally, there is a mental health factor that can be treated conservatively by occupational therapists, as a return to meaningful physical occupations can be facilitated while also guiding patients through the mental burdens that come with this life-changing event. Similarly, when someone is diagnosed with a serious mental illness, occupational therapists can help facilitate the transition of these individuals back into society as productive and independent members of their communities through routine management, social support, and skills training.

Metacognitive Reflection and Insight Therapy (MERIT) is a widely accepted, manualized, psychology-based approach that is already being used within the VA as a treatment method for patients with schizophrenia and other serious mental illness. However, the implications for use of this approach extend even further when applied to the occupational

therapy scope of practice. Work by Wasmuth et al., (2022) translated MERIT into the occupational therapy scope of practice for publication, now referred to as MERIT-OT. In their article, they delineate how MERIT aligns with the fundamentals of meaningful engagement seen within occupational therapy practice, making the potential for utilization of this approach in mental health OT high.

Veterans seeking healthcare services at the Veteran's Administration (VA) experience a wide range of functional limitations that occupational therapy (OT) can address. When compared to the general population, in addition to routine physical healthcare, the Veteran population also experiences a uniquely high likelihood of houselessness, being diagnosed with serious mental illness (SMI), traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), suicide, depression, and substance use disorder (SUD) which can negatively impact community re-integration, and lead to lower quality of life (Olenick et al., 2015). These data illustrate the dynamic intersection of physical health, mental health, and socioeconomic health. As reported by Cree et al., (2020), "nationwide, an estimated 17.4 million adults with disabilities experience frequent mental distress 4.6 times as often as adults without disabilities. Adults living below the federal poverty level report mental distress 70% more often than do adults in higher income households". Additionally, the 4-quadrant integration model of healthcare (Collins et al., 2010), suggests that physical health cannot be separated from mental health and that in settings where the treatments of both physical and mental health factors are addressed, patient outcomes are better. Therefore, the addition of MERT-OT research and integration within the IN VA will help to meet a patient population need, fill a professional service gap, and improve the quality of care offered at the VA.

Background on Metacognition and MERIT

Metacognition is commonly defined as “thinking about one’s thoughts”. While there are many similar definitions outlining components of metacognition, the MERIT approach defines metacognitive capacity as a person’s ability to reflect on their own thoughts and actions, and thus form a complex sense of self in the world (Lysaker et al., 2017). This metacognitive capacity can be considered a client factor that impacts how a person views and functions in the world, where higher metacognitive scores reflect a greater ability to respond to psychological stressors. This capacity can be measured using the Metacognition Assessment Scale (MAS-A), based on results from either the Indiana Psychiatric Illness Interview (IPII) or other commonly used occupation-based narrative assessments such as the Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS), The Occupational Performance History Interview-II (OPHI-II), and The Model of Human Occupation Screening Tool (MOHOST). Once a client’s life narrative is recorded using one of these assessments, the therapist can use the MAS-A scale to rate their metacognitive capacity across four related but semi-independent domains: Self-reflectivity (S), Understanding the Other’s Mind (O), Decentration (D) and Mastery (M) (Semerari et al., 2003). Deficits in these areas of metacognition can explain a client’s “lack of apparent goals and motivation, social alienation, poor insight hopelessness, lack of emotional experience and expression, disorganized reasoning, speech and behavior, and disturbances in first person experience” (Lysaker et al., 2017).

To target deficits in these four domains, the MERIT approach offers a manualized intervention framework consisting of eight elements that should occur within each therapy session. These elements are broken down into content elements, process elements, and superordinate elements. The four content elements focus on the main subject matter covered in a

session including: understanding the client's agenda, eliciting a narrative episode to reflect upon, insertion of the therapist's mind, and attempting to define the psychological problem. The two process elements include reflection on progress and reflection on the therapeutic relationship. Finally, the two superordinate elements focus on the therapist's ability to choose and modify interventions that will stimulate metacognitive growth including: stimulating self-reflection and awareness of others and stimulating mastery. The goal of MERIT is: "not to produce another standalone treatment for a specialized problem, but to create an overarching set of elements that could be utilized by therapists with different backgrounds in order to enhance metacognition" (Lysaker et al., 2020, p 334). As this approach directly aligns with the occupational therapy intervention process and can address barriers to a client's occupational engagement, further research is needed to measure the feasibility and impact of MERIT within occupational therapy practice.

Capstone Importance

This capstone project was an important step in the process of supporting evidence-based practice (EBP) in mental health occupational therapy. Current EBP literature supports the valuable impact that occupational therapy can have within the mental health field (Burson et al., 2017). However, only eight states currently recognize the role of occupational therapists as mental and behavioral health specialists (Wilburn et al., 2021). The addition of MERIT-OT research will support the distinct impact that occupational therapy can have within mental health settings, therefore increasing access to mental health care and supporting advocacy efforts during a time when the United States is seeing a shortage in mental health care practitioners. Within the Veteran population, there is a higher incidence of substance use disorders and diagnosis of mental health disorders than in the general population (Olenick et al., 2015; Office of Mental

Health and Suicide Prevention- Veterans Affairs, 2021). Thus, information gained in this capstone can bring additional services to support Veteran health. With occupational therapy being a holistic practice, it is primed to address the growing need for practitioners by addressing the dynamic relationship between mental health, physical health, and overall function, and to address the complex healthcare needs of Veterans.

Problem Statement

Based on the best EBP and population needs, OT should be providing mental health services. However, within the VA setting, there are needs in the areas of advocacy, program design, and clinician education to allow mental health services to be fully implemented. Training and integration of Metacognitive Reflection and Insight Therapy for Occupational Therapy (MERIT-OT) could help fill this gap, but data on the barriers and facilitators to mental health service implementation within the current practice model need to be understood.

Capstone Purpose

The purpose of this capstone experience was threefold. The first goal was to assess the needs, gaps, and current VA services in Indianapolis, and to explore the feasibility of using MERIT-OT in this setting. The second goal was for the capstone student to build clinical skills in assessing metacognition and providing mental health interventions in group and individual treatment sessions informed by the MERIT-OT approach to aid in building a MERIT-OT training guide and intervention framework. The final goal was to provide staff training in MERIT-OT and a broad range of mental health resources and clinical approaches that could fit into their current practice workflow.

Needs Assessment

In preparation for this needs assessment a guiding question was created: does MERIT-OT translate to practice guidelines that address the VA site needs and service gaps? In order to answer this question many resources were gathered including a Marion County community profile, a site interview with one of the VA hospital's inpatient occupational therapists, three weeks of observation in various VA healthcare settings, a literature review, and a gap analysis. The goal of this needs analysis was to better understand the barriers and facilitators that each stakeholder was experiencing to assure that the capstone project was meeting and fulfilling the needs of those involved. Site partners for this project included VA occupational therapists, the VA Veteran population, VA psychiatrists, and Indiana University Purdue University Indianapolis (IUPUI) researchers. Together these partners worked to understand 1) opportunities to integrate MERIT-OT into current VA OT practice; 2) the needs of VA OTs to feel confident integrating mental health care; 3) the utility of MERIT-OT in VA mental health services extending beyond OT clinic service.

Results and Analysis of the Community Profile and Service Profile

The Indianapolis Veteran's Health Administration is located in Marion County, Indiana. The community profile for this area highlighted that it is among the least healthy areas in the state for both health factors and health outcomes, with higher levels of poverty, violent crimes, housing problems, and lower ratios of care providers when compared to statewide averages. However, due to the nature of this specific site, Veterans from many rural communities all over the state travel here to receive their healthcare.

Taking this often-long commute into account, practitioners are often pressured to implement all levels of medical interventions a client may need within a short visit, often leaving

outpatient mental health unaddressed. Specifically, within this Veteran population, many patients are homeless, suffer from dual-diagnosis, struggle with close social relationships, and rely heavily on the disability financial reimbursement system and services. Unlike other populations, many of these individuals may have put their lives on the line to protect our country and are now living the rest of their lives struggling to cope with what they experienced, both physically and mentally. These struggles are often followed by role loss, relationship loss, and inability to participate in occupations that were once fulfilling to them.

The VA offers many medical services where OTs currently practice including acute medical, post-surgical, neurological, and rehabilitation care, as well as both primary and specialized outpatient services. Each of these services typically take a biomechanical, medical model approach to rehabilitation and discharge planning-- meaning that OTs currently only address the physical aspects of recovery, such as functional mobility, daily living independence, occasional splinting, and adaptive equipment. There is room for the integration of mental health OT services within this current workflow in order to fully meet the needs of this patient population.

Further services offered at this site, in which OT does not have any staff or programming include a geriatric clinic, homeless Veteran rehabilitation at an off-site domiciliary, whole health life coaching at an off-site Veteran's center, and psychiatric care within an inpatient mental health wing. Common diagnoses seen on the mental health wing include cognitive deficits, TBI, schizophrenia, bipolar, suicide, depression, PTSD, and SUD, among others. Within these diagnoses, occupational deficits can occur in all areas of function. Mental health concerns are not always as obvious as physical health concerns. However, as supported by the literature reviewed below, mental, and physical health should not be separated, as each impacts the other. Integration

of mental health occupational therapy services into these additional practice areas can help to meet this service need, improving continuity and quality of care offered at the Indianapolis VA.

The Interview Process, Site Observation, and Analysis of Results

As a part of the needs analysis, a site interview was completed with an onsite OT to better understand the VA's needs in mental health programming. This interview examined common diagnoses seen, OT's current role and programming, other mental services offered, and the OT department's feelings toward the addition of mental health programming. A general summary of questions included information overarching VA administrative support, OT staff and department procedures, and Veteran specific mental health trends seen (see Appendix A for a full list of detailed questions). The reasoning for these questions was to understand how mental health services are viewed within every level of the VA organization- from the client and their community to their practitioners, care team, and the VA's upper regulatory bodies. By better understanding each of these areas, the barriers and facilitators in place to support the inclusion of OT mental health programming were identified. This supplied vital guidance on what has or has not worked in the past while keeping future MERIT-OT program design client-centered and preventing harm.

After interviewing the onsite VA OTs, many limiting factors and goals for mental health OT service integration were highlighted. Some general themes that were found included a profound desire for OT to have a place within the current mental health and whole health rehabilitation model recently introduced at the site. However, the OTs at the IN VA were not currently practicing mental health interventions. If a patient in acute care or inpatient psychiatry was noted to be at their physical functional baseline, they were not being picked up on the occupational therapy caseload. An initial explanation for this service gap was that it may be due

to a lack of assessment and intervention knowledge targeting specific mental health concerns. This explanation was later confirmed by the OT team through individual interviews in which they shared their barriers to implementing mental health interventions. These barriers included time limitations, staffing concerns, and a lack of confidence in addressing mental health concerns due to limited training and practice using mental health-focused assessments and intervention plans. In this therapy setting, OT's primary role involves addressing physical function and discharge planning. With the emphasis on these aspects, there was a general lack of understanding as to how OT's expanded role in mental health could fit within their current workflow.

This site also had a goal to lower the levels of client re-admission. Three possible causes were offered as explanations for the high levels of re-admission: 1) there was a missing link in the continuum of care, preventing appropriate provider follow-up in a timely manner after discharge; 2) there was limited collaborative care between multidisciplinary teams, limiting holistic preventive care; 3) due to the prior 2 points, there was often a learned reliance on the financial disability systems which can decrease a Veteran's motivation to return to higher levels of independent functioning. Together these factors created an ineffective cycle of service provision and re-admission instead of addressing the underlying causes of disability. Further analysis of the site's scheduling and referral processes found these factors to be true as it was concluded that interprofessional care teams often work in silos and are unaware of all services offered by each profession. Additionally, among the Veteran population, it was often observed that achieving higher disability status in order to increase financial reimbursement was of greater importance than improving health factors as a means to improve quality of life.

The site's targeted outcome was for their OT staff to have increased general mental health education and programming; this aligns with the VA's recent choice to begin implementing a whole health model approach to treatment planning. One further supporting factor was recent Indiana state policy changes including direct access to occupational therapy services under Medicare/ Medicaid regardless of diagnosis and recognition that OT can be a valuable resource to enhance care within behavioral health teams. These interview responses aided in the formulation of the capstone purpose by identifying areas of opportunity within the processes at the VA. Opportunities centered around how the site, Veterans, and OTs could each be supported by the addition of MERIT-OT. Initial steps for this capstone project to address these opportunities included the capstone student training in the MERIT approach, clinical observation to ascertain the role of occupational therapy when implementing this approach within various mental health settings, creation of OT staff mental health education, and integration of MERIT-OT into current OT interventions.

Literature Review

In order to better inform the development and implementation of this capstone project, a literature review exploring the most current research on metacognition and interventions for adults with serious mental illness was conducted. This research helped identify where practice gaps may have been occurring between researched best practices and what is occurring in the field, as well as ensuring that MERIT-OT was a good fit for the needs of the site. Articles were systematically chosen through searches in PubMed, AJOT, and Google Scholar. Primary search terms included: adults/Veterans, mental health, serious mental illness, metacognition, improved quality of life, and occupational therapy. The focused clinical question was: "within the adult and Veteran populations, what is the effectiveness of metacognitive-based occupational therapy

interventions in positively impacting patient quality of life and general well-being?”. To ensure the most recent data was found, articles were limited to level 1-3 evidence created within the last 10 years, with priority given to articles published within the last 5 years. Articles were reviewed for content, level of evidence, and relevance to this capstone project’s needs.

Evidence for the Impact of Metacognitive Therapy on Patient Quality of Life

In their study with adults with schizophrenia disorder, Daoud et al., (2022) found that when measured with the MAS-A, metacognitive deficits were found in all patients, across all four dimensions of metacognition, with “Mastery” being the most affected dimension. Further analysis of the results showed that client factors with the greatest correlation to metacognitive deficits were occupational inactivity, low insight, and the presence of negative symptomatology. They proposed that metacognitive programming which focuses on improving these factors will help to improve this population’s quality of life. As occupational therapists can a use multitude of frameworks to address mastery as a means to improve occupational inactivity, OT’s ability to address metacognition to improve patient outcomes is already outlined within the current scope of practice.

“Metacognitive Narrative Psychotherapy” has been shown to have long-term efficacy as well. In their 2-year longitudinal follow-up case study Schweitzer et al., (2017) implemented long-term metacognitive therapy averaging fifty-two sessions over the course of 13-26 months. They stated that “it is possible that more sessions and longer treatment duration may be important for some individuals with a schizophrenia diagnosis. For example, a person’s initial level of recovery may impact the length of treatment required to facilitate and maintain gains in recovery” (Schweitzer et al., 2017). At 2-years post-therapy completion, they showed that positive therapeutic gains in metacognitive capacity could be maintained over time. As they were

following a recovery model perspective, it is important to note that there was no expectation of symptom reduction, but participants can still develop skills that can help them lead productive and fulfilling lives through improvements in metacognitive capacities. This information will help inform future OT program design for vulnerable populations with serious mental illness. These programs may require greater longitudinal durations, but successful outcomes can be maintained long-term.

Finally, a randomized controlled trial by Jelinek et al., (2016) examined the efficacy of the addition of metacognitive-based therapy (D-MCT) to usual treatment (TAU), compared to health training (HT) with usual treatment for patients with depression. Treatment as usual consisted of 5 days a week for 8 hours of various treatments including physical, occupational, and psychological interventions. Health training included two sessions per week consisting of one walking session and one psychoeducation session on various health topics such as stress reduction. The D-MCT group focused on the reduction of depressive thought patterns by targeting dysfunctional metacognitive coping strategies. This study found strong evidence for the reduction of depressive symptomology in participants who engaged in the D-MCT+ TAU compared to the HT+TAU. As depression is a more common diagnosis that will likely be seen at this capstone site, this study shows that metacognitive therapies can be generalizable to larger mental health populations. In addition, it highlights the importance of specifically targeting metacognitive capacities in addition to typical treatments as a means for improved quality of life.

Evidence for Occupational Therapy's Role in Mental Health

A scoping review completed by Rocamora-Montenegro et al., (2021) investigated what OT interventions for adults with SMI are most investigated in intervention studies. They stated that "treatment for people with SMI requires the integration of different levels of care and

different interventions that include, in addition to pharmacological treatment, rehabilitation and social support programs that allow them to participate in the community in a more independent and integrated way" (Rocamora-Montenegro et al., 2021). Although they found results for 790 articles published on OT interventions in mental health, they found only thirty-five studies that met their inclusion criteria, and only 60% of which were published in the last decade. These intervention groups in descending order of most studied included psychosocial interventions, psychoeducational interventions, cognitive interventions, and exercise interventions, although this is not an exhaustive list of possible OT interventions for those with SMI. Additionally, they found that regardless of intervention type, each article provided evidence of the positive effects of OT interventions. This shows a great need for more current research studies to be completed to add more evidence regarding OT interventions with SMI, such as those to be completed based on data collected during this capstone experience.

Next, in a systematic review completed by Gibson et al., (2011), interventions involving components of community reintegration and normative life roles for adults with serious mental illness were evaluated. This review found moderate to strong evidence for the effectiveness of social skills training, moderate evidence for life skills and instrumental activities of daily living (IADLs) training to improve performance, and moderate evidence for neurocognitive training paired with work, social participation, and IADLs. As community re-integration is often a focus of concern for Veterans, many of whom are also experiencing service-related PTSD, depression, SUD, or have underlying SMI, this article shows that occupational therapists can effectively assist with community re-integration and reduction of hospital readmission among this population.

Finally, in a more recent systematic review, D'Amico et al., (2018) state that "although occupational therapy in the United States has its roots in mental health practice, over the years it has become less prevalent, and only recently have occupational therapy practitioners been reclassified nationally as providers of mental health services [the American Occupational Therapy Association, 2017]" (D'Amico et al., 2018). However, they found that the evidence for the role of OT interventions to improve occupational performances and participation in individuals with SMI is only growing stronger. When specifically looking at interventions that combined occupation with psychoeducation and cognitive-based interventions, they found strong evidence for its efficacy but also a need for more consistent use of occupational performance measures within psychoeducation. As MERIT-OT follows a manualized design and relies on occupation-based narrative assessment measures such as the Occupational Circumstances Assessment Interview Rating Scale (OCAIRS), this capstone project with help meet this gap in the evidence. This review highlights not only the need for more occupational therapists practicing in mental health settings but also the likelihood that metacognitive OT intervention approaches will improve patient outcomes and quality of life.

Evidence for the Intersection of Mental and Physical Health

As discussed earlier, there is a clear intersection between mental health and physical health and it is expected that in cases of physical disability rehabilitation, there will be a greater likelihood of negative mental health experiences such as anxiety and depression. As a majority of the adult populations that are encountering OT services at the VA hospital are seen due to some sort of new medical management for chronic, acute, scheduled, or traumatic physical disabilities, it is important for interprofessional teams to practice holistic care as they consider how the mental health needs of these populations can be met. In a systematic review by Pisegna

et al., (2022), they discussed that depression and anxiety are highly prevalent within physical disability inpatient rehabilitation and have negative impacts on functional recovery, including an increased risk for poor adjustment to disability as well as increased mortality. Within the studies that met their systematic review inclusion criteria, they found limited but moderate evidence for the use of OT cognitive and behavioral strategies to address patient mental health needs when embedded into occupational interventions. Additionally, they found that "currently recommended treatments for depressive and anxiety symptoms (medication typically managed by the attending physiatrist and talk-based psychotherapy, often delivered by either social work or rehabilitation psychology) have minimal effects on enhancing functional independence and efficacy of OT interventions to improve patient outcomes" (Pisegna et al., 2022). This highlights the idea that mental health cannot always be medicated away, but as part of an interprofessional healthcare team, occupational therapists can work with patients to better understand their own minds, and work toward a state of self-agency and mastery, that will then improve their ability to function in the physical world.

Next, when looking for OT interventions for Veteran specific needs such as PTSD, a study completed by Bormann et al., (2013) found that a nonpharmacological complementary therapy of mind–body–spiritually based programming "Mantram Repetition Program (MRP)" showed significant improvements in symptoms of hyperarousal and insomnia. They state that "since stigma continues to be associated with mental illness and mental healthcare [Hoge et al., 2004], it is critical that interventions be proposed that are less stigmatizing for those seeking mental health treatment" (Bormann et al., 2013). This concern for stigma as a barrier to receiving mental health services has been echoed by providers within the VA capstone site. It has been proposed that some adult and geriatric populations do not feel comfortable seeking out

psychiatric counseling services due to stigma or pre-existing beliefs about these services. OT may be able to fill the service gap by taking a more functional approach to mental health services and recovery, without the barriers of stigma surrounding service rendering.

Finally, Kinney et al., (2022) found that occupation-based interventions that promote participation have been shown to mediate suicidal ideations within Veteran populations experiencing mild traumatic brain injury (mTBI). They argue that "preventive services could mitigate suicide risk among Veterans with mTBI by enabling sustained engagement in meaningful and health-promoting activity (e.g., reasons for living) and targeting post-concussive symptoms" (Kinney et al., 2022). This statement of helping patients engage in meaningful activities to provide a reason for living directly aligns with the principles within the MERIT-OT framework to help individuals regain their self-agency through meaning-making and self-reflection.

Gap analysis

Best practices

The occupational therapy profession was founded in mental health practice spurred by a need for specialized care teams for Veterans of the armed forces suffering from shellshock (now known as PTSD) and physical trauma (Boyt et al., 2018). Medication-only approaches to mental health treatments are rarely 100% effective as a standalone treatment method to support mental health recovery and community reintegration. Evidence-based practice literature supports the valuable impact that occupational therapy can have within the mental health field (Burson et al., 2017), and finds that outcomes are better when looking at the integration of mental and physical components of rehabilitation as seen in the 4-quadrant model of integrated care (Collins et al., 2010).

Occupational therapy can be highly effective in lowering readmission rates by helping to create holistic treatment plans when added to an interprofessional care team. As occupational therapy takes such a client-centered and holistic approach to overall health and well-being, it is imperative that more evidence-based practice opportunities be created to allow for the presence of occupational therapy within mental health settings as well as the inclusion of mental health assessments and interventions in traditionally physical rehabilitation settings.

The Gap

As identified above, there are many interventions with research to support the role of mental health occupational therapy across many settings. However, there have been state and agency-level policies that limit the full extent of the role OT can play in delivering mental health services, with roughly only 2%-3% of practitioners working exclusively in this area (American Occupational Therapy Association [AOTA], 2020). This trend has also been seen within the IN VA setting where there was limited or no presence of OT within the mental health wing, geriatrics outpatient clinic, or SUD programs. Furthermore, in the traditional physical rehabilitation settings where OTs *were* being utilized at this site, mental health was rarely addressed within their daily practice as discharge planning and physical functioning outcomes are the primary concerns for rehabilitation. Occupational therapy has a wide range of theories, models, and frames of reference to holistically guide practice. However, OTs at the VA were not providing mental and behavioral health interventions but were instead limited in large part to a biomechanical frame of reference commonly seen within a typical acute care floor.

This service gap was reported to be due to limited provider knowledge and comfort in using mental health assessments, interventions, and approaches, with no clear path forward at this time. In addition, they reported a lack of support in access, policy, training, or staffing to

cover the need for mental health OTs. This strict limitation of the OT scope of practice within this setting should be investigated for correlation with higher rates of patient readmittance after discharge, as research shows that OT interventions are effective in reducing readmission and improving the overall health and well-being of mental health patients. This gap did not align with the VA's newly integrated whole health recovery model, or the OT department's generally accepted wish to begin providing mental and behavioral health services. To address this need, more rigorous occupational therapy mental health programs such as MERIT-OT must be implemented, and clinicians must receive further training and staff support to implement these interventions. In alignment with this site's new addition of a whole health model of rehabilitation, occupational therapy would make a valuable addition to the mental health care team.

Problem Statements

1. OT Clinicians currently wish to practice on the mental health wing but do not have programming, materials, or staffing support to fill the need for mental health OTs.
2. OT clinicians would like a full program to be trained on and begin implementing, but the MERIT-OT approach must first be translated into an OT scope of practice through clinical observation and further clientele needs assessment.
3. OT Clinicians want to work to meet patients' mental health needs but currently do not follow mental health EBP with patients they are already working with, due in part to limited education in intervention approaches.

Guiding Theory and Model

Two primary theories/ models were chosen to guide the design of this project. The Theory of Metacognition created first by James H. Flavell in the 1970s (Flavell, 1979), focuses

on understanding the various aspects of a person's ability to "think about thinking" (Moritz, S., & Lysaker, P. H., 2018). The concepts within this theory have provided a model to guide the original creation of MERIT with psychology called the Integrated Model of Metacognition:

> This model of metacognition also includes three assumptions which are foundational for MERIT. First, metacognition as a human activity is fundamentally integrative in nature. That is, for persons to be able to form complex ideas about themselves and others, they must have the ability to perceive the constituent elements of an experience which could later be integrated. Concretely, a larger sense of oneself would seem in part contingent upon the recognition of the pieces which will be integrated to create that larger whole. (Lysaker et al., 2020)

This model parallels the Model of Human Occupation (MOHO) created by Kielhofner, & Burke (1980). Both models suggest being human is fundamentally tied to our experiences and understanding of occupational participation. They both also include the use of narrative self-reflectivity to incorporate new experiences and ideas into one's evolving sense of self to develop habituation, volition, and performance or mastery; with mastery also including a person's understanding of their own mind. As MERIT relies on narrative understanding, MOHO offers tools such as the OCAIRS and narrative slope that can be used in MERIT-OT to understand a patient's internal agendas (volition) and life story (Wasmuth et al., 2022), which can be used to inform their habits and performance. Using MOHO as a guiding model will help ensure that we are staying within our occupational therapy scope of practice while implementing an originally psychology-based approach.

Project Plan

The doctoral capstone student's plan was to 1) gain clinical skills in providing mental

health occupational therapy services through a deeper understanding of MERIT-OT concepts in practice, 2) understand how MERIT-OT could be integrated into the Indianapolis VA setting, and 3) provide mental health training and resources to the OT team. The student reviewed the project plan and objectives with the site and faculty mentors prior to the start of the experience and agreed on the weekly scheduling flexibility required to meet both focus areas of clinical skills and research.

To complete each objective, a plan was created to build the student's experience starting with observation and activity analysis. This was followed by the implementation of staff training and Veteran mental health programming. Finally, the project ended with advocacy, follow-up support, and a final analysis of remaining site needs with recommendations for next steps.

By completing observation of each OT staff member within the multiple settings, the student was able to meet the objectives of understanding the team culture, mental health knowledge gaps, and daily workflow requirements. Through this process, the student was also able to examine the administrative and individual staff barriers/ facilitators to the integration of MERIT-OT at this site. This information guided the student in choosing the most effective mental health OT resources and training steps to provide to OT staff members. OT staff training in mental health helped to meet the objectives of increasing practitioner knowledge and confidence in this area.

By completing an independent study of MERIT-OT literature and providing OT group sessions at the Domiciliary, the student was able to meet the objective of improving clinical skills. Additionally, this aided in the understanding of the needs of the patient population as well as the processes and resources that needed to be created in order to develop a MERIT-OT

training framework. Goals were updated throughout the experience to reflect the needs of the site as a deeper understanding was gained.

As explained by Deluliis & Bednarski, 2019, program evaluation is imperative to support the sustainability of the capstone project. The evaluation plan to measure the student's successful completion of the capstone project was based on the achievement of each goal agreed upon in the student learning plan (see Appendix B for the full list of student learning goals and objectives). Qualitative data were recorded through journaling of strengths, weaknesses, opportunities, and threats (SWOT analysis) after daily workflow observations to measure opportunities for MERIT-OT integration in future practice. A final survey was conducted among staff members to measure satisfaction with project implementation and remaining needs at the site.

Process

Weeks One through Four

The first several weeks of the experience were used to orient the capstone student to the culture and programs at the VA, deepen the understanding of site needs, and make updates to the needs assessment. During this time, the student also completed an independent study to build knowledge regarding MERIT principles that could be transferred to VA OT staff workflow.

This orientation phase included meeting with different care teams and departments, attending OT meetings discussing mental health, and setting up contact with the geriatric clinic (GeriPACT) team to begin receiving consults. A schedule was also established at the Domiciliary, which included observation of social work groups and multidisciplinary care team meetings to understand the needs of Dom residents and plan for program implementation. A broad understanding of VA whole health programming was gained through observation of

various rehab team members including art therapy, whole health, recreation therapy, and physical therapy.

Within the rehab team, the student shadowed OTs during direct patient care within the acute care, an outpatient satellite location, and inpatient rehab. In-depth activity analysis of workflow and individual non-formal interviews were completed to elicit the perceived barriers to implementing mental health OT services among the rehab team. This observation informed the capstone student of what mental health resources and training needed to be developed throughout the capstone experience.

Weeks Five through Twelve

Throughout the experience, the student found a balance to dedicate time to each area of clinical focus between research, project work time, and clinical skills building. The student requested weekly meetings with the site mentor to discuss site and scheduling needs, and weekly meetings with the faculty mentor to discuss MERIT-OT development needs. The student also began attending weekly MERIT supervision care team meetings with VA psychology graduate students to discuss the principles of MERIT, barriers/facilitators to integration, and to gain feedback on MERIT-OT care delivery experiences. Beginning in week five, the student began implementation of direct patient care through weekly mental health OT groups at the Domiciliary to build clinical skills and inform the integration of MERIT-OT within this setting. An individual treatment session with a GeriPACT patient was also completed during this time.

The student gathered mental health OT resources and created three training presentations to improve staff confidence in addressing mental health within their typical workflow. The resources were stored within the VA Teams file-share and included screenings, assessments, and interventions based on the area of deficit. Two of the three training courses were given during

this phase of the experience. Continued follow-up and workflow observations were completed with each OT to assess the carryover of training and the effectiveness of the resources provided. Instances of using mental health approaches/materials as well as missed opportunities for skilled mental health OT service utilization were noted and discussed with each OT when observed. Continued journalling of the barriers, facilitators, and opportunities for MERIT-OT to be integrated into the Indianapolis VA setting was completed.

Beginning in week ten, the capstone student was able to partner with the whole health and suicide prevention team to facilitate the integration of OT services within the suicide screening follow-up process on an outpatient basis. The student analyzed the necessary steps required to support the smooth integration and long-term sustainability of this new program and created resources to meet these needs. Resources developed included referral process sheets based on the VA protocols, scripts to be used by scheduling staff when contacting Veterans to schedule services, and outcome-tracking forms to gather data on the impact of services. A service evaluation plan was scheduled for sixty days after the start of the pilot program. Key OT staff members were identified and trained in the appropriate process of service implementation and data collection. To ensure continuity of care, the student connected key members of the multidisciplinary healthcare team and provided them with updates on the plan and purpose of this new service offering.

Final Weeks

During the final weeks of the capstone experience, the student provided staff training on the basic principles of MERIT-OT. Additionally, a lunch-and-learn presentation was given to the rehab service team which included physical, occupational, speech, recreation, and art therapies. The focus of this meeting was to advocate for the role of OT in mental health and share findings

of the capstone experience. Recommendations were made for further OT services, staffing, and programming to meet current service gaps seen within each observed setting. Finally, recommendations for MERIT-OT integration were summarized and shared with research project stakeholders.

Project Implementation

MERIT-OT Integration

Appropriate integration opportunities for future MERIT-OT research were considered for setting, patient population, and staff workflow based on observations made by the student throughout the fourteen weeks. To inform this decision, the student completed an independent study of MERIT literature to understand how this framework is used from theory, assessment, intervention planning, and translation into OT scope of practice. These principles were used to inform the student's practice during group facilitation at the Dom. Application of these principles required the student to serve as a facilitator to translate the group's narratives and self-reflections to higher/ lower metacognitive levels based on the metacognitive capacities of individual group members. From this study and application, the student was able to find gaps in the translation from OT theory to practice that could then be filled by the creation of training aids (see Appendix C student-created MERIT-OT intervention guides).

The student created two MERIT-OT training presentations that could be given to audiences based on their level of knowledge and practice in mental health OT approaches. The introductory presentation was given to VA OT staff followed by a discussion on barriers to integration within the team. OTs who were interested in further training and the next steps of implementation were connected to the MERIT-OT research team and monthly online meetings. This deeper knowledge of MERIT-OT, as well as the individual site workflow characteristics,

led the student to the decision of the most appropriate integration setting and staffing recommendations for future research and grant proposals.

Staff Training

To meet the goal of increasing staff knowledge of mental health OT, training was implemented in three micro-cycles following Vygotsky's model of scaffolding learning (Vygotsky, 1978). The cycles were built upon each other to increase the knowledge and application of mental health OT in order to meet the overall needs of the site and aid in the future integration of MERIT-OT. Each cycle was focused on 1) gathering information to identify a knowledge gap within the OT staff, 2) building resources and providing training to address the knowledge gap, 3) providing individual support to staff implementing the new concepts, and 4) re-assessment for next level of learning and knowledge gaps. Implementation in this way ensured that the resources provided were relevant to the needs of the Veterans and appropriate for the confidence level of the OT practitioners. It also allowed time for higher repetition and follow-up to increase understanding and implementation of concepts covered.

The first training focused on the basic principles of OT's role in mental health followed by a discussion of perceived barriers and further needs to begin implementation. Discussion led to a deeper understanding of site needs. This shifted the capstone student's focus from staff implementation of MERIT-OT, to building self-efficacy of OT staff to begin implementing basic mental health approaches for the remainder of the experience. Topics covered included basic mental health terminology, screenings and assessments, interventions, documentation, and processes for when and to whom to refer. Weekly individual support was given to aid in the implementation of concepts.

The second training was focused solely on training staff on the use of the Kolhman

Evaluation of Living Skills (KELS) (Thomson & Robnett, 2016). As OT staff were not currently operating within other areas of mental health as a part of their daily practice, it was imperative to begin to grow their skills in the one mental health area they were occasionally asked to consult in. The KELS was chosen in order to provide a resource to begin confidently completing evaluations of independent living skills for patients located on the inpatient psychiatric floor. This training took place in person during the monthly OT staff meeting. A copy of the KELS manual was distributed along with the needed equipment. A short lecture-style presentation was given followed by hands-on use of the KELS with partners and a discussion. On-call support was given to staff who would be receiving consults on the psychiatric floor to aid in implementation.

The final training included a broad overview of MERIT-OT. This presentation was provided to increase the general understanding of future MERIT-OT programming implementation. Training expanded upon the staff's knowledge of mental health approaches which were taught in previous presentations. This included how to measure and address the factors of metacognition outlined in the MERIT framework, followed by an open discussion of remaining barriers to implementation, and OT staff interest.

Clinical Skills Building

One deviation from the original student project plan was not providing individual sessions within the GeriPACT. Although one patient was referred, scheduled, and seen by the student, no further GeriPACT patients were seen. This was due to referral barriers that included an underutilization of OT services which could have been due to limited understanding and value of the role of OT among GeriPact providers which remained after the student provided education and follow-up. Furthermore, patient population factors such as mobility, dementia, low vision, and hearing limited regular travel to the VA and the use of telehealth options. Therefore, clinical

skills were built throughout the course of the fourteen weeks through independent study and implementation of mental health OT groups at the Domiciliary, with MERIT-OT principles in mind. Prior to program implementation at the site, the student was able to build interprofessional clinical skills over four weeks by gathering data and establishing rapport with Dom staff and Veterans. This included observation of various groups and activities at the site and participation in interprofessional care team meetings to understand the needs of the Veterans. The student then chose an appropriate program to implement and worked with staff to schedule and advertise the group.

The program chosen followed the Do-Live-Well framework which addresses 8 areas of occupational balance (Moll et. al., 2015). Group sessions were conducted one day a week for 60 minutes, over the course of 9 weeks. The first and last weeks were focused on group formation/ wrap-up and pre/post assessments. Weekly journalling was completed by the student to track the barriers and facilitators to group process with the implementation of MERIT-OT concepts. The student noted increased confidence in the ability to facilitate mental health OT groups as a therapist and overall ability to integrate MERIT-OT into practice. Skills built during group implementation included collection of implementation effectiveness data, intervention plan adjustment to continue to meet Veteran needs, improved time management, refined documentation skills, and improved real-time assessment of MERIT-OT concepts during practice.

Evaluation

The site mentor completed midterm and final evaluations of the student's clinical skills to note progress made during the experience. Qualitative interviews and workflow observations were completed to achieve the capstone purpose of understanding how MERIT-OT could be

integrated into the Indianapolis VA system. Additional quantitative and qualitative data were collected through weekly journalling of the feasibility of MERIT-OT implementation, and surveys evaluating the need for more OT staff training and support in mental health.

Methods

In order to collect data on individual OT practitioner barriers to providing mental health OT, the student's initial plan was to create a pre/post survey for staff members. Upon reflection, surveys alone were not nuanced enough to understand the underlying factors of staff needs, thoughts, and feelings related to providing mental health OT. Therefore, these data were collected through informal open discussions and individual activity analysis of the daily workflow styles of multiple OT staff members. Observation was also completed with professionals from separate practice areas within the VA system including social work, art therapy, psychology, and recreation therapy at sites where OT did not have programming. This activity analysis aided in the understanding of the VA system-wide barriers and facilitators to implementing MERIT-OT and the most appropriate populations to do so. The student recorded and analyzed this qualitative data through daily journalling and SWOT analysis, using no personal identifying factors.

After program implementation of mental health trainings, the site mentor and capstone student determined a survey would best capture the final outcomes and remaining needs of the site. The student used Qualtrics to develop the survey including five 5-point Likert scale questions and three open-ended questions, allowing respondents to rate their level of agreement with each statement. Statements included staff perceived views on the impact of the capstone project and remaining needs of the site (see Appendix D). This survey was given over a pre-scheduled department meeting time to not take away from patient care productivity. Responses

were then analyzed to identify the percentage of agreement with each statement within the quantitative data and themes within the qualitative data.

To record the barriers, facilitators, and feasibility of implementing MERIT-OT as an individual practitioner, the student completed a weekly self-assessment by journaling about experiences during group sessions at the Domiciliary. Additionally, the student administered activity patterns pre/post-assessments to aid in group goal setting and gauge changes in the group's average satisfaction as a result of group participation. The assessment was from the Do-Live-Well framework and was a self-report measure of satisfaction in the areas of engagement, meaning, control/choice, balance, and routines on a scale of one to ten (Moll et. al., 2015). Pre-assessments were given to group members who attended in the first two weeks of group to capture the greatest impact across the nine scheduled weeks. Post-assessments were given during the last week of group to members who attended at least two prior group sessions and all data was de-identified.

Results

SWOT analysis of mental health OT approaches within the VA

Seven OTs participated in informal open group discussions of mental health concepts after each of the three in-service trainings. Initial discussion themes included needing more staff to carry a greater caseload, more training to gain confidence in assessments, and more materials to support intervention planning. The student participated in individual OT observation of direct services after each training to provide individualized, real-time reinforcement and training on mental health OT approaches, and gain an understanding of general areas of practice gaps as a department which were recorded in a SWOT analysis (see Table 1). Workflow observation trends included a scope of practice that focused mainly on the physical attributes of functional

rehabilitation and a hesitancy to address comments made by patients that were outside of that area of focus. After noting this trend, the OTs agreed that addressing the mental health portion of rehabilitation would help to save time and improve patient outcomes in the future. With continued staff training and follow-up, integration of these concepts was beginning to be seen by the final weeks of the project. At the conclusion of the project, seven OTs completed a survey to measure final opinions on OT's role in mental health, remaining needs, and future steps for MERIT-OT integration at the site (see Figure 1 for quantitative results).

Table 1

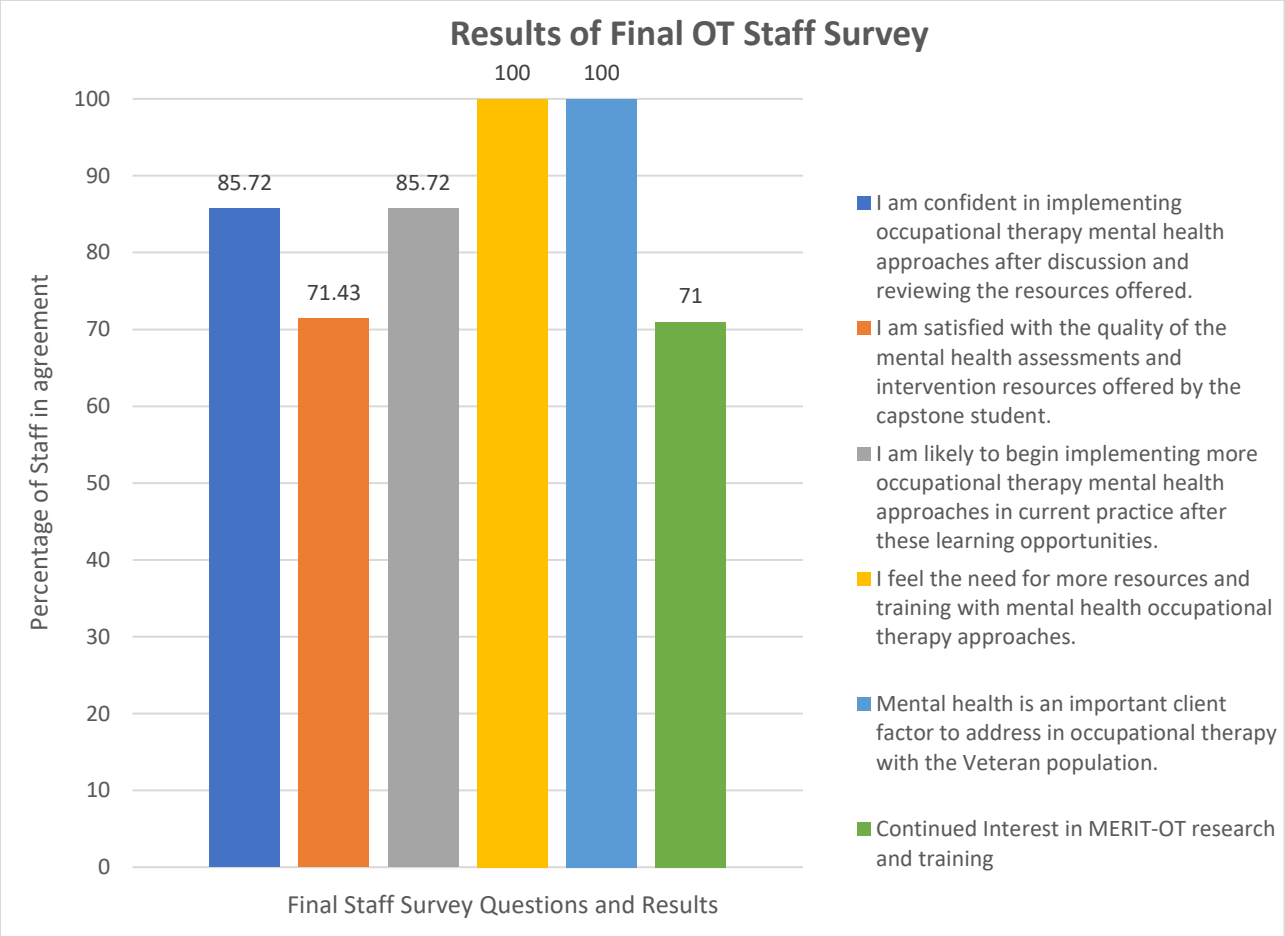
Indianapolis Veteran's Health Administration Occupational Therapy Practitioner SWOT analysis for the implementation of mental health services

Strengths	**Weaknesses**
- OTs have received training and resources available to implement. - VVC Telehealth availability -New implementation of Suicide prevention programming -Teams files to share training documents -Staff OT support of the role of OT in mental health -Top-down support of OT's role in Mental health -Staff have been trained in crisis protocols -Monthly department meetings and lunch &learns to integrate continued training	- Time- Due to lacking staff, providers are at productivity limits and will require more OTs to cover the current workload before implementing more responsibilities -limited time/ length of assessments -limited provider confidence in mental health approaches -Limited understanding of mental health screening responsibility among OT staff -Limited understanding of all VA services offered to aid in referral among OT staff -Need for continued training
Opportunities	**Threats**
-Continued training and integration of mental health approaches in practice - Strategic planning to further explore program development and related staffing increase needs - Hire a full-time Floater OT to begin implementing MH OT services on all floors/ sites, help support fostering more MH programming and workflow implementation	-Limited staffing to meet new program needs -Staff report feeling overworked and burnout/ unable to expand to the full scope of practice - Some OTs do not want to take on more training due to other certification requirements - Recruitment- Not all patients are consulted by OT in acute care and very few in inpatient mental health ward.

-OT needs to be included in all general mental health care team meetings, join the conversation -Should follow the Johns Hopkins model -Further training and implementation of MERIT-OT	

Figure 1

Results of Final Staff Survey



Shadowing multiple other professions within the vast number of VA settings helped the student to identify additional populations that would benefit from the inclusion of OT services, as well as serve as an advocacy platform for the OT profession (see Table 2). By completing this SWOT analysis, the student was better able to understand the administrative factors that could

influence the integration and sustainability of new mental health OT programs. In addition to beginning to offer further mental health services within the areas where OTs already function, there are many service settings where OT services are not offered but would be beneficial to improve the quality of Veteran care. These additional programs include inpatient mental health, the Domiciliary, GeriPACT, Housing and Urban Development-VA Supportive Housing (HUD-VASH) the Psychosocial Rehabilitation and Recovery Center (PRRC), Substance Use Disorder Recovery Program (SUDRUP), and Whole Health.

Table 2

Indianapolis Veteran's Health Administration Administrative SWOT analysis for the implementation of mental health services

Strengths	**Weaknesses**
-Many existing VA programs/ services for OT to integrate into -Alignment of OT in mental health to a new whole health model and programming -Documentation system supports the ability to document OT's distinct role in mental health -VA offers travel pay and multiple sites to meet veterans -Many training resources through TMS and VHA train	-Consult/ referral process limits OT's ability to see patients - Poorly coordinated rehab efforts as OTs are not currently part of the mental health care team; therefore, not as efficient when consulted presently. -Inefficient scheduling process -Travel and use of VVC can be a barrier for some patient populations to receive services
Opportunities	**Threats**
-The continued education and integration of OT's role on the mental health care team -Addition of OT to the Mental Health care team meetings -MERIT-OT programming and general mental health OT within each of these settings: Inpatient Mental Health, The Domiciliary, GeriPACT, Acute: Stride+, Inpatient rehabilitation groups, HUDVASH, PRRC, SUDRUP, Outpatient, Whole Health -Apply for grants/ create a new FTEE proposal -OT can meet service access need with MERIT-OT	-Limited understanding or Value of OT's role in expanded services among multidisciplinary care teams --OT is not consulted in all clinics/ populations -Complex VA system structures and funding limit the introduction of new programs/ roles and continuity of care due to the "siloing" of multidisciplinary teams and various settings

-Access to mental health services takes too long with poor show-rate for traditional mental health services which could be overcome by OT	

MERIT-OT Barriers, Facilitators, and Opportunities

The capstone student completed weekly journalling of their ability to successfully integrate the principles of MERIT-OT into mental health groups at the Domiciliary (see Appendix E for a Journal of MERIT-OT integration success). Results show that the capstone student was successfully able to implement MERIT-OT into the OT mental health groups. From this information, the student was able to define the barriers, facilitators, and opportunities that individual practitioners may experience when integrating MERIT-OT into daily practice. As these barriers could be faced by practitioners who are newly implementing the framework but overcome with further practice, they are listed as conditional barriers (see Table 3). Additionally, averaged pre/post data collected from group members' satisfaction with activity patterns showed improvements in four out of the five domains (see Figure 2).

Table 3

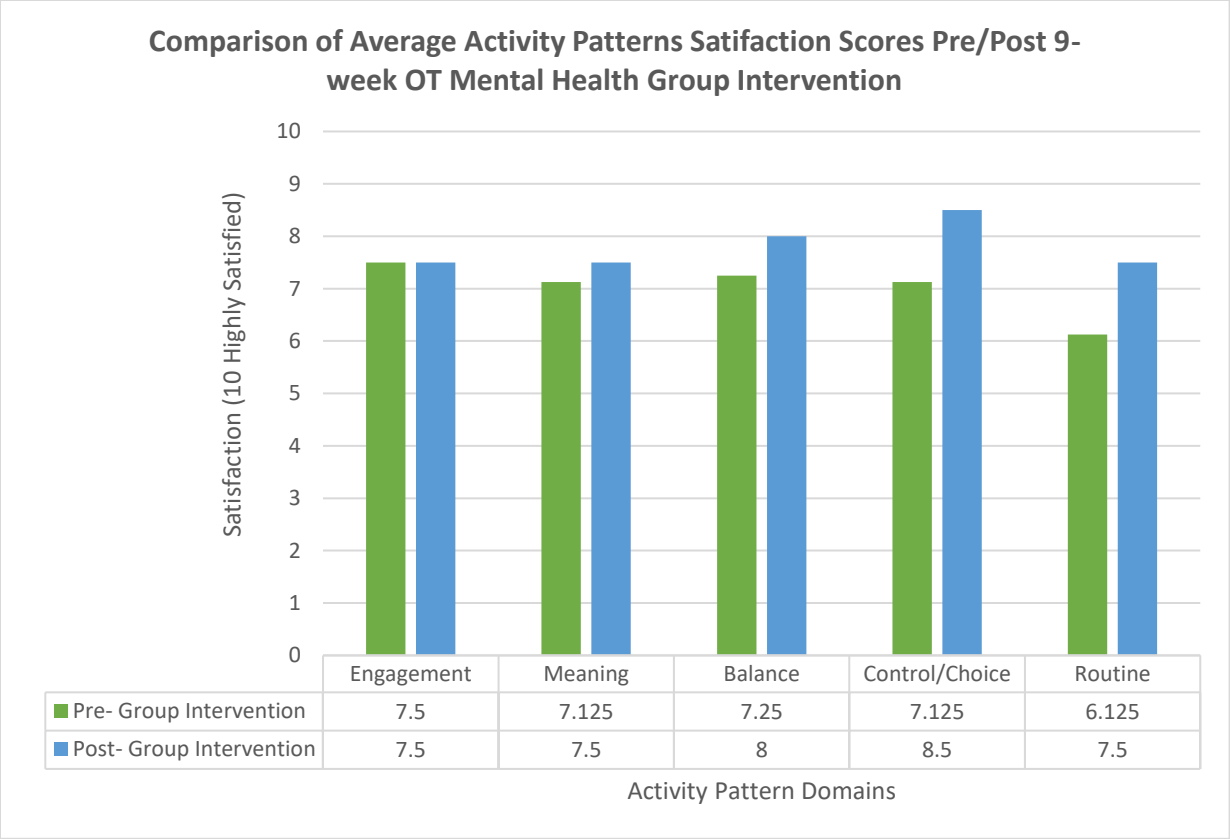
Individual Practitioner Barriers, Facilitators, during the implementation of MERIT-OT groups at the Indianapolis Veteran's Health Administration Domiciliary

Conditional Barriers	Facilitators	Opportunities
Limited practice in offering groups in a real-time setting	Natural alignment of MERIT-OT process to OT process	Further development of MERIT-OT intervention framework
Limited practice with live rating of MAS-A levels	Strong therapeutic use of self-skills to help reflect thoughts back to group	Further development of MERIT-OT training materials and opportunities
Possibility for low confidence in creating interesting occupation-based experiences to engage return group members each week	Use of MERIT-TAS to evaluate clinical implementation success	Generally, more guidance and assessment from strong MERIT-OT therapists

Time does not always allow for individual sharing of narrative episodes	Weekly self-reflection of skills implementing MERIT-OT	Need for individual sessions to assess metacognition prior to starting groups
Individual agendas can be difficult to fully understand during the flow of group process with competing personalities	Group process helps to facilitate stimulation of mastery, self-reflection, and awareness of others as the group reaches cohesiveness	Hiring an onsite OTR
The Dom may not have the available funding to employ a new full-time OT staff member	Flexibility within the Domiciliary setting to create groups that meet patient's occupational outcomes	Further Advocacy for the role of OT with homeless rehabilitation populations
Dom members come and go, and drop into sessions they wish to attend which may slow progress of metacognitive development	Extremely cohesive and supportive interprofessional care team	Dom residents are required to attend groups during their stay, increasing the likelihood of having long-term participants and outcomes

Figure 2

Comparison of average scores pre/ post Veteran mental health group intervention



The student used information gained from an independent study of MERIT principles, VA administrative and OT department observation SWOT analyses, and implementation of MERIT-OT principles during groups to define the barriers, facilitators, and opportunities for MERIT-OT integration within the IN VA system in the future (see Table 4).

Table 4

Barriers, Facilitators, and Opportunities for Implementation of MERIT-OT within the Indianapolis Veteran's Health Administration

Barriers	Facilitators	Opportunities
Limited/ no staffing to meet integration of new MERIT-OT program	Staff training completed on MERIT-OT implementation purpose and process	Grant proposal to hire dedicated mental health OT to implement MERIT-OT
Current staff are limited in MERIT-OT implementation due to limited time/ staff to meet daily workflow requirements	MERIT-OT intervention guides and Scripts for schedulers/ staff to describe MERIT-OT are available	MERIT-OT would integrate well within the Domiciliary, Inpatient Mental Health, and Inpatient Rehabilitation, Outpatient Mental health, and Outpatient general OT with
OT is not functioning in traditional mental health settings currently due to these staffing limitations	The Domiciliary has the infrastructure to support programming needs	New FTE to hire full-time mental health OT
Complex system barriers that make the hiring of new full-time employees a difficult and drawn-out process	Cohesive support from the top down, within the OT team, and within the mental health team to integrate MERIT-OT	Further development of training programs and simulation practice
Not all staff are interested in offering mental health interventions- CHT	Identification of both private and group rooms to complete interventions at the main hospital, the outpatient clinic, and the domiciliary with VVC and travel pay possibilities	OT practitioners will require follow-up support to continue to integrate mental health approaches into daily practice
Need for continued training and practice with MERIT-OT	71% of OT staff show continued interest in MERIT-OT integration	Hiring of dedicated mental health OT
	Multiple OT assessments work with MERIT-OT based on practitioner focus	
	Onsite support for MERIT through Dr. Lysaker and Local support from OT research team	
	OT functioning in an outpatient mental health role	
	Identification of Populations to integrate MERIT-OT with	

Discussion

Barriers

Initially, many barriers were discovered to the integration of MERIT-OT at this site due to the limited practice of OT mental health approaches within the traditional rehabilitation settings and the lack of OT presence in any mental health setting. However, through staff training, advocacy among the multi-disciplinary team, and new OT presence in mental health programming, many of the original barriers were overcome throughout the course of this project.

The remaining administrative barriers to integration included a continued need for education and integration of OT's role on the mental health care team and limited staffing to meet any new program needs. The remaining staff reported barriers to the integration of MERIT-OT into the current OT workflow centered around time restraints and the need for continued training and practice opportunities. As the OTs were reporting high levels of burnout due to limited staff and feelings of being undervalued within the VA environment, they felt unable to begin integrating new programs and approaches into their daily workflow as they felt it would be difficult to meet their daily caseload needs. A meta-analysis completed by Park, 2021 highlights that these reported causes of burnout align with findings in broader burnout research and can impact quality of care. Hiring a full-time OT that could serve as a dedicated mental health OT across settings while also completing MERIT-OT research, and continuing to advocate for the value of OT in expanded programming could be a comprehensive solution. However, the process to create a new full-time position within the VA has many cost-analysis and data requirements that could limit the possibility of hiring new employees to meet this need.

MERIT-OT training resources were developed to facilitate the training of other therapists wanting to utilize MERIIT-OT in practice by overcoming any barriers experienced during group

sessions. Therefore, no remaining individual OT practitioner barriers to 1:1 session integration were noted aside from the continued need for further skill building and practice refinement. OT staff requested future online training videos and simulation opportunities be created to meet this need. Considerations to be made for further group integration include the need to have an introductory 1:1 session to complete metacognitive capacity assessments. Additionally, as it is difficult to prepare a group OT activity when it may not fit with the client agenda or psychological problem defined, development of a new group process focus may need to be developed. However, neither of these factors are considered true barriers as they will not prevent integration.

Facilitators

The IN VA offers many factors that will facilitate the integration of MERIT-OT. It has the necessary infrastructure, programming, telehealth capabilities, Veteran travel reimbursement for services, patient population alignment, and cohesive multi-disciplinary support from the local and national levels to expand OT's role in mental health services. The OT staff have completed training to understand OT's role in mental health, given access to multiple assessment and intervention resources, and have been integrated into a new role in mental health suicide prevention programming. Staff have completed introductory training in MERIT-OT concepts and have onsite and local support from Dr. Lysaker and the MERIT-OT research team. Finally, therapists would have the flexibility to schedule follow-up sessions and create plans of care that align with MERIT-OT expected treatment durations once staffing limitations are addressed.

Opportunities for MERIT-OT Integration

MERIT guidelines suggest that treatment gains can occur with as few as 12 sessions, and

clinical trials should consider no fewer than 26 sessions to allow for development of the therapeutic relationship and rudimentary metacognitive skill development within the client (Lysaker and Klion, 2017, p.134). Therefore, MERIT-OT research should be provided within the settings of inpatient psychiatry, the Domiciliary, and the inpatient rehabilitation "RITZ", with transitional outpatient OT long-term services available. As each of these patient groups typically have longer inpatient stays, researchers will be able to lower the possibility for attrition as compared to outpatient-only settings that require Veterans to travel each week. Lower levels of attrition will prevent skewing of outcome data and show more accurate impacts. Veterans in inpatient psychiatry and the Domiciliary settings have been noted to have a higher incidence of mental and emotional health concerns, aligning with the treatment aims of MERIT-OT. If a therapeutic relationship is built during an inpatient stay, and patients are invested in the goals of care, they may be more likely to continue their progress through an established outpatient support system that can aid in community re-integration and continuity of care (Ljungholm et. al, 2022).

Impact

The student was able to meet each of their project goals and objectives. A final evaluation of the capstone student completed by the site mentor noted growth in the student's clinical and professional skills. Meaningful notes were made about the student being a strong leader and advocate, a self-starter able to complete tasks without much direction, exceeding expectations for all tasks assigned, motivated to explore all VA programming, ability to identify gaps within VA services areas, positive interactions with Veterans during group and individual care, and positivity to promote OT in the VA system of care. The student was able to build confidence in areas of professionalism, clinical skills, and research throughout the experience by showing

positive outcomes of the mental health OT group process and integration feasibility of MERIT-OT concepts in practice. Group members reported improvements in satisfaction with activity patterns in areas of meaning, balance, routine, and control/choice. These positive results helped to advocate for the long-term integration of OT services within the Domiciliary setting.

The student was able to elicit the barriers and facilitators to MERIT-OT integration, identify appropriate sites/ populations for future research opportunities, and advocate for the impacts that this research would provide. Meeting this goal helped to support rigor and fidelity within the OT profession by supporting EBP for OT's role in mental health. Advocacy within the multidisciplinary team led to integration of OT into the whole health suicide prevention follow-up process and screenings on the inpatient mental health floor. Implementation of staff training helped to meet the site goals of increasing OT provider knowledge and access to mental health resources. This ultimately helped to meet the capstone purpose of improved patient care and access to mental health OT services. Results of the final staff survey showed 100% of staff agreed that mental health is an important factor to address during OT with the Veteran population. 85% of staff reported feeling confident and more likely to implement mental health approach in their future practice, meeting the capstone objective of increasing mental health OT services. 71% of OT staff reported feeling satisfied with the quality of mental health resources offered by the capstone student, with 100% of staff requesting continued training opportunities. Finally, 71% of OT staff reported continued interest in MERIT-OT training, showing a positive implementation climate to facilitate future research integration.

Sustainability

Sustainability was considered in three main areas through each phase of the planning and implementation of this capstone project to ensure that any impacts could be maintained after the

completion of the experience: programming, staff training/ support, and MERIT-OT.

1) Programming. With the addition of new suicide prevention follow-up OT services, the mental health team was updated on the purpose of OT services within this population which will aid in the creation of future OT referrals. The student created and shared a procedural guide with the OTs. This guide included training materials from start to finish on the implementation of OT services with this high-risk population and how OT fits into the overall whole-health programming plan. The student also created a tracking spreadsheet to collect data on service utilization and outcomes of therapy. These data will be reviewed after 60 days to decide if changes need to be made, or if the program can be made permanent.

Within the current practice model given the staffing restrictions, three primary OTs were identified to see future mental health OT consults until further staffing support could be identified. These individuals were 1) one acute care OT who could see consults on the inpatient psychiatry floor, 2) one outpatient OT who felt comfortable identifying mental health barriers and scheduling follow-up visits within her current setting, and 3) the OT team supervisor to provide top-down support and act as an administrative advocate within the VA.

2) Staff training and support. The student created and completed 4 staff trainings on OT's role in mental health which included scope, assessments, intervention planning, documentation, coding/billing, and MERIT-OT. The student built a Teams folder to house multiple resources for assessments and short intervention activities that the OTs can access quickly. The student also advocated the need for more OT staff positions with the service chiefs which could allow for a mental health OT to be hired full-time in the future.

To sustainably achieve the site goals of increasing OT’s role in mental health, it was recommended that a full-time mental health OT be hired into the Indianapolis VA system. This

role would serve as a launching pad for general mental health OT services within each practice setting. Job responsibilities for this position would focus on joining the mental health care team meetings, design and implementation of mental health OT programming, MERIT-OT research, and continued staff training for the OT team. Given the current factors of staff responsibilities, time barriers, limited mental health OT programming, and introductory confidence in mental health approaches, this full-time employee would fill a crucial role required to build a foundation for MERIT-OT pilot research. This role will also support increased mental health training within the OT primary service roles of acute care, outpatient, and inpatient rehab. To fund this new full-time position a "Full Time Equivalent Employee" (FTEE) request would need to be completed outlining the need, impact, and details of the position. If accepted, this role would become a temporary position until one year of productivity data can be gathered. After which, a decision will be made to make this a permanent full-time role.

3) MERIT-OT. The information gathered on barriers, facilitators, and appropriate populations for MERIT-OT implementation will be shared with research partners. Through the deeper understanding of integration gained during the experience, the student was able to create training materials and implementation guides that synthesize the knowledge of MERIT into an accessible and easy-to-implement OT intervention guide. These materials will be shared with IUPUI students, interested MERIT-OT practitioners, and through an AOTA poster presentation in 2024. The remaining barriers/ facilitators will inform a grant proposal for future pilot research within this VA site.

Limitations and Future Directions

Limited opportunities to participate in mental health OT were available to the capstone student during this experience due to staffing limitations, direct supervision requirements, and

pre-existing internal referral processes limiting OT contact with target populations. However, the student gained valuable insight into the referral and system processes that informed the future integration of MERIT-OT research at this site. Future research would benefit from understanding the unique qualities of mental health OT service provision within the target service areas and populations with serious mental illness within the IN VA. Additionally, future research should focus on the effectiveness of MERIT-OT interventions to promote motivation, occupational engagement, and quality of life.

Conclusion

The purpose of this capstone was to improve the quality of care offered at the IN VA by increasing OT's role in mental health services and understanding the barriers/facilitators/ and appropriate populations to integrate MERIT-OT research into this site in the future. The student was able to meet all site goals and objectives while supporting professional development and advanced knowledge in the focus areas of clinical skills and research. Outcomes of this capstone project included sustainable addition of staff training, mental health program integration, advocacy for the role of OT within the multidisciplinary team, and next steps for MERIT-OT research. With the VA's new whole health approach, OTs can and should be functioning throughout their full scope of practice to improve the quality of care and decrease healthcare costs. Integration of MERIT-OT within OT's newly established and growing roles in mental health services at the IN VA healthcare system will improve the quality of care, meet the growing need for mental health professionals, and support rigor and fidelity within the field of mental health OT.

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Appendix A

Site Interview Questions

Staff information:

1. How many OTs are on staff?
2. How much do OTs currently work with the mental health department?
3. How much training/ confidence do current OTs have with mental health interventions?
4. What programming ideas do OTs currently know of/ use?
5. What do the current OT roles/ days at the VA look like?
6. What is the client admission "life cycle" from admittance, evaluation, intervention to discharge and beyond?
7. Who makes up the care team?
8. How do you view the current effectiveness of treatment in long-term readmission prevention?
9. What are staff members the most excited about with this collaboration?
10. What do you see as the long-term outcome- best possible scenario, of this collaboration?

Site information:

11. What are some of the common diagnoses currently seen in mental health at the VA?
12. What are the VA's biggest priorities in relation to mental health services?
13. Are there any funding or other limitations preventing OTs from working on the mental health wing?

Clientele information:

14. What are some of the client's biggest concerns related to recovery?
15. How do clients feel about current treatment options or effectiveness?
16. What are some of the common barriers seen by these clients that are unique to the VA

population?

17. What needs are seen when client re-enter the community?

18. What local community resources are available to support Veterans upon discharge?

19. Community team

Appendix B

Student Learning Plan Goals and Objectives

Project Goal 1: The student will gain and utilize knowledge about Metacognitive Reflection and Insight Therapy for Occupational Therapy (MERIT-OT) development, analysis, and implementation to assist in clinical skills building and appropriate data gathering for future research and program design.	
Objective 1:	The student will identify and utilize learning and training opportunities directly connected to MERIT-OT through online or hands-on observation to improve clinical skills.
Objective 2:	The student will learn how to administer, record, analyze, and translate the IPII assessment into MAS-A metacognition scores to improve validity of data gathered.
Objective 3:	The student will create an implementation plan for providing MERIT-OT services including assessments, interventions, and documentation to aid in hands-on implementation experience.
Project Goal 2: The student will identify which patient population within the VA would be most appropriate for a future research pilot study with MERIT-OT.	
Objective 1:	The student will observe practitioners within 4 practice areas within the VA to gain an understanding of current practice processes within each department and how factors of MERIT-OT could be implemented in each- including acute care, geriatrics, inpatient psychiatry, and the domiciliary.
Objective 2:	The student will implement and journal feasibility results of providing MERIT-OT services (with supervision) within appropriate patient populations to identify challenges that OTs may have when implementing MERIT-OT in the future and to prepare for how to teach this tool to other practitioners
Objective 3:	The student will identify *patient population-specific* barriers and facilitators to analyze and correlate trends related to stigma and comfort in seeking various mental health services.
Project Goal 3: The student will increase VA OT practitioner confidence in addressing mental health concerns within each practice population to improve patient health outcomes, through observation, providing information, and offering practice opportunities.	
Objective 1:	After observation, the student will engage OT practitioners in an open-ended discussion in order to gain an understanding of existing thoughts on OT's role in providing mental health services and possible barriers or concerns.
Objective 2:	The student will create a simple lunch and learn to discuss OT's role in providing general mental health services within each department to create an

	open conversation, share ideas, and collaborate on what practitioners would most like to learn to be successful.
Objective 3:	The student will create and implement a lunch-and-learn introductory training for MERIT-OT to give practitioners a manualized tool to begin implementing mental health services as needed within their settings.
Objective 4:	The student will create, administer, and analyze a post-survey after the training program to measure opinions on whether they believe MERIT-OT is a feasible addition to their practice.
Objective 5:	The student will continue to follow up with practitioners to provide support and answer questions.

Appendix C

Student-Created MERIT-OT Intervention Guides

MERIT-OT Quick Start Guide

Guiding Theory & Model: Theory of Metacognition and the Model of human occupation (MOHO)
Materials needed: An assessment that elicits live narrative (IPII-C, OPH-II, Narrative slope, MOHOST, or OCAIRS), MAS-A rating scale, MERIT-OT intervention framework, Intervention plan template, The 8 elements blank session note guide, The 8 elements of MERIT-OT self-assessment (MERIT-TAS).
Prior to implementation, OT should have a basic knowledge of: the role metacognition plays in volition and occupational participation, how to rate metacognition using a narrative assessment along with the MAS-A scale, understanding of the 8 elements of MERIT-OT that should be present in each session.
Helpful learning resources:

- MAS-A guidebook
- Recovery, Meaning-Making, and Severe Mental Illness: A Comprehensive Guide to Metacognitive Reflection and Insight Therapy 1st Edition by Paul H. Lysaker (Author), Reid E. Klion (Author)
- CJOT Article: Wasmuth S, Horsford C, Mahaffey L, Lysaker PH. "Metacognitive Reflection and Insight Therapy" (MERIT) for the Occupational Therapy Practitioner. Canadian Journal of Occupational Therapy. 2022;0(0). doi:10.1177/00084174221142172
- AOTA Mental health specialty conference presentation
- MERIT-OT Training presentations
- MERIT-OT Case Studies
- MERIT-OT Research team

Referral Received

1. **Step one- Introducing OT and Mental health to the client.**
   - Contact the client.
   - Explain the role of OT in mental health and ask for interest in participation.
     - OT works to help you get back to doing what's important to you by helping you to overcome barriers in all areas of your life, whether it's physical, social, emotional, or mental health…….. So that may look like activities and discussions related to you and your life, and reflection on how some things have gone poorly, and others have gone well……. We want to help you become fully in charge of your own health and wellbeing. Is this something that you'd be interested in?"
   - Scheduling
     - Similar to joining a weekly CBT therapy, there is an expectation of weekly re-occurring sessions.
     - Plan for initial evaluation to take 45 minutes with 15 minutes to review assessment rating and results until skilled in live rating.

- Impacts can be measured as early as 6 sessions with more complex cases requiring up to 26 sessions for clinical research purposes.
- Note: some clients may show temporary regression in metacognitive levels when new achievements have been made. This can be due to new feelings of shame or hurt which can accompany higher levels of metacognitive understanding of the self and others. With this regression may come times when the client requires a break from sessions but does not fall under discharge. If clients have not been seen for extended periods, the therapist should try to reengage the client and reassess whether OT services are still appropriate.

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2. **Step two- Evaluation and 8 elements of MERIT**
   - Reiterate purpose of OT in mental health and the purpose of evaluation.
     - Mental Health Example Script- OT Blurb
       - "As I described when we last spoke, OT works to help you get back to doing what's important to you by helping you overcome barriers in all areas of your life, whether its physical, social, emotional, or mental health……. The question I've chosen today will help me to get to know you better and allow us to reflect on what's been going well in your life, as well as areas you'd like to see some improvement in…… We'll be using an approach called MERIT-OT which looks at developing your sense of self and how to have a better life. Does that sound ok?
       - For research: Ask patient for consent and signature for use of de-identified results.

       Follow-up information
       - Risks include the possibility that greater awareness of self and others may bring emotional pain.
       - Purpose and effect should be tailored to a client's individual concerns. i.e. treatment may help patients to improve in areas of occupational engagement.

   - Complete a narrative assessment.
     - (OPHI-II, IPII, OCAIRs, MOHOST)
   - Work with the client to identify an appropriate intervention plan and goals.
   - End session with plan to begin therapy upon next meeting.

   - **After the session-** complete MAS-A rating of narrative assessment inform intervention planning
   - **Document** the need for services related to occupational deficits and appropriateness for MERIT-OT based on MAS-A scores and impact on occupational engagement.
     - Ensure goals include improvement of metacognitive mastery factors in relation to occupational performance.
     - **Note:** Small notes can be made during the session using the MERIT-OT 8 elements note guide, but electronic documentation should be avoided to limit

client distractions, remove non-verbal communication barriers, allow the therapist to respond to small changes in client presentation, and to remain present in the therapeutic relationship.

- **Billing and Coding-** High, Medium, Low Complexity Evaluation
  - Deficits in metacognition are another factor in terms of evaluation complexity.

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3. **Step three- Intervention planning**
   - Create intervention plan to address occupational deficits and MAS-A levels using intervention plan template and MERIT-OT intervention framework. (Element 7and 8).

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4. **Step four- Implementation**

Integrate 8 elements of MERIT throughout the session (not a stepwise process)

Example session flow:

	Step	**Note**	**Element**
1.	Elicit the client's agenda by asking how the client is doing that day and what they are hoping to achieve from the session. Throughout session: Monitor for changes in agenda	The client's agenda may be more nuanced than what they are reporting. The therapist should be aware of shifts in the client's agenda and able to respond or adjust the focus of therapy session as needed. The therapist's agenda of completing an occupational intervention should not overshadow changes in the client's agenda.	Element 1: Agenda
2.	Follow intervention plan to address occupational deficits. Explain activity.	The intervention plan should be at the appropriate metacognitive level of the client.	Element 7 and 8: Stimulating Self-Reflection and Mastery
3.	Use chosen intervention activity to facilitate self-reflection and narrative stories.	The therapist should ask for specific examples of situations in the client's life while completing occupational intervention activity and provide feedback on observed thought processes, noting the client's responses to the therapist's thoughts.	Element 2 and 3: Narrative episode and Insertion of therapist's mind
4.	During intervention: In reflectively thinking through problems, the therapist and client attempt to mutually identify the psychological barriers to occupational engagement.		Element 4: Define the psychological problem.
5.	During intervention: Stimulate metacognitive mastery through therapeutic use of self by reflectively thinking with client	Stimulate metacognitive mastery is a dynamic skill, "live rating" should be taking place throughout each session to understand/ track changes in	Element 7 and 8: Stimulating Self-Reflection and

	about their problems, at their current metacognitive capacity level.	metacognitive mastery while completing occupational tasks and narrative reflection.	awareness of others & Mastery
6.	Reflect with the client on their thoughts on how therapy is progressing and their thoughts on the therapeutic relationship.	Can be a simple discussion or more in-depth progress assessment with discussion of results and remaining areas of need.	Element 5 and 6: Reflection on the therapeutic relationship and Reflection on progress.
8.	End session with plan for next session.		

After the session:

- **Adjust intervention plan related to new understanding of patient progress.**
- **Documentation-** highlight the impact of metacognitive deficits on occupational participation, make note of any improvements in metacognitive capacity, motivation, or performance patterns. Make note of changes in patient's agenda and ability to identify psychological problem.
- **Billing and Coding-** depends on area of occupational intervention focus,
  - **97537 Work/ Community re-integration**
  - **97535 Self-care**
  - **97533- Sensory integrative techniques**
  - **97530- Therapeutic activities**
  - **"Cog codes" 97129-** (initial) **+97130** Each additional 15 minutes (List separately in addition to code for primary procedure.)
  - **97150- Groups**
- **Reflect** on therapist's ability to meet all 8 elements of MERIT using MERIT-TAS

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2. **Step five- Progress notes**

- As live rating has been completed throughout sessions, general progress can be reported based on current metacognitive performance and the impact on occupational performance patterns.
- Create discharge plan with client to ensure feelings of readiness to end services.
- When goals have been met, assess for discharge readiness through Re-administration of initial assessment with MAS-A rating.

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3. **Step six- Discharge**

- Clients may be ready for discharge once metacognitive components are no longer impacting occupational participation and all goals have been satisfactorily met.
- Document overall impact of MERIT-OT on metacognitive factors and occupational participation. Outcome data will be needed for research purposes.

MERIT-OT Intervention Plan Template

Name: **Pronouns:** **Evaluation date:** **Session Time:** **Setting:**
Diagnoses: **Reason for referral/visit:** **Long-term occupational aim:**
Assessment used: IPII-C, OPHII, OCAIRS, or MOHOST **Results:** **MAS-A Scores:** Self-reflectivity (S): ___/9, Understanding of other's mind (O): ___ /7, Decentration (D):___ /3, Mastery (M):___ /9
Baseline (problem statements; also include strengths/weaknesses and assessment plan to better understand what remains unknown): Also document how metacognition and mental health barriers are affecting occupational performance and participation. *1)Problem statement*: *2)Positive/Negative Attributes*: *3)Possible Additional assessments*:
Model: MOHO **Frame of reference: Cognitive Behavioral** **Framework: MERIT-OT**
Interventions to address occupational deficit: **Interventions to stimulate self-reflection and awareness of others:** **Interventions to stimulate Metacognitive Mastery:**
SOAP Note Documentation: **S-** **O-** **A-** **P-**

Long-Term Goal 1: COAST GOAL			
Short-term Goal #	**Date Set**	**Objective**	**Actual outcome:** Met/ Partially Met/ Unmet
Goal #1		**COAST GOAL**	**TBD**
	Intervention 1	OT intervention: Overlapping MERIT-OT intervention area and level:	
	Intervention 2	OT intervention: Overlapping MERIT-OT intervention area and level:	
Goal #2		**COAST GOAL**	**TBD**
	Intervention 1	OT intervention: Overlapping MERIT-OT intervention area and level:	
	Intervention 2	OT intervention: Overlapping MERIT-OT intervention area and level:	

Long-Term Goal 2: COAST GOAL			
Short-term Goal	**Date Set**	**Objective**	**Actual outcome:** Met/ Partially Met/ Unmet
Goal #1		**COAST GOAL**	**TBD**
	Intervention 1	OT intervention: Overlapping MERIT-OT intervention area and level:	
	Intervention 2	OT intervention: Overlapping MERIT-OT intervention area and level:	
Goal #2		**COAST GOAL**	**TBD**
	Intervention 1	OT intervention: Overlapping MERIT-OT intervention area and level:	
	Intervention 2	OT intervention: Overlapping MERIT-OT intervention area and level:	
Overall therapy outcome: Numbers of Goals and objectives met and how they were measured**. TBD (**Improved MAS-A scores and improved occupational engagement?) **Potential factors contributing to poor outcomes: TBD** (low show/ adherence rate, over-ambitious goals, inappropriate aims?) **Expected Discharge date:** POC can be made for 6 months to 1 year and adjusted as appropriate.			

MERIT-OT 8- Elements Session Notes Guide

Element	Notes:
Element 1: Eliciting the Client's Agenda	Agenda: Underlying Agenda: Changes in Agenda:
Element 2: Insertion of the Therapist's mind	Client Responses:
Element 3: Eliciting a Narrative Episode	Was it possible? At what level? Themes?
Element 4: Defining the Psychological Problem	Was it possible? Problem: Impact on Occupational engagement:
Element 5: Reflecting on the Therapeutic relationship	Client thoughts:
Element 6: Reflecting on progress	Client thoughts:
Element 7: Stimulating self-reflection and awareness of others	Baseline MAS-A scores: Self-reflectivity (S): ___/9,Understanding of other's mind (O):___/7, Decentration (D):___/3 Intervention: Level: _____ Impact: MAS-A levels achieved during session:
Element 8: Stimulating Mastery	Baseline MAS-A score- Mastery (M): ___ /9 Intervention: Level: _____ Impact: MAS-A levels achieved during session:
Barriers to implementation	

Appendix D

Occupational Therapy Staff Final Survey Questions

Rate your level of agreement to each of the following 5 statements with 1 being "I strongly disagree" and 5 being "I strongly agree".					
	Strongly disagree	**Somewhat Disagree**	**Neutral**	**Somewhat Agree**	**Strongly Agree**
I am satisfied with the quality of the mental health assessments and intervention resources offered by the capstone student.	1	2	3	4	5
I am confident in implementing occupational therapy mental health approaches after discussion and reviewing resources offered.	1	2	3	4	5
I am likely to begin implementing more occupational therapy mental health approaches in current practice after these learning opportunities.	1	2	3	4	5
I feel the need for more resources and training with mental health occupational therapy approaches.	1	2	3	4	5
Mental health is an important client factor to address in occupational therapy with the Veteran population in your setting.	1	2	3	4	5
The following questions are free response.					
What barriers do you see to the implementation of mental health resources in your daily practice?					
What barriers do you see to the implementation of MERIT-OT in your daily practice?					
Do you have any other comments?					
I am interested in learning more about MERIT-OT implementation research.	Yes	No	If Yes, please enter- Name: Email address:		

Appendix E

Student Therapist MERIT-OT Journal

Student therapist journal of MERIT-OT integration during Domiciliary groups									
DOM Group	Attendance: 6	4	5	3	6	3	3	5	7
Week	1	2	3	4	5	6	7	8	9
Group Focus	Intro to Do-Live-Well framework. Initial assessment	Activating your body, mind, and senses	Connecting with others	Contributing to community and society	Taking care of yourself	Building security and prosperity	Developing and expressing identity	Developing capabilities and potential	Experiencing pleasure and joy Final assessment
OT activity	Client education and group reflection discussion Reflection Guide Activity Patterns Assessment Group reflective discussion Weekly routine tracker	CDC Physical activity guidelines, goal setting, self-assessment of Physical activity routines Weekly exercise tracker	Social supports identification worksheet, relationship green flags, Journaling meaningful connections	Client education Identifying meaningful way to engage in the community as well as benefits to doing so. "advocacy pitch" Acts of kindness bingo	Client education on the types and importance/ timing of Self-care routines, self-care check-up 3-month vision board Sleep hygiene	Client education on Maslow's Identifying supports and threats to security and prosperity Habit tracker	Client education, Values identification, Personal Coat of arm, Elevator pitch	Self-efficacy video, strengths list, strengths use plan, Self-esteem journal And worksheet	Activity Patterns Assessment Do live-well experiencing pleasure and joy worksheet. Musical Art activity Group wrap-up and reflection on progress/ participation
Specific skill targeted	Understanding activity patterns when well vs unwell	Learning new activities and how they can support your mental health, pattern recognition	Building social skills to support social participation and mental health	Building a sense of purpose and motivation to participate in life	Understanding self-care habits/routines that support mental health	Building ability to identify safety threats and supports in various life areas	social skills Understanding self and others	Building habits and routines	Engaging in healthy occupations, self-reflection
Occupational Aim	Promoting healthy occupational engagement	Promoting healthy occupational engagement and mental health/ chronic disease prevention	Promoting social participation/ preventing isolation	Identifying areas of passion/ giving back to support occupational engagement	Building self-care routines Stress and burnout prevention	Safety/ community re-integration Identifying safe vs unsafe habits in each area of life	Building self-esteem	Supporting mental health and confidence through learning how to integrate new habits that create balanced occupational engagement	Supporting stress reduction and positive mood through participation and understanding of joyful occupations
Student therapist Learning event/ Opportunity	1 Group member voiced rigid thoughts on experiences with daily patterns and challenged the effectiveness of the learning activity and thoughts shared by others	1 Group member directly answered each of the Student therapist's statements leaving little room for other group members to participate in	1 Group Member became agitated due to event that happened outside of session and began commandeering the group session to vent **Solution:**	1 Group member shared occurrence of encountering hazardous materials in the community when cleaning up garbage. **Solution:** Insertion of the therapist's mind and	1 Group member began sharing personal details of traumatic experiences which could have triggered other participants (against group rule),	1 Group member was dominating conversation and was agitated over topic covered, preventing group from moving forward with activity	1 Group member was dominating conversation and disliked the idea of some topics covered **Solution:** Insertion of therapist mind,	1 group member was routinely very verbose and tangential whenever he shared with the group **Solution:** The Student therapist was able to translate	Group flowed well with good participation from all members

	Solution: Insertion of the therapist's mind- The Student therapist reflected the member's thoughts back to the group at a lower complexity and asked for group feedback. This helped the original member to gain a deeper understanding of topic application	the discussion. **Solution:** Stimulating awareness of self and others through insertion of the therapist's mind. Student Therapist reflected back to the group member that he seemed really excited about the topic, and wondered out loud if any of the other group members felt the same way	Attempted stimulation of mastery ineffective, Redirection required. Followed up with care team	group reflective thinking Additional Follow-up with staff on proper procedures, discussed during next group	**Solution:** Insertion of therapist mind, Stimulating awareness of self-and others: member was stopped before sharing more and rules were re-enforced weekly	**Solution:** Stimulating mastery, Ideas may have needed to be offered at a lower level for the group	Stimulating awareness of self-and others	correctly translate abstract themes to share with the group, and redirect the flow of lengthy abstract explanation to more concrete thoughts.	
Element 1 Agenda	Student Therapist asked group members what their goals were for joining the group. Individual client Agenda noted to be to convince Student therapist that they are at a higher level than likely based on life circumstances	Individual client Agenda noted to win Student therapist over through excitedly answering each question	Individual client Agenda noted to "bring Student therapist to their team" over something they were upset about	Individual client Agenda noted to win Student therapist over through excitedly over-sharing	Individual client Agenda noted to convince Student therapist that they are un-helpable/ to avoid responsibility	Individual client Agenda noted to be to convince Student therapist that they are at higher level than likely based on life circumstances and make the Student therapist understand their life experiences to "give them a pass" on why their life hadn't gone well	Individual client Agenda noted to be to convince Student therapist that they are at higher level than likely based on life circumstances Individual client Agenda noted to want to learn from Student therapist and other group member's experiences	Group members seemed eager to help their fellow participants and underlying agendas were difficult to elicit. One group member appeared to remain distant and frequently overt eyes from student therapist as to not be called on for discussion	Group members wanted to play along and utilize the opportunity to engage in a "goofy" and light hearted group.
Element 2 Insertion of the Therapists mind	Facilitation and group education on topic	Reflection of ideas	Challenging of ideas	Reflection of ideas, group solution facilitation	Facilitation - guiding group think higher MC level	Reflection of ideas and translation of conversation into various MC levels	Challenging of ideas Engaging group members in pointed discussion of personal self-understanding	The student therapist made collective over-arching statements based on group discussion to ask if she was on the right track with her understanding.	Reflection and connection of ideas and general themes discussed by individual group members.
Element 3 Eliciting a narrative episode	Can you share an example?	Can you give us an example of that?	Does this information relate to any of you?	Specific narrative shared by all group members	Can you walk us through what that looks like?	A group member shared a personal life	Can you share what you did this week and how you're	The student therapist asked each group member	The student therapist was able to ask for personal

			Specific narrative shared			event without prompting.	planning to adjust for next week	multiple times throughout the session to share an experience related to the part of topic discussion	situation examples to contextualize the information shared by each group member. They noted greater ease at which members were able to report narrative episodes when compared to prior weeks.
Element 4 Defining the Psychological Problem	The group defined common psychological problems as being unable to recognize when they are well vs unwell	The group defined the common psychological problem as turning to unhealthy coping strategies when in a state of mental unwellness	Group attempted to define the psychological problem as being scared/ not knowing how to connect with others	The group defined the psychological problem as wanting to complete community activities as a group but being frustrated at the inability to convince others participate, leaving them to feel defeated. This discussion lead to identifying unhealthy choices made in situations where they're unsure of what to do	The group defined the common psychological problem as increased stress and burnout which can lead to a decrease in self-care activities (but can also be treated with self-care)	The group defined the common psychological problem as an inability to address higher levels of self-actualization when physiological and safety needs are not met. They decided that identifying safety threats and supports was the same as learning how to "be prepared"	The group defined the psychological problem as being unable to identify what they value or how they would describe themselves to another person	The group defined the psychological problem as being felling unconfident to complete challenging tasks which leads to an over-all feeling of low motivation to participate, but not knowing where to start	The group defined the psychological problem as letting low mood drive them into deeper states of depression and self-isolation due to an inability to self-reflect on that process and see joyous or "the positive side of things".
Element 5 Reflection on the therapeutic relationship	X	x	Student Therapist asked if group members were liking the topics covered and the general structure of group	x	Group member shared that they enjoyed coming to group and were glad to have Student therapist there	Group member provided reflection without prompting on enjoying Student therapist presence in group reflections/ facilitation	X	Student Therapist asked for feedback on what participants felt was effective within the therapeutic style	Student Therapist asked for direct feedback on clinical skills and areas for improvement
Element 6 Reflection on progress	Student Therapist asked how group members felt about topic covered during session and hopes for	Student Therapist asked for reflections/ thoughts on group focus	Student therapist asked for reflections on how group members have begun implementing new skills in daily life	Student Therapist asked for direct feedback on individual member's progress	Student Therapist asked for group reflection on topics learned over the course of group attendance	Student Therapist asked how group enjoyed topic covered during session	Student Therapist asked group if they feel they've seen any improvement in thinking/ emotional support/ life	The student therapist asked how they liked the topic of this group	Student Therapist asked for direct feedback the groups experiences with participation and make

	future sessions						habits since starting group		take-aways/ progress from attendance.
Element 7 Stimulating self-reflection and awareness of others	Group activity included individual self- reflection with both concrete and abstract examples and group sharing	Activity included self-reflection and group discussion	Group activity and discussion allowed for members to hear various ideas/ activity patterns that differ from their own, with reflection on how those differences may impact thoughts, emotions, and actions	Student Therapist asked group members to reflect on whether actions taken in the past were right or whether a better action could have been taken	Activity and discussion prompted self-reflection on how self-care impact's mental health, and awareness of others through asking how we can recognize when others might not be doing well. Awareness of others (through reminding them not to share triggering information)	Activity prompted self-reflection and student therapist worked through "insertion of therapist's mind" to help dominating group member reflect on how their thoughts and conclusions on the topic may be different from other groups members, which was supported by group reflection	Student Therapist reflected group members ideas about incorrect assumption they had made about understanding another person's identity based on limited sharing of details which lead to a breakthrough discussion moment for the group	Student Therapist asked group members to reflect on how they think other people may show signs of low-self efficacy similarly or differently than themselves	The student therapist prompted many opportunities for self-reflection directly after each phase of the group intervention activity. They also guided discussion to connect an understanding of self to awareness of others having similar experiences.
Element 8 Stimulating Mastery	Student Therapist reflected on group member interactions to meet the MC levels of the various members by translating abstract concepts into concrete thoughts	The student Therapist asked why the topics covered were important and how they could be integrated into their daily routines and what the long-term outcomes could be/ how they'll adjust as their situation changes	The student Therapist asked when/ how/ why and who group members might rely on in the future to support their mental and emotional health	The student Therapist asked group members to apply new information and discuss how implementation will impact/change outcomes in the future	The student Therapist asked how the group members will begin to implement new self-care strategies, and how that will support their mental health and occupational engagement	The student therapist could have offered lower-level interventions with more structure	In guiding deeper discussion/ expanding on one group member's opportunity for growth, another group member gained useful information that they could begin implementing	Student Therapist offered activities that scaffolded the group members understanding of the topic leading them from learning new information to integrating it into their lives	The student therapist guided the group to connect learnings from class to integration into daily life.