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Prevocational and vocational rehabilitation in community psychiatric occupational therapy

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psychiatric occupational therapy**

Epstein, Beth S., M.S.

San Jose State University, 1990

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PREVOCATIONAL AND VOCATIONAL REHABILITATION
IN COMMUNITY PSYCHIATRIC OCCUPATIONAL THERAPY

A Thesis
Presented to
The Faculty of the
Department of Occupational Therapy
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

by
Beth Epstein
December, 1989

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ABSTRACT

This study identified and described most beneficial and least beneficial occupational therapy prevocational and vocational community psychosocial rehabilitation programs in the Commonwealth of Massachusetts. It identified the most and least beneficial activities for promoting gainful employment and described the incidence of interactive treatment/leadership styles and theoretical models/frames of reference used by occupational therapists in community mental health.

Day treatment programs situated within psychiatric hospitals and in sheltered workshops were viewed as being most beneficial sites for community psychosocial prevocational/vocational rehabilitation. The clubhouse was found to be the least beneficial program.

Activities identified as being most beneficial in promoting gainful employment of discharged clients were food service, clerical, cashiering, janitorial service, crafts, and discussion groups. Intrapersonal components of the most beneficial activities were identification of skills, intrinsic motivation, and coping skills. Most beneficial interpersonal components were small group interaction and membership; work-related components were attendance, punctuality, and acceptance of supervision.

Least beneficial rehabilitative activities were

recreational games and sports. Least beneficial intrapersonal component was motivation to earn tokens, privileges, and money. Least beneficial interpersonal components were peer tutoring and large group interaction; work-related components were quality work, work endurance, identification of skills, writing resumes, and money management.

Most respondents reported using an informal, non-intimate, interactive treatment style and preferred treatment groups organized and led by the therapist. The most common theoretical models/frames of reference used were occupational behavior, human occupation, and developmental. Fewer therapists utilized occupational performance and psychodynamic frames of reference.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was to explore factors relevant to the practice of occupational therapy in prevocational and vocational rehabilitation in community mental health programs in the Commonwealth of Massachusetts.

Statement of the Problem

A review of the literature in community mental health, prevocational and vocational rehabilitation, and occupational therapy revealed a lack of information on program effectiveness in prevocational and vocational rehabilitation as they relate to the promotion of gainful employment of former clients. Information concerning prevocational and vocational rehabilitation in community mental health centers within the Commonwealth of Massachusetts was also lacking.

The majority of psychosocial rehabilitation studies reported outcomes of psychiatric hospital-based programs. Outcome studies, rather than focusing on treatment methodology and theoretical frames of reference, emphasized the relationship of clinical diagnosis, severity of illness, IQ, employment history,

work-adjustment skills, and hospitalization history (Anthony, Howell, & Danley, 1983; Llorens, Levy, & Rubin, 1964; Maurer, 1971; Morgan & Cheadle, 1975). Although the above predictors provided an indication for treatment direction, they did not provide information on the methods of intervention related to therapeutic treatment and leadership styles for specific rehabilitative activities.

Questions

The questions asked in this study were:

1. What are the types of facilities/programs in which community psychiatric occupational therapists provide services?
2. What are the types of facilities/programs in which community psychiatric occupational therapists provide services that are considered to be the most and least beneficial in promoting gainful employment among discharged clients?
3. What are the types of rehabilitative activities used by community psychiatric occupational therapists in prevocational and/or vocational rehabilitation?
4. Which rehabilitative activities do community psychiatric occupational therapists consider to be the most and least beneficial in promoting gainful employment of discharged clients?
5. Which intrapersonal components are considered to be related to the most beneficial rehabilitative activity?

6. Which interpersonal components are considered to be related to the most beneficial rehabilitative activity?
7. Which work-related components are considered to be related to the most beneficial rehabilitative activity?
8. Which intrapersonal components are related to the least beneficial rehabilitative activity?
9. Which interpersonal components are related to the least beneficial rehabilitative activity?
10. Which work-related components are related to the least beneficial rehabilitative activity?
11. What are the interactive treatment styles utilized by community psychiatric occupational therapists?
12. What are the leadership styles utilized by community psychiatric occupational therapists?
13. What are the theoretical models and/or frames of reference utilized by community psychiatric occupational therapists?

Definitions

Definitions of terms used in this study are:

1. Community psychiatric occupational therapists: those occupational therapists who are currently, or have been, employed in community mental health settings.
2. Gainful employment: both full- and part-time paid work positions.
3. Interactive treatment styles: modes of professional conduct which include formal, informal/non-intimate,

informal/intimate levels of rapport with clients.

4. Leadership styles: organizational service delivery models of work/therapy groups, including those organized and led by the therapist, organized by the therapist but led primarily by the clients, and/or those organized and led by the clients.

5. Least beneficial: interventions which are regarded as least helpful in promoting future part and/or full time paid employment positions for former psychiatric clients.

6. Massachusetts community psychosocial prevocational and/or vocational rehabilitation centers: community psychiatric rehabilitation centers in the Commonwealth of Massachusetts that focus upon providing work adjustment skills such as punctuality, attendance, grooming, hygiene, task completion, quality control, and socialization.

7. Most beneficial: interventions which are regarded as most helpful in promoting future part- and/or full-time paid employment positions for former psychiatric clients.

8. Prescribe: to identify and direct the use of treatment techniques.

9. Prevocational rehabilitation: treatment programs focusing on prerequisite work skills in the areas of work adjustment training and personal adjustment training.

10. Rehabilitative activities: purposeful tasks

incorporated by occupational therapists into treatment techniques. Rehabilitative activities are used by occupational therapists to develop, improve, and/or restore the performance of necessary functions.

11. Theoretical models and/or frames of reference: guiding philosophies used in occupational therapy and in general mental health rehabilitation, including those identified as clubhouse, humanistic, behavioral, developmental, psychodynamic, occupational performance, occupational behavior, human occupation, biopsychosocial, and adaptive response.

12. Vocational rehabilitation: treatment programs which place and supervise clients on the job site as a means of remediating deficits in the area of work.

Significance

The significance of this study is that it provides information concerning community-based mental health facilities and occupational therapy programs which focus upon prevocational and vocational training that has not been previously available. Methods of service delivery which include types of rehabilitative programs and activities, interactive treatment styles, and leadership styles are described. Rehabilitative activities have been explored in terms of their perceived value for promoting future gainful employment of discharged occupational therapy clients. This study also identified those

theoretical models and/or frames of reference utilized by psychiatric occupational therapists in community mental health centers.

Limitations

As the survey was sent to a small population of community psychiatric occupational therapists within the Commonwealth of Massachusetts, the information generated may only partially represent facilities, programs, rehabilitative activities, leadership styles, interactive treatment styles, and theoretical models and frames of reference common to other community psychiatric occupational therapy programs in the United States. The questionnaire was designed to obtain perceptions from occupational therapists and did not request facts to support these statements. It is therefore possible that the answers obtained may not accurately reflect all aspects of the occupational therapy programs surveyed.

Assumption

It is assumed that subjects answered the questionnaires honestly.

CHAPTER 2

LITERATURE REVIEW

A review of the literature in the areas of community mental health, prevocational and vocational rehabilitation, and occupational therapy revealed a lack of literature which addressed the interrelationship of these three areas. The literature reviewed was organized according to the following sub-headings:

1. Occupational Therapy in Prevocational and Vocational Rehabilitation.
2. Theoretical Models/Frames of Reference in Prevocational and Vocational Rehabilitation.
3. Occupational Therapy Psychosocial Prevocational and Vocational Programs.
4. Interactive Treatment and Leadership Styles in Occupational Therapy Prevocational and Vocational Rehabilitation.

Occupational Therapy in Prevocational and Vocational Rehabilitation

The conceptualization of occupation or work as a therapeutic modality originated during the late 18th century when the quality of patient care in mental asylums received criticism for being inhumane. Moral treatment arose in an effort to provide mentally ill patients with

productive activities. Productivity was defined broadly as being self-productive, fulfilling the basic human needs for self-actualization. In this context, the therapeutic value of work was not related to paid employment, but to an intrinsic sense of productivity gained from participation in both leisure and self-care activities.

These activities included domestic work, agricultural, recreational, and craft activities, and appeared to be among the earliest recorded forms of work as a means of rehabilitation in the health-care field (Harvey-Krefting, 1985; Hopkins, 1983; Tiffany, 1983).

The primary purpose of prescribing work as a therapeutic activity was to provide the mentally and physically disabled (blind) with a sense of dignity. It reinforced the work ethic of society and thus provided the patient with a link to the community at large.

This philosophy underwent revisions when the new focus centered not on general treatment principles, but on individualism and personal accountability of therapists for their prescriptions (Harvey-Krefting, 1985; Kester, 1983). Mental illness was now attributed to brain pathology and no longer viewed as being the result of emotional or moral dilemmas which could be treated with simple diversional work activities. Therapeutic work activities declined during this period, re-emerging in the early 1900s with its new focus upon the physically

disabled.

A major influence upon the re-emergence and development of occupational therapy was the onset of World War I. Occupational therapists emerged in the form of Reconstruction Workers, providing craft activities to wounded soldiers. During this period, the primary emphasis was on the treatment of the physically disabled since they were viewed as being far more curable than the mentally ill (Harvey-Krefting, 1985; Hopkins, 1983; Kester, 1983).

During the 1920s, therapeutic work activities became incorporated as part of curative therapy. These programs consisted of self-care, exercises, sheltered workshop tasks, and vocational training (Marshall, 1985). The 1930s brought with it industrial therapy and employment therapy. Occupational therapists utilized patient evaluations, work evaluations, job analysis, interviews, and grading of tasks at a hierarchical level. Work was assigned to patients based on individual interest, aptitude, and experience. The mentally ill were assigned jobs within state hospitals.

During this time frame, the concept of prevocational activities emerged in the literature and referred to those craft activities which facilitated skill development transferable to industry. Occupational therapists became involved in directing prevocational programs, performing

work evaluations and in providing prevocational therapy. The Social Security Act of 1935 resulted in the integration of services among vocational rehabilitation agencies, especially among those offering work evaluations and industrial workshops. This served to promote vocational rehabilitation in the community, particularly for the physically disabled.

During the 1940s, prevocational rehabilitation and work evaluations were major components of the occupational therapy profession, providing individuals with a means of livelihood, social status, satisfaction within the family unit, and a structure for habit formation.

The 1950s saw the decline of the profession's role in work evaluation and the increase of structured prevocational programs geared towards injured workers (Harvey-Krefting, 1985; Tiffany, 1983). The aim of these prevocational programs was to develop work habits, work tolerance, and degrees of efficiency necessary for patient entry into vocational training programs. Work evaluations, work samples, cognitive skills, and industrial therapy reflected the application of specific job skills needed for re-entry into industry.

Emphasis was placed upon treating those assessed as having the highest probability of returning to employment. Hospital jobs were graded for endurance so that patients were eventually enabled to hold jobs in the

community. Crafts, as a therapeutic modality were criticized both from within the occupational therapy profession and outside of the profession by the medical community for their failure to provide patients with a realistic arena of challenges inherent in paid community employment positions.

During the 1960s, the meaning of work was explored in its relationship to the values of the work ethic, to the new federal labor laws, and to the connection between work and leisure (Lamb & Edelson, 1976). Reilly and Clark in the 1970s further expanded the concepts of work and play behavior. The human occupation and occupational behavior frames of reference became strong, emerging themes for guiding therapy (Harvey-Krefting, 1985).

Occupational therapists in the early 1980s utilized work samples, skill checklists, and promoted work speed, attention to tasks, and successful employment (Creighton, 1985). Individual traits could thus be isolated and measured in accordance with scientific procedures. Learning theories also provided the basis for popular techniques used in evaluation and treatment.

Another shift in the 1980s was the profession's movement away from specialization towards generalization. This related to prevocational and vocational rehabilitation, in that work had been defined as all forms of productive activity, regardless of reimbursement

(Kielhofner, 1983). Kielhofner stated that the mechanization of work could result in a loss of intrinsic sense of productivity, mastery, and, thus, competence.

Theoretical Models/Frames of Reference

in Prevocational and Vocational Rehabilitation

Occupational therapy models and frames of reference utilized in prevocational and vocational rehabilitation programs include: developmental, occupational behavior, human occupation, sensory-integrative, cognitive, psychodynamic, humanistic, biopsychosocial, occupational performance, and behavioral.

In looking at developmental, human occupation, sensory-integrative, and cognitive frames of reference, those with psychiatric disabilities are often viewed as not able to process information received from the environment and, therefore, unable to respond in a way that reflects the expected levels of development for that individual (King, 1978).

Developmental theory recognizes occupation as an integral part of the developmental process. Positive attitudes towards work are believed to be developed early in life as children are exposed to working family members (Bailey, 1971; Matsutsuyu, 1971; Maurer, 1971). Work roles are practised through participation in civic groups, clubs, and in school.

Llorens (1976) identified two processes of development

that occur in human beings. Horizontal (simultaneous) development is viewed as occurring across the areas of neurophysiological, physical, psychosocial and psychodynamic development, social language, daily living, and sociocultural skills. Longitudinal (chronological) development is viewed as occurring through the years as the individual matures.

Trauma resulting from physical and/or psychological disease, injury, environmental insufficiencies or individual vulnerabilities is viewed as causing a gap in the developmental life cycle (Anthony, Howell, and Danley, 1983; Gray, 1972; Llorens, 1970; Matsutsuyu, 1971; Shannon, 1972; Simmons, 1965). A difference between the expected coping skills and adaptive behavior and those skills required to meet these expectations is a common occurrence with dysfunction (Llorens, 1970).

The human occupation frame of reference which utilizes a systems approach for treatment views the person in treatment as a whole although components of occupational behavior may be assessed individually (Clark, 1979; Kielhofner, 1978; Kielhofner and Burke, 1980). Therapists assess and remediate deficits within three subsystems. Kielhofner and Burke (1980) identified the three subsystems of the organism to be: (1) volitional, (2) habituation, and (3) performance. The volitional subsystem is composed of personal causation, values, and interests. The

habituation subsystem includes one's values and habits. The performance subsystem includes skills and abilities.

The psychodynamic frame of reference emphasizes the importance of early experiences on the unconscious mind. Early trauma can often result in later pathology (Tiffany, 1983). Fidler (1966) identified a primary principle of psychodynamic psychology and interpersonal therapy as the identification of the relationship(s) between basic needs, need fulfillment, and mental health. As basic needs are satisfied, a foundation is established for the mature integration of information received from the environment. Therapeutic activities include use of free association and projective techniques for catharsis, insight, and transference (Tiffany, 1983).

The psychodynamic, socio-cultural, biopsychosocial, and humanistic frames of reference all view prevocational and vocational activities as addressing the basic needs of the individual by providing an opportunity for development and enhancement of self-concepts, feelings of worth, and fulfillment of the needs for relatedness (Beard, Propst, and Malamud, 1982; Fidler, 1966; Keith, Engelkas, and Winborn, 1977; Maurer, 1971; Simmons, 1972).

The occupational performance frame of reference examines functional abilities in the areas of work, leisure, education, and self-care. Purposeful activities provide an opportunity for remediation in the occupational

performance areas. Prevocational and vocational rehabilitation programs primarily address the occupational performance area of work. Remediation focuses upon poorly developed work habits and skills.

The last frame of reference to be described here is behavioral. The behavioral frame of reference views human behavior as that which is learned and influenced by reinforcers. Behavior can be reinforced or extinguished. Behavioral treatment techniques include operant conditioning, reciprocal inhibition, and desensitization techniques (Tiffany, 1983).

Occupational Therapy Psychosocial Prevocational and Vocational Rehabilitation Programs

Kester (1983) described several prevocational programs common to occupational therapy: (1) Work Tolerance Programs, (2) Personal Adjustment Training, and (3) Work Adjustment Training. Work tolerance programs were primarily used to improve physical abilities such as range of motion, work endurance, and speed, and are not commonly incorporated into mental health rehabilitation, since major deficit areas among the psychiatrically disabled are in the behavioral/attitudinal realm and not in the physiological areas. Programs focusing upon personal adjustment training and work adjustment skills were used more frequently for those with psychosocial disabilities. Personal adjustment training was focused upon minimizing

inappropriate self-care and home management behavior, which adversely affect vocational potential. Work adjustment training was focused upon remediating behavioral deficits specific to obtaining and maintaining a job (paid or volunteer status).

Occupational therapy goals for personal adjustment training include improving inter- and intrapersonal relationships, increasing use of leisure activities, and normalizing responsibilities for self-care and work chores (Kester, 1983). Rehabilitative activities spanned classes in practical math and reading for basic survival, personal hygiene, grooming, etiquette, dating, and recreation. Additional groups focused on money management, time management, and transportation skills.

Similar skill areas often overlapped in work adjustment training programs as they related to employment. Work adjustment programs also included training to improve the development of a realistic self-concept as a worker, derivation of work satisfaction, adjustment to work pressures, acceptance of disabilities, and effective utilization of individual abilities. At this level of rehabilitative training, rehabilitative activities included the job search process, developing resumes, completing job applications, interviewing, and developing appropriate job expectations. Activities at this level were designed to simulate the competitive job

market as closely as possible.

The following section of the literature review is presented according to Kester's above-mentioned categories of personal and work adjustment training programs. Research articles which describe the primary program focus, personal adjustment programs, combination personal and work adjustment programs, and work adjustment programs are presented, in addition to information on predictors of program efficacy. Chapter subheadings do not include a separate section on personal adjustment as those programs that incorporated personal adjustment training did so in combination with a work adjustment training program component. A section on specific work adjustment programs is included since these programs incorporated only work adjustment training and did not include a personal adjustment program component.

Combination Personal and Work Adjustment Programs

A study by Friedlob, Janis, and Deets-Aron (1986) reported on rehabilitative activities used by occupational therapists in a half-way house connected to a psychiatric hospital. Rehabilitative activities focused upon remediation of both personal and work adjustment skill areas. The staff consisted of two occupational therapists, a dietitian, a social worker, a registered nurse, and a physician. The house was located outside of the hospital grounds and was connected via telephone

services only.

Treatment goals included developing competence in health, hygiene, nutrition, budgeting, household management, interpersonal relationships, and accessing community resources, leisure activities, and vocational opportunities. Goal-setting reviews occurred weekly. There were rehabilitative activities which included planning and preparing balanced meals, marketing, and storing food. Household-management activities included doing laundry, sewing or mending clothes, financial lessons in making change, and classes on interpersonal interactions.

Those residents who displayed more independence participated in vocational training and training in effective use of leisure time. Rehabilitative activities included exploring community resources, planning and executing integration into the community through participation in neighborhood activity programs. Financial rehabilitative activities included banking, establishing a payment schedule, and establishing a realistic base of understanding of the costs of living in the community and how to cope with those stresses.

Those residents who required minimal supervision were responsible for planning and balancing daily activities. Individuals were involved in work, school, and/or volunteer work. They established their routine and found

places of employment. They participated in weekly assessment meetings and in weekend planning groups. The role of the occupational therapists was that of supervisor, with their primary responsibility directed to those performing self-care activities in the home.

This study discussed follow-up of the 19 residents over a 5-year period. Of the 19 residents who completed the program, 73% had reduced their number of rehospitalizations: 8 required no rehospitalization, 4 required multiple rehospitalizations with reduced durations from 3-6 months to 2-4 weeks. Therapists found an increase in independent living among clients: 12 moved to apartments or cooperative housing; 2 married shortly after living in apartments; and 3 moved in with parents. There was also improvement in vocational stability: 13 clients expressed dissatisfaction with their jobs and were able to effect positive change through job training or formal procedures, 6 attended junior college, and 3 others attended a trade school. Therapists found that the connected half-way house was the most beneficial for those with schizophrenia. Of those clients who were hospitalized 1 year prior to entry, only 2 required hospitalization. Those with other disorders, especially bipolar, required more frequent admission.

The half-way house set high expectations and provided a nurturing environment. Health and well-being were

emphasized, and residents were expected to assume responsibilities for community living and to cope with pressures. The above leadership and interactive treatment styles have been noted and described in the following study related to half-way houses, day treatment and to board and care facilities.

Lamb and Goertzel (1972) designed a 3-year follow-up study of long-term, ex-state hospital patients who participated in high- and low-expectation-oriented community rehabilitation programs. The typical ex-patient was female, aged 40, single, diagnosed as having schizophrenia and had been hospitalized 2-3 times in a period of 5 years. After discharge, the demonstration group (N=40) was placed in a high-expectation program, consisting of residence in a half-way house, with participation in both day-treatment programs and in a psychiatric vocational services center. The comparison group (N=44) was referred to board and care facilities and given the option of involving themselves in vocational services although there were no stated expectations by board and care managers for client participation.

It was found that the high-expectation programs, which required clients to participate in all domestic chores of the household as well as to engage in social activities and to participate in vocational activities, did not result in a reduction of recidivism. There was no

significant difference between the two groups in the length of stay in the community. The main finding revealed that high-expectation rehabilitation programs in the community resulted in a higher level of adaptive function in the areas of social integration and vocation. Fifty percent of the demonstration group was involved in productive activities 90% of the time, whereas only 12% of the comparison group demonstrated productive involvement. Although the level of productive function was great among those in high-expectation settings, it did not result in sustained full-time employment in the community.

Another important finding in the study was the difference between rehabilitative activities offering primarily verbal skills training at the day treatment center and the sheltered workshop offering vocational opportunities for skill development. Clients appeared to progress more rapidly when they were placed directly into a vocational training program where they could learn social skills in the context of work. Clients experienced greater levels of satisfaction and productivity in vocationally oriented programs than in those programs offering verbal skills activities.

Another study which supported these findings was reported by occupational therapists Klyczek and Mann (1986), both professors at the State University of New York in Buffalo. This study compared two forms of treatment

modalities commonly utilized at day treatment centers. It examined the effectiveness of verbal-insight therapy and of activity-oriented therapy. Although the relapse rate was 3.5 times greater for patients in activity therapy, the length of stay in the hospital was less than for those participating in verbal-insight therapy.

Patients were assessed quarterly using the Comprehensive Mental Health Assessment (CMHA), which focused upon expressing symptom reduction through assessment of six life skill areas: vocational/occupational adjustment, decision making, leisure time use, lethality to self, self-esteem, and lethality to others. The study showed that symptom reduction was four times greater for those participating in activity therapy. This was felt to be due to the fact that clients participated more frequently in sessions and were able to achieve treatment goals more readily. Activity therapy was believed to result in a greater amount of time being spent by clients in productive life-skill areas than by those clients participating in verbal-insight therapy. Rehabilitative activities included traditional crafts (leather, ceramics, woodworking, weaving, and photography) and social/leisure activities (parties, dinners, games, hobbies, bowling and cultural/educational field trips).

Fountain House (F.H.) established the clubhouse model in New York City, in 1948. The concept of the clubhouse

referred to an intentional community which offered a variety of social, prevocational, and vocational opportunities for its members. The clubhouse model was based on the belief that the club belonged to all who participated and contributed to its existence (Beard, et al., 1982; Beard, 1976; Fountain House, Inc., 1982). Work was the common vehicle through which contributions were made to the club. Members worked with staff to operate the clubhouse. It was in this context that both personal and work adjustment skills were remediated. The clubhouse provided a place and purpose for its members. It provided concrete work experiences in a normal environment, which differed from the simulated work settings located on hospital grounds (Beard, et al., 1982; Dulay & Steichen, 1981). Program components included a prevocational day program, Transitional Employment Program (TEP), evening and weekend program, apartment program, reach-out program, thrift shop program, clubhouse newspaper, medication, psychiatric consultation and health care, evaluation and clubhouse accountability.

Fountain House has conducted two long-term follow-up studies on the effectiveness of its rehabilitation program (Beard, Malamud & Rossman, 1978). In 1959, Fountain House conducted a 9-year follow-up study on 333 subjects to determine the extent to which rehabilitation can decrease the number of hospitalizations and the duration of time

spent in the hospital. The experimental group was divided into three subgroups to measure the effects of reach-out services. Reach-out services are support services, which consist of phone calls and visits to members who no longer attend the clubhouse program due to hospitalization, employment, or other situations. The first subgroup (88) received reach-out as needed for 2 years. The second subgroup (83) received reach-out services for the first month only. This was later dropped altogether, as the staff objected to the abrupt discontinuity of rehabilitation services. The last subgroup (81 subjects) participated in all rehabilitation services, with the exception of receiving reach-out services.

The second study, conducted in 1964, was a replication of the one in 1959. The purposes of this study were to expand the TEP and to evaluate the effects of community-based rehabilitation services on rehabilitation patterns. A total of 202 randomly assigned subjects were divided into three subgroups, comparable to those in the 1959 study.

The results of the first study were as follows: attendance was related to rehospitalization. In this study, those with 10 or less visits to Fountain House services, comprising 51% of the population, had rehospitalization rates similar to that of the control group (77% for clubhouse members versus 74% for

controls). The 18% who attended 100 or more sessions had a rehospitalization rate of 37%. Those receiving reach-out attended twice as much as those not receiving this service.

The second study showed little difference between the experimental group and the control group for the average time spent in the hospital (18.1% for controls, 14.2% for experimental), regardless of the type of service provided. The main finding was that regardless of the services provided to this population, hospitalization was only delayed, not prevented.

The Oakland Towne House Center study described two programs at the Towne House Center (Howe, Weaver, & Dulay, 1981). The first program was a day program, which offered a general activity program one day a week (Wednesday) and was directed by a social worker. The staff included occupational therapists, as well as college students and volunteers.

Several activities were offered concurrently in order to provide members with a selection. These included crafts, meal preparation, exercises, field trips, and special interest groups such as writing and gardening. An important component of the day program was the community meeting for planning, reporting and sharing information.

The Tuesday pilot program began in 1975 and was more

goal directed than the Wednesday group. This program required a greater commitment from members toward independence. Classes were offered in human growth and development, personal care, planning for the future, and basic living skills. Teaching methods included individual and group instruction, field trips, role playing, growth and educational games, practice sessions, peer teaching, value clarification, exercises, guest presenters, and audio-visual presentations.

The pilot program began with two members and increased to 35. The prevocational activities of the Tuesday pilot program were to count, stuff, package, and deliver envelopes. Work sessions lasted from one to two hours. This was the general length of classes and field trips.

The purposes of this pilot program were to utilize work activities as a means for the individual to evaluate abilities, to increase motivation, and to increase skills. The program did not attempt to train members for entry or re-entry into competitive employment. The theoretical frames of reference inherent in both programs were Lamb's educational model, which states that skills are learned as opposed to being endowed; Maslow's self-actualization and Mosey's biopsychosocial models, which view the individual as a member of a community, striving for self-actualization in a milieu designed to meet his/her basic physical, psychological, and social

needs.

The accumulated data revealed that the Tuesday group was more goal directed, had more commitment to learn to better themselves, and met their objectives of being able to create positive changes in their lives. Based on these data, a permanent prevocational rehabilitative program was established for four days a week. It was staffed by an occupational therapist who developed a TEP group, and by two mental health workers, two teachers and one program coordinator.

Afternoon classes were offered in math, office skills (typing, answering telephones, and using the adding machine), basic reading, women's issues, self-awareness, and living skills. During the morning hours, members worked in the prevocational division. The prevocational program was divided into two components: house and grounds division and food services division.

Those members who participated in the house and grounds division rotated jobs related to recycling, car washing, gardening, and janitorial work. Members of the food service division participated in menu planning, food shopping, food preparation, waiting on tables, distributing meals, bake sales, and community catering jobs. The center began functioning as a licensed bakery.

A TEP component was directed by an occupational therapist who evaluated the following readiness

skills necessary for participation in TEP:

1. Attends regularly
2. Demonstrates ability to be on time
3. Demonstrates the ability to work for one hour with a project
4. Demonstrates ability to deal with authority
5. Demonstrates the ability to get places on a bus
6. Demonstrates the ability to follow directions
7. Comes to work clean and appropriately dressed
8. Displays a willing attitude
9. Demonstrates the ability to get along with coworkers
10. Demonstrates flexibility in moving in and out of a variety of jobs

Work Adjustment Training

Several researchers have claimed that the best clinical predictors of future work performance are the ratings of an individual's work adjustment skills made in the work shop or sheltered job site (Anthony, 1982; Anthony, Howell & Danley, 1983; Griffiths, 1977; Morgan & Cheadle, 1975; Maurer, 1971; Simmons, 1972; Watts, 1978). Anthony (1982) described the three main work adjustment skills needed as: (1) getting along with coworkers and supervisors, (2) doing the job, and (3) being dependable, which includes attendance, punctuality, completing old tasks and initiating new ones. Of these,

the most relevant to vocational performance were "getting along with others" and "being dependable." Watts (1978) also found that task competence showed little or no significance as a predictor of future employment.

Llorens, Levy, and Rubin (1964) also explored the utilization of work adjustment skills as predictors of future employment. This study looked at a psychosocial rehabilitation program at Lafayette Clinic, Detroit, Michigan, which utilized work adjustment training as a means of remediating vocational disabilities. A follow-up survey was administered to the first 29 people who had participated in the program from November, 1960 through July, 1961. The final sample consisted of 25 persons. The three purposes of this study were as follows: (1) to determine the whereabouts of these individuals, (2) to determine whether employment had been achieved, and (3) to determine the effectiveness of the ratings from the work adjustment training program in predicting employability of its clients.

According to the work adjustment rating scale, which rated participants in simulated work settings in the hospital program, 14 or 56% of the sample population were rated as successful in the program and predicted as highly likely to become employed. The results showed that successful participation in the program was not an accurate predictor for employment. Other factors such as

intelligence quotient and severity of diagnosis affected employability (Llorens, Levy, and Rubin, 1964).

A number of studies reported the result of job clubs as a viable form of vocational rehabilitation. Job clubs generally assisted the client in overcoming deficits in work skill areas related to job searching, resume development, completion of applications, and participation in interviews. Studies of the effectiveness of job clubs or job clinics revealed contradictory conclusions on program outcome.

In a study by Azrin and Philip (1979), high employment rates of 94% were reported for the 58 subjects participating in job clubs. Members participating in this group for 6 months found jobs at a quicker rate than those in a control group. Jobs were obtained by the experimental group within 10 days versus 30 days for the control group. The experimental group received a higher pay (22% more) of \$2.61 per hour versus \$2.20 per hour as the median number of dollars. Jobs were obtained within an average of five sessions and within five job interviews.

Similar positive results were reported by Azrin, Flores, and Kaplan (1975). After three months, 93% of those in the job club became employed full time, versus 60% of those in the control group. At 12 months, 90% of the total population was employed. Eighty-six percent of

these subjects received public funding, which contradicted the belief that those with benefits were less likely to become rehabilitated. Success was attributed to consistency in attendance and to the number of interviews. Clients also received individual attention and guidance for several weeks or months. It was not clearly reported to what extent the individual attention contributed to the high-employment rates, nor were the exact methods of intervention reported.

Wesolowski and Zawlocki (1980) reported success for 38 members of a job club which offered group support and assistance in functional vocational skills. Within 5 days of training, 18% became employed and 34% had quit the club. After 15 days of being in the club, 39% of the remaining 26 clients became employed and 39.4% quit. After a 29-day period, 60% became employed. This study did not provide data on follow-up after the first month.

A study by Deacon, Dease, and Dunning (1974), took a slightly different approach to the traditional job club. A Los Angeles consulting firm assisted with this study. The study emphasized a "self-help" and a "merchandising" approach. Thirty-five clients were selected on the basis of a subjective staff rating on "the likelihood of success" and "willingness to participate." A total of 13 subjects participated in the study and received instruction on objective evaluation of assets and

liabilities during an 8-week training period.

Clients developed resumes which were sent to numerous employers. Eight of the 13 clients received interviews, but only one person was hired. It was felt that failure to become gainfully employed was not due to an unresponsive job market, but was attributed to anxiety, hostility, drinking, high expectations, and the loss of benefits. Full-time work posed too great a psychological risk for this population.

Massachusetts Prevocational and Vocational Studies

The only study on TEP which made an attempt to show comparative data was conducted by Marrone and LaRue (1983). They reported outcomes for those clients involved in three Massachusetts' TEPs: Crossroads Employment Service, Job Placement Center, and Riverway Day Treatment Center. The total number of participants in this study was 71: 27 clients at Crossroads, 26 for Job Placement Center, and 18 at the Riverway Day Treatment Center.

The results of this study showed that of the 46 persons who completed TEP, 21 supported themselves on part- or full-time employment. Of the 5 individuals who attended Crossroads Employment Service, 4 held full-time positions. Nine of 11 who attended Job Placement Center held full-time positions, and 3 of 5 of those who attended Riverway Day Treatment Center became employed full time. The overall rehabilitation rate was 78%, with individual

programs ranging from 70 to 74%. Almost half of the population still remained as open cases 3 months after TEP completed.

Interactive Treatment and Leadership Styles

The literature did not identify specific leadership or interactive treatment styles. Instead, researchers offered general guidelines for their organization and delivery of rehabilitative activities. Friedlob et al. (1986) and Lamb et al. (1972) both incorporated high expectations and nurturing, but did not specify the degree or the method of interaction. Azrin et al. (1975) reported the use of self-help techniques for participants in the job club. Guidance and individual attention were offered to the participants for several weeks or months. The clubhouse used peer tutoring and activities, which were co-led. Howe et al. (1981) used individual and group instruction, as well as peer tutoring, during rehabilitative activities.

Summary

This literature review presented research on occupational therapy in prevocational and vocational rehabilitation, which incorporated aspects of Kester's categories of personal and work adjustment training. The prevocational and vocational rehabilitation literature was organized into two subheadings: combination personal and work adjustment programs, and work adjustment training. A

separate subheading for personal adjustment programs was not created as these programs functioned only in conjunction with a work adjustment program component. Combination personal and work adjustment programs included those by Beard et al. (1978), Beard, et al. (1982), Dulay et al. (1982), Fountain House, Inc. (1982), Friedlob et al. (1986), Howe et al. (1981), Klyczek et al. (1986), and Lamb et al. (1972). Rehabilitative activities included crafts, meal preparation, household management, clerical, retail, journalism, landscaping, classes in personal and financial management, and community meetings.

Work adjustment programs included those by Azrin et al. (1975), Azrin, et al. (1979), Deacon et al. (1974), Llorens et al. (1964), Maronne et al. (1983), and Wesolowski et al. (1980). Rehabilitative activities described in these programs included: job searching, resume development, completion of applications, participation in interviews, and participation in temporary, supervised entry-level paid employment positions.

Although there was a tendency for researchers to associate improved work adjustment skills as predictive of future work performance or recidivism; this was not supported (Beard, et al., 1978; Deacon et al., 1974; Klyczek et al., 1986; Lamb et al., 1972; Llorens et al., 1964; Watts, 1978).

Studies by Azrin et al. (1975), Azrin et al. (1979), Friedlob et al. (1986), and Weslowski et al. (1980) provided findings that work skills training, in combination with personal adjustment skills training, resulted in an increase in independent living skills, social interactive skills, and vocational stability. The above prevocational program also resulted in a decrease of rehospitalization.

Reported interactive treatment and leadership style components included high expectations, nurturing, self-help, peer tutoring, and co-leading in activities (Azrin et al., 1975; Beard et al., 1982; Friedlob et al., 1986; Howe et al., 1981; Lamb et al., 1972).

Six theoretical models/frames of reference were specified in the literature reviewed. These are listed in order of appearance.

High-expectation model: Friedlob et al. (1986); and Lamb et al. (1972).

Clubhouse model: Fountain House (1982); and Marrone et al. (1983).

Lamb's educational model: Howe et al. (1981).

Maslow's hierarchy of needs model: Howe et al. (1981).

Mosey's biopsychosocial frame of reference: Howe et al. (1981).

Self-help merchandizing model: Deacon et al. (1974).

CHAPTER 3

PROCEDURES AND METHODOLOGY

A survey questionnaire was used in this study to determine the prevocational and vocational psychosocial facilities, programs, rehabilitative activities, interactive treatment and leadership styles, and theoretical models/frames of reference used by community psychiatric occupational therapists in the Commonwealth of Massachusetts.

The questions answered in this study were as follows:

1. What are the types of facilities/programs in which psychiatric occupational therapists provide services?
2. What are the types of facilities/programs, in which psychiatric occupational therapists provide services that are considered to be the most and least beneficial in promoting gainful employment among discharged clients?
3. What are the types of rehabilitative activities that are used by community psychiatric occupational therapists in prevocational and/or vocational rehabilitation?
4. Which rehabilitative activities do community psychiatric occupational therapists consider to be the most and least beneficial in promoting gainful employment of discharged clients?

5. Which intrapersonal components are considered to be related to the most beneficial rehabilitative activity?

6. Which interpersonal components are considered to be related to the most beneficial rehabilitative activity?

7. Which work-related components are considered to be related to the most beneficial rehabilitative activity?

8. Which intrapersonal components are considered to be related to the least beneficial rehabilitative activity?

9. Which interpersonal components are considered to be related to the least beneficial rehabilitative activity?

10. Which work-related components are considered to be related to the least beneficial rehabilitative activity?

11. What are the interactive treatment styles utilized by community psychiatric occupational therapists?

12. What are the leadership styles utilized by community psychiatric occupational therapists?

13. What are the theoretical models/frames of reference utilized by community psychiatric occupational therapists?

Subjects

The subjects for this study were community psychiatric prevocational/vocational occupational therapists in the Commonwealth of Massachusetts. A preliminary survey was mailed to 207 occupational therapists in Massachusetts who

receive the Occupational Therapy Mental Health Special Interest Section Newsletter. The preliminary survey was conducted to determine the population of occupational therapists who work or have worked in the area of prevocational and/or vocational rehabilitation within community mental health centers (Appendix A). One hundred and two occupational therapists responded. Twenty of these were community psychiatric occupational therapists and were considered the appropriate population for this study.

A questionnaire was then sent to the 20 community psychiatric occupational therapists (Appendix B). A cover letter was enclosed informing the therapists of the purpose of this study and the ways it would contribute to the field of community mental health, prevocational and vocational rehabilitation, and occupational therapy (Appendix C). Respondents were asked to complete the questionnaire and return it to the researcher. A stamped, self-addressed envelope was included in the questionnaire packet. A follow-up post card was sent within 2 weeks of the time that the questionnaire was mailed to insure an adequate return (Appendix D). Sixteen therapists (80%) responded to the questionnaire and became the final sample for this study.

Instrument

The questionnaire, developed by the researcher,

contained the following categories: Section I, Types of Community Rehabilitation Centers; Section IIA and IIB, Rehabilitative Activities; Section III, Interactive Treatment Styles; Section IV, Leadership Styles; and Section V, Theoretical Models/Frames of Reference (Appendix B).

Section I gathered data on places of present and past employment by community psychiatric occupational therapists, as well as those programs which were considered to be the most and least beneficial in promoting full- or part-time paid employment. Subjects were asked to check all responses that applied with respect to the following programs/facilities: clubhouse program, sheltered workshop, job club, day treatment affiliated with a psychiatric hospital, counseling center independent of a psychiatric hospital, and an "other" category.

The second section, Rehabilitative Activities, gathered descriptive information on the types of activities perceived by community psychiatric occupational therapists as being the most and least beneficial in promoting gainful employment. This section was divided into two parts: A and B. Part A focused on the most beneficial rehabilitative activities. Part B focused on the least beneficial rehabilitative activities. Subjects were asked to complete responses to questions and

statements regarding the type of rehabilitation center, location, types of clients, age range and number of clients attending the activity, number of staff supervising the activity, number of occupational therapists supervising the activity, existence and length of follow-up services, materials/resources for activity, and percentage of discharged clients who obtained full- or part-time paid employment.

In Section IIA (most beneficial rehabilitative activity), subjects were asked to place a check beside all components of the most beneficial rehabilitative activity which addressed intrapersonal, interpersonal, and work-related skills. Intrapersonal skills included: hygiene and grooming, identification of strengths and weaknesses, concentration on tasks, intrinsic motivation to become healthy/self-sufficient, motivation to earn tokens, motivation to earn privileges (non-token related), motivation to earn money, and coping skills. Interpersonal skills included: sense of belonging to the group (membership), small-group interaction skills, large-group interaction skills, peer tutoring, and an "other" category. Work-related skills included: attendance, punctuality, acceptance of supervision, task completion, expected level of quality work, ability to function on the job, independence during work-related tasks, work endurance of four or more hours, ability to

identify work skills, formulation of a job resume, arrangement and completion of job interview(s), completion of job application(s), money management, and an "other" category. Section IIB (least beneficial rehabilitative activity) maintained the same questions and format as Section IIA, with a shift in focus. Subjects were asked to check intrapersonal, interpersonal, and work-related tasks that were not addressed in the least beneficial rehabilitative activity.

In Section III, subjects were asked to check the interactive treatment style that best characterized the one that they used as a community psychiatric occupational therapist. The choices given included: formal, informal/non-intimate, informal/intimate, and an "other" category.

Subjects were asked in Section IV to select, by checking, the leadership style that best described the one that they used most frequently during treatment. Choices included: work therapy groups organized and led by the therapist, work therapy groups organized by the therapist but led by clients, work therapy groups organized and led by clients, and an "other" category.

In Section V, subjects were asked to place a check beside each theoretical model/frame of reference that they utilized during treatment. Selections included: clubhouse, humanistic, behavioral, developmental,

psychodynamic, occupational performance, occupational behavior, human occupation, adaptive response, and an "other" category.

In summary, the purpose of the survey was to identify the prevocational and vocational community psychosocial occupational therapy rehabilitative facilities, programs, activities, demographic variables of current and past employment, interactive treatment styles, leadership styles, and theoretical models/frames of reference perceived by Massachusetts community psychiatric occupational therapists as being beneficial to promoting future employment of discharged clients.

CHAPTER 4

DATA ANALYSIS AND RESULTS

Among the 207 occupational therapists in the Commonwealth of Massachusetts in 1987 who were recipients of the Mental Health Special Interest Section of Occupational Therapy, 20 registered therapists indicated that they were currently working or had worked in the area of psychosocial prevocational and/or vocational rehabilitation in community mental health centers. The Mental Health Special Interest Section referred to a subgroup of occupational therapists, including registered therapists, certified assistants, and students, who received regular bulletins from the American Occupational Therapy Association on mental health issues. A questionnaire was sent to the 20 eligible registered therapists. Sixteen responded (80%). The data received from the survey were tabulated. Many of the respondents included brief descriptions, especially on sections IIA and IIB, pertaining to the most and least beneficial rehabilitative activities. The degree of specification varied from one respondent to another.

The variables studied in this research included types of facilities, rehabilitative activities, interactive treatment styles, leadership styles, and theoretical

models/frames of reference. The data are presented in the order of the questions asked on the questionnaire.

Question 1: What are the types of facilities or programs in which community psychiatric occupational therapists provide services?

Six respondents (33%) were currently employed at community health centers. Four of these respondents were employed at a day treatment facility affiliated with a psychiatric hospital. One person was employed at a day treatment center not affiliated with a psychiatric hospital, and the sixth therapist worked at a clubhouse. The sixth therapist did not indicate whether the clubhouse was affiliated with the Fountain House model. Four of the currently employed therapists also had prior work experience at community mental health centers. Previous places of employment indicated by these 14 respondents included, in order of frequency: day treatment center affiliated with a psychiatric hospital (11), clubhouse (4), sheltered workshop (4), residential day activities program (2), independent day treatment program (2), school system (1), job club (1). Respondents were permitted to check all that apply.

Question 2: What are the types of facilities/programs in which community psychiatric occupational therapists provide services that are considered to be the most and least beneficial in promoting gainful employment among

discharged clients?

Among those occupational therapists currently employed as a community psychiatric occupational therapist (N=6), 2 (33%) listed the sheltered workshop as the most beneficial, with one each (17%) favoring the job club, counseling center affiliated with a psychiatric hospital, day treatment center independent of psychiatric hospital, and a combination of sheltered workshop and day treatment center.

Among those occupational therapists whose past employment history included employment in community mental health centers (N=14), the following data were reported with respect to the most beneficial program and/or facility: sheltered workshop, 2 (14%); day treatment affiliated with psychiatric hospital, 2 (14%); combination sheltered workshop and day treatment affiliated with a psychiatric hospital, 2 (14%); Transitional Employment Program (TEP), 1 (7%); clubhouse, 1 (7%); job club, 1 (7%); counseling center independent of psychiatric hospital, 1 (7%); and unavailable responses, 1 (7%). Therapists were asked to check all that apply.

Among those occupational therapists currently employed (N=6), 2 (33%) listed the clubhouse as the least beneficial. The remainder of the respondents equally rated the following as the least beneficial: the social club, 1 (17%); job club, 1 (17%); the day treatment

affiliated with the psychiatric hospital; 1 (17%); and counseling center independent of psychiatric hospital, 1 (17%).

Of the occupational therapists previously employed in community mental health centers (N=14), four respondents did not answer this questionnaire item. Ten respondents selected the following as the least beneficial programs and/or facilities: clubhouse, 4 (40%); sheltered workshop, 1 (10%); and day treatment affiliated with a psychiatric hospital, 3 (30%); social club, 1 (10%); and job club, 1 (10%).

Question 3: What are the types of rehabilitative activities used by community psychiatric occupational therapists in prevocational and/or vocational rehabilitation?

The respondents numbered 14 (N=14). The activities were grouped into the categories of "direct job involvement" and "indirect job involvement." Ten (74%) described direct job involvement and three (26%) described indirect job involvement activities. Direct job involvement activities indicated that clients performed job-related rehabilitative activities either at the rehabilitation center or in the community. Rehabilitative activities may have been performed both at the rehabilitation center and within the community but were not differentiated in the responses. Indirect job

involvement activities indicated that clients performed rehabilitative activities related to the job search process. These tasks involved searching and selecting classified ads, completing job applications and resumes, role playing, interviewing, and working with the Massachusetts Rehabilitation Commission as co-leaders or advisers.

Question 4: Which rehabilitative activities do community psychiatric occupational therapists consider to be the most beneficial in promoting gainful employment of discharged clients?

The rehabilitative activities that were considered as the most beneficial are presented below according to the title and descriptors identified by respondents:

1. Work in coffee shop - community coffee shop, training positions in cashier, stockperson, and janitor.
2. Prevocational groups - crafts, clerical machines such as adding machines, duplicators, and typewriters.
3. Field trips - visits to local industry and discussions of trip.
4. Independent living skills - inhouse jobs and discussion.
5. Lunch program - shopping in local food stores, operating kitchen equipment, and cash register.
6. Work crew job - no descriptors listed.
7. On real job site - jobs at community food

cooperative.

8. Simulated vocational settings - no descriptors listed.

9. Thrift store - client-operated thrift store in community, donated items made by clients in occupational therapy (crafts, baked goods, and plants).

10. Sheltered workshop - paid-sheltered jobs in clerical, maintenance, cafeteria, and library.

Of the above direct job involvement rehabilitative activities, the number of responses to this question was 10 (N=10). Common descriptors included food-related services, clerical retail duties (cashier), and maintenance. Those components are arranged according to the frequency of response in Table 1. Those rehabilitative activities categorized as indirect job involvement and perceived as being the most beneficial were described as follows:

1. Vocational issues group - co-led groups with a Massachusetts Rehabilitation Commission counselor, using workbooks, sample job applications, and classified ads.

2. Prevocational workshop - involvement with Massachusetts Rehabilitation Commission (degree unspecified).

3. Job-hunting group - involvement with Massachusetts Rehabilitation Commission (degree unspecified), speakers, hand-outs, behavior contracts, and visits to workshops.

Table 1

Frequency of Descriptors for the Most Beneficial
Rehabilitative Activity: Direct Job Involvement
n=10

Descriptors	No. responses
<hr/>	
1. Food Service	5
2. Clerical	2
3. Cashier	2
4. Janitorial	2
5. Crafts	2
6. Discussion	2
7. Field Trips	1
8. Library	1

4. Work group - involvement with Massachusetts Rehabilitation Commission (degree unspecified), dictionary of occupational titles, vocational inventories, role playing, and discussions.

Descriptive components are listed in Table 2 according to the number of times each appeared among the indirect job involvement rehabilitative activities. Common descriptors included contact with the State rehabilitation agency, literature, applications, ads, speakers, visits to work sites, role playing. The most common descriptor was the Massachusetts Rehabilitation Commission, with literature being the second most common descriptor. The remainder was mentioned only once in the text.

Question 5: Which intrapersonal components are considered to be related to the most beneficial activity?

The survey also inquired about specific activity components related to the areas of intrapersonal, interpersonal, and work-related skills. Respondents were asked to identify each component that was included in the rehabilitative activity they selected as being most beneficial. Components referred to as intrapersonal yielded the following frequencies: identification of strengths and weaknesses, 13 (81%); intrinsic motivation, 13 (81%); coping skills, 13 (81%); concentration on tasks, 12 (75%); and hygiene and grooming, 12 (75%). Motivation

Table 2

Frequency of Descriptors for the Most Beneficial
Rehabilitative Activity: Indirect Job Involvement
n=4

Descriptors	No. responses
1. State agency	4
2. Literature	3
3. Discussion	1
4. Applications	1
5. Ads	1
6. Speakers	1
7. Visits to job sites	1
8. Role playing	1

to earn money, 5 (31); motivation to earn privileges, 1 (6%); and motivation to earn tokens, 0 (0%). See Table 3.

Question 6: Which interpersonal components are considered to be related to the most beneficial activity?

In the interpersonal skill development areas, the most common components included: small-group interactions, 12 (75%); sense of belonging, 11 (69%); and peer tutoring, 5 (31%); large group interactions, 3 (19%); skill development, 1 (6%); and communication, 1 (6%). Responses are indicated on Table 4.

Question 7: Which work-related components are considered to be related to the most beneficial activity?

In the area of work-related skills, the incorporation of individual rehabilitative activity components were also tabulated. Respondents checked all that applied. Results are indicated in Table 5. All 14 respondents (100%) to this section of the questionnaire listed both attendance and punctuality as components provided by the most beneficial rehabilitative activity. Other popular components included: acceptance of supervision, 12 (86%); task completion, 11 (79%); ability to function on the job, 11 (79%); expected level of quality work, 10 (71%); and identification of work skills, 9 (69%).

Twelve respondents answered questions on the least beneficial rehabilitative activity (n=12). The least beneficial rehabilitative activities were described and

Table 3

Intrapersonal Components of the Most Beneficial
Rehabilitative Activity

n=16

Components	No. responses
1. Identification skills	13
2. Intrinsic motivation	13
3. Coping skills	13
4. Hygiene/grooming	12
5. Concentration on tasks	12
6. Motivation to earn money	5
7. Motivation to earn privileges	1
8. Motivation to earn tokens	0

Table 4

Interpersonal Components of the Most Beneficial
Rehabilitative Activity

n=16

Components	No. responses
1. Small-group interaction	12
2. Membership	11
3. Peer tutoring	5
4. Large-group interactions	3
5. Skill development	1
6. Communication	1

Table 5

Work-Related Components of the Most Beneficial
Rehabilitative Activity

n=14

Components	No. Respondents
1. Attendance	14
2. Punctuality	14
3. Acceptance of supervision	12
4. Task completion	11
5. Ability to function on the job	11
6. Quality work	10
7. Identification of skills	9
8. Independence on tasks	8
9. Applications	6
10. Money management	5
11. Interviews	3
12. Work endurance	3
13. Resumes	3

grouped into the following categories of "task performance activities lacking introspective processing (task performance only)," "verbalization component only," and "combination of task performance and verbalization with psychodynamic orientation."

The least beneficial rehabilitative activities reported in the task performance only category are listed below with their titles and descriptors as stated by respondents in the survey:

1. Social Club--cooking and sports.
2. Clubhouse Drop-In Center--recreational games and television.
3. Clubhouse Social Activities--social activities and recreational games.
4. Sports--no specific descriptors listed.
5. Music--records, tapes, and instruments.
6. Task Performance Alone--no specific descriptors listed.
7. Production Oriented Sheltered Workshop--no specific descriptors listed.

The least beneficial rehabilitative activities grouped according to verbalization only included the following titles and descriptors:

1. Community Meeting--verbalization only
2. Day Treatment--verbal groups.
3. Janitorial--Massachusetts Rehabilitation

Commission, speakers, and videos.

The least beneficial rehabilitative activities reported in the combination of task performance and verbalization with a psychodynamic orientation included art therapy as the title and art supplies as the main descriptor. Specific supplies were not indicated. Of the above categories, 11 activities were identified (N=11), with 7 (58%) of the least beneficial rehabilitative activities reported under task only; 3 (25%) were grouped under verbalization only; and 1 (17%) was grouped under the combination of task performance and verbalization with a psychodynamic orientation. Within the task only group (N=7), three of the seven activities referred to the social clubhouse (43%); all others were one of seven (14%) and not viewed as being highly significant. The social clubhouse activities, in relationship to all other listed activities (N=11), represented 27% of the least beneficial activities selection.

The least beneficial activities were also analyzed and categorized according to whether activities contained recreational sports and games, fine arts, food, and discussions. Of the 12 responses, 2 did not include sufficient descriptors to determine the above; therefore, the number of activities described below will be 10. Sports and games were contained as a descriptor in 4 (40%) of the least beneficial rehabilitative activities; fine

arts and meetings were each contained as descriptors in 3 (30%) of the least beneficial rehabilitative activities. Food was contained as a descriptor in 1 (10%) of these activities.

Question 8: Which intrapersonal components are considered to be related to the least beneficial activity?

The data on interpersonal, intrapersonal, and work-related components were also analyzed according to the total number of possible responses (N=12). The following information was generated (Table 6). The intrapersonal skill areas that were not addressed by 9 (75%) of the least beneficial rehabilitative activities were motivation to earn tokens, privileges, and money. Six (50%) of the least beneficial rehabilitative activities did not include a component on intrinsic motivation; 5 (42%) lacked identification of strengths and weaknesses; and 4 (33%) lacked both hygiene and grooming.

Question 9: Which interpersonal components are considered to be related to the least beneficial activity?

The following information was generated regarding deficient interpersonal skill components of the least beneficial rehabilitative activity (Table 7). Six (50%) of the least beneficial rehabilitative activities did not address peer tutoring or large-group interaction skills, and 4 (25%) lacked a focus on small-group interactive skills.

Table 6

Intrapersonal Components of the Least Beneficial
Rehabilitative Activity

n=12

Components	No. responses
1. Motivation to earn tokens	9
2. Motivation to earn privileges	9
3. Motivation to earn money	9
4. Intrinsic motivation	6
5. Identification skills	5
6. Hygiene/grooming	4
7. Concentration on tasks	3
8. Coping skills	2

Table 7

Interpersonal Components of the Least Beneficial
Rehabilitative Activity

n=12

Components	No. respondents
1. Peer tutoring	6
2. Large-group interaction	6
3. Small-group interaction	3
4. Membership	2

Question 10: Which work components are considered to be related to the least beneficial activity?

The deficient work-related components of the least beneficial rehabilitative activities are reported as follows (Table 8). Ten (83%) did not address skills related to the expected level of quality work, work endurance of four or more hours, completion of job resumes, identification of work skills, or money management. Nine (75%) did not address skills related to completion of job applications or interviews, or the ability to function on the job. Eight (67%) did not address the ability to perform independently.

Question 11: What are the interactive treatment styles utilized by community psychiatric occupational therapists?

Out of 16 respondents, 12 (75%) psychiatric occupational therapists used an informal, non-intimate interactive treatment style; 4 (25%) used an informal and intimate interactive treatment style; and none (0%) of the occupational therapists used a formal interactive treatment style.

Question 12: What are the leadership styles utilized by community psychiatric occupational therapists?

Fifteen respondents answered this question, with 8 (53%) of the occupational therapists reporting that they organized and led work therapy groups; 5 (33%) organized

Table 8

Work-Related Components of the Least Beneficial
Rehabilitative Activity

n=12

Components	No. responses
1. Quality work	10
2. Work endurance	10
3. Identification of skills	10
4. Resumes	10
5. Money management	10
6. Application	9
7. Interviews	9
8. Functioning on the job	9
9. Independence on tasks	8
10. Attendance	3
11. Punctuality	3
12. Acceptance of supervision	3
13. Task completion	3

the groups but preferred to have the clients conduct them; 1 (7%) preferred to co-lead groups with clients; and 1 (7%) said it depended upon the level of the clients.

When examining additional relationships between interactive styles and leadership styles, the following was noted: Four of the 12 (33%) occupational therapists who preferred the informal, non-intimate style, also preferred groups to be organized by the therapist but led by clients, whereas, 6 of the 12 (50%) therapists who used the informal, non-intimate leadership styles preferred to both organize and lead groups. It was interesting to note that on the two extremes, formal interactive treatment styles and groups organized and led by clients, there were no selections by occupational therapists.

Question 13: What are the theoretical models and/or frames of reference utilized by community psychiatric occupational therapists?

The results of the survey (Table 9) were as follows: Given a total of 15 possible responses, 13 (87%) respondents reported using the Occupational Behavior frame of reference; 11 (73%) respondents also utilized the Human Occupation frame of reference; 8 (53%) respondents used Developmental; 7 (47%) respondents used Psychodynamic, 7 (47%) respondents used Occupational Performance, and 6 (40%) used both Humanistic and Behavioral. One (7%) occupational therapist each used cognitive and

Table 9

Theoretical Models/Frames of Referencen=15

Models/frames of reference	No. responses
<hr/>	
1. Occupational behavior	13
2. Human occupation	11
3. Developmental	8
4. Psychodynamic	7
5. Occupational performance	7
6. Humanistic	6
7. Behavioral	6
8. Adaptive response	2
9. Cognitive	1
10. Biopsychosocial	1
11. Clubhouse	0

biopsychosocial. Therapists were asked to check all that apply.

The data are summarized and interpreted in the following section on Results, Implications, and Summary.

CHAPTER 5

RESULTS, IMPLICATIONS, AND SUMMARY

Results

The results of this study are:

1. The majority of the community psychiatric occupational therapists (15 or 94%) who responded to the survey, currently hold or previously held positions in day treatment centers affiliated with psychiatric hospitals. Other frequent responses included positions held in day treatment not affiliated with psychiatric hospitals (3 or 19%) and the clubhouse (5 or 31%). The above percentages reflect a combination of both previously held positions and current positions, as applicants were asked to check all that apply.

2. Sheltered workshops were viewed as being the most beneficial facility or program for community psychiatric prevocational/vocational rehabilitation. Among those therapists who were previously employed in community psychiatry, the day treatment center affiliated with the psychiatric hospital was also viewed as beneficial.

3. Among currently employed occupational therapists, the least beneficial program or facility for community psychiatric prevocational/vocational rehabilitation was

the clubhouse. This was also true for previously employed therapists.

4. Among rehabilitative activities defined as being the most beneficial in promoting gainful employment of discharged clients, the respondents reported the most common activity descriptor as food service. Others included clerical, cashiering, janitorial, crafts, and discussions. The majority of the above were also classified as direct job involvement activities.

The majority of the least beneficial rehabilitative activities reported included recreational games and sports as components. These activities were viewed as being task-only in nature and did not include any introspective processing.

5. The top three intrapersonal components utilized by 13 (81%) of the respondents reported the most beneficial rehabilitative activities as including: identification of skills, intrinsic motivation, and coping skills.

6. The two most identified interpersonal components of the most beneficial rehabilitative activities were small group interaction (12 or 75% of respondents) and membership (11 or 69% of respondents).

7. All of the 14 respondents listed attendance and punctuality as those work-related components included in the most beneficial rehabilitative activities. Other work-related components reported include: acceptance of

supervision (12 or 80% of respondents), task completion (11 or 79% of respondents), and ability to function on the job (11 or 79% of respondents).

8. The least beneficial rehabilitative activities did not address the following intrapersonal components: motivation to earn tokens, privileges, and money (9 or 75% of respondents).

9. The least beneficial rehabilitative activities did not address the following interpersonal components: peer tutoring (6 or 50% of respondents) and large group interaction (6 or 50% of respondents).

10. All ten (83%) of the respondents listed quality work, work endurance, identification of skills, writing resumes, and money management as those work-related components which were not included in the least beneficial activities.

11. Among the 16 community psychiatric occupational therapists who responded to the question on interactive treatment styles, 12 or 75% used an informal, non-intimate treatment style. None of the therapists used a formal treatment style.

12. The majority (8 or 53%) of the 15 therapists who responded to this question on leadership preferred a leadership style indicative of a therapist-organized and led occupational therapy program in prevocational rehabilitation. None preferred clients to both organize

and lead groups.

13. The three most commonly used theoretical models/frames of reference were occupational behavior, human occupation, and developmental. The least commonly used theoretical models/frames of reference were clubhouse, biopsychosocial, and cognitive.

Implications and Recommendations

This study provides preliminary data to indicate where, in the opinion of professional experts, beneficial programs for prevocational and vocational rehabilitation in community psychiatry have been located; the types of programs that are considered to be most and least beneficial; the types of rehabilitation activities that are the most and least beneficial; the types of interactive treatment and leadership styles most and least commonly used; and the theoretical models or frames of reference most and least frequently used.

Occupational therapists who are planning to develop prevocational/vocational psychiatric rehabilitation programs in the community could target psychiatric hospital settings, with a specific focus upon day treatment programs. In addition, sheltered workshops may be considered as excellent sites for program development.

Occupational therapists interested in promoting efficacy in prevocational/vocational rehabilitation programs would consider including task groups

related to food service, clerical, cashiering, and maintenance. Indicated intrapersonal components of each of the above areas would include identification of strengths and weaknesses, intrinsic motivation, coping skills, concentration on tasks, hygiene and grooming. Indicated interpersonal components include small groups which promote a sense of belonging. Work-related components reported as necessary for providing a beneficial rehabilitative activity include: attendance, punctuality, acceptance of supervision, task completion, ability to function on the job, quality work performance, identification of skills, and fostering independence on work tasks. Tasks related to sports and recreation are not recommended for community prevocational/vocational psychiatric rehabilitation programs.

This study indicated that community psychiatric occupational therapists engage in an informal, non-intimate treatment style, and provide groups that are both organized and led by the therapist. As therapists in the study reported utilizing mainly occupational behavior, human occupation, and developmental frames of reference, it would be recommended that therapists planning new programs become well informed regarding how these frames of reference impact upon the organization of community psychiatric prevocational/vocational rehabilitation.

As this study was limited in size and geography,

further research to determine the validity of these findings is needed. Research to study the outcomes for participants in prevocational/vocational programs designed to incorporate the components and characteristics identified in this study as most beneficial is recommended.

Summary

This study focused on community psychiatric occupational therapy with emphasis upon prevocational and vocational rehabilitation within the Commonwealth of Massachusetts. It explored the role of occupational therapy within community mental health centers and examined programs, facilities, rehabilitative activities, interactive treatment styles, leadership styles, and theoretical models/frames of references, as reported by occupational therapists who were currently or had previously held positions in community psychiatry.

The subjects for this study were community psychiatric prevocational occupational therapists in the Commonwealth of Massachusetts. A preliminary survey was sent to 207 Massachusetts occupational therapists who belonged to the Mental Health Special Interest Section of Occupational Therapy to determine the population of psychiatric registered occupational therapists who work or had worked in the area of prevocational/vocational rehabilitation within community mental health centers. Twenty of the 102

respondents were selected as the appropriate population for this study.

A survey questionnaire was mailed to the 20 registered occupational therapists who qualified for the study. The questionnaire contained five sections: (1) types of community rehabilitation centers, (2) rehabilitative activities, (3) interactive treatment styles, (4) leadership styles, and (5) theoretical models and/or frames of reference.

Descriptive analysis was used. Sixteen of the 20 (80%) occupational therapists surveyed responded. The results of the study were described according to the main questions of this thesis. Fifteen of the respondents work or had worked primarily in day treatment centers affiliated with psychiatric hospitals. Three work or had worked at day treatment centers not affiliated with psychiatric hospitals, and 5 work or had worked at clubhouses. Respondents were asked to select all that apply.

These therapists have identified the sheltered workshop as being the most beneficial facility for psychiatric prevocational/vocational rehabilitation, along with the day treatment programs, and the clubhouse as the least beneficial program, with recreational sports and games as the least beneficial rehabilitative activities.

The rehabilitative activity considered to be the most

beneficial was classified as being both a direct job-involvement task and a task relating to food service. Commonly contained intrapersonal and interpersonal components of the most beneficial rehabilitative activity were: hygiene/grooming, identification of strengths and weaknesses, concentration on tasks, intrinsic motivation, coping skills, sense of belonging, and small-group interaction skills. Commonly stated work-related components included: attendance, punctuality, acceptance of supervision, task completion, expected level of quality work, functioning on the job, independence during the job, and identification of work skills.

Among the 16 therapists surveyed, 12 (75%) utilized an informal, non-intimate interactive treatment style characterized by both scheduled and spontaneous interaction with the clients. Therapists were called by first-names and practical advice was shared in a reciprocal manner. Intimate information or contact was not exchanged between therapists and clients. Fifteen therapists indicated leadership preferences. The majority of the 15 therapists preferred to both organize and lead therapy groups, 8 (53%), and 5 (33%) preferred to organize groups, but allowed more client initiative in leading groups. Two (13%) indicated an "other" response.

Among the Massachusetts psychiatric occupational therapists, the most common theoretical models or frames

of reference were: occupational behavior, 13 (87%); human occupation, 11 (73%); developmental, 8 (53%); occupational performance, 7 (47%); psychodynamic, 7 (47%); humanistic, 6 (40%); and behavioral, 6 (40%). The least common theoretical models and frames of reference were: clubhouse (0%); biopsychosocial, 1 (7%); and cognitive, 1 (7%). Therapists were asked to select all that apply.

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APPENDIX A

PRELIMINARY SURVEY QUESTIONNAIRE

Beth Epstein OTR
165 Crescent St.
Northampton, MA
01060

Beth Epstein OTR
165 Crescent St.
Northampton, MA
01060

(REFOLD HERE) ↑

Dear Occupational Therapist,

I will currently be sending out a survey to community psychiatric occupational therapists who have worked in the past or do work now in community mental health centers. Please place a check beside all that apply and return this card to me. This card is self-addressed and stamped already. When completed, refold on the line above so that my address is on the outside of the card and staple closed. Do not remove your address label as it will be needed for future coding.

- () I currently work in a community mental health center.
 - () I have worked in the past at a community mental health center.
 - () I have never worked in a community mental health center.
 - () The center(s) in which I work/worked offer/offered programs in vocational rehabilitation which operated in relation to (included) occupational therapy.
-

* Please return this card within 2 days of receiving. Thank you for your time.

Sincerely,

Beth Epstein OTR
Beth Epstein OTR

APPENDIX B

**QUESTIONNAIRE ON COMMUNITY
MENTAL HEALTH PREVOCATIONAL/VOCATIONAL
REHABILITATION**

QUESTIONNAIRE ON COMMUNITY MENTAL HEALTH:PRE-VOCATIONAL/VOCATIONAL REHABILITATION

Please place a check beside the appropriate answer(s) when indicated. Other questions may require a more detailed description. If you desire additional space than that which has been allotted, please use the reverse side of the questionnaire. Completion of this questionnaire provides consent to use the data in reporting the findings for presentation or publication.

SECTION I: TYPE OF COMMUNITY REHABILITATION CENTER

1. Do you currently work at a community mental health center? () Yes () No.
2. If you answered "yes" to the above question, please answer the following:
In what type of facility/program do you work?
 Clubhouse program (); Sheltered workshop (); Job club ();
 Day treatment affiliated with psychiatric hospital ();
 Counseling center independent of psychiatric hospital ();
 Other () Please specify _____
3. If you have worked in the past at a community mental health center, please place a check beside each of the facilities/programs with which you were affiliated:
 Clubhouse program (); Sheltered workshop (); Job club ();
 Day treatment affiliated with psychiatric hospital ();
 Counseling center independent of psychiatric hospital ();
 Other () Please specify _____
4. Please place a check beside each of the facilities/programs in which you work/worked that provides/provided prevocational and/or vocational activities as part of occupational therapy:
 Clubhouse program (); Sheltered workshop (); Job club ();
 Day treatment affiliated with psychiatric hospital ();
 Counseling center independent of psychiatric hospital ();
 Other () Please specify _____
5. How long have you been a practicing psychiatric OTR? _____
6. How long have you been a practicing community psychiatric OTR? _____
7. Please place a check beside the type of facility/program you consider to be most beneficial in promoting full or part-time paid employment positions for discharged clients. "Most beneficial" implies clients were able to obtain paid employment in the community.
 Clubhouse program (); Sheltered workshop (); Job club ();
 Day treatment affiliated with psychiatric hospital ();
 Counseling center independent of psychiatric hospital ();
 Other () Please specify _____

8. Please place a check beside the type of facility/program you consider to be least beneficial in promoting full or part-time paid employment positions of discharged clients. "Least beneficial" implies clients were unable to obtain paid employment in the community.

Clubhouse program (); Sheltered workshop (); Job club ();
 Day treatment affiliated with psychiatric hospital ();
 Counseling center independent of psychiatric hospital ();
 Other () Please specify _____

SECTION IIA. REHABILITATIVE ACTIVITIES

This section will gather descriptive information on the types of activities you have found to be most beneficial in promoting successful future gainful employment for clients who have participated in your prevocational/vocational community mental health center. Please complete the following questions by either writing brief descriptive answers or checking the appropriate selections.

1. "Most beneficial" rehabilitative activity (title): _____
2. Type of rehabilitation center: _____
3. Location of center (city/town): _____
 Urban (); Suburban (); Rural ()
4. Type of client population (diagnoses): _____
5. Age range of clients: _____
6. Number of clients attending activity: _____
7. Number of staff supervising activity: _____
8. Number of OTR staff supervising activity: _____
9. Does/did your rehabilitation center provide follow-up services?
 Yes () No ()
10. If follow-up services are/were provided, for what length of time are/were these services provided? _____
11. What percentage of clients were able to obtain full or part-time paid employment in the community? _____
12. Materials/resources used in this rehabilitative activity: _____

13. The activity I regarded as being "most beneficial" in question 1 of this section, provided opportunity for intrapersonal and interpersonal skill development in the area(s) below (please check all that apply):

- A. ☐ Hygiene and grooming
- B. ☐ Identification of strengths and weaknesses
- C. ☐ Concentration on tasks
- D. ☐ Intrinsic motivation to become healthy/self-sufficient
- E. ☐ Motivation to earn tokens
- F. ☐ Motivation to earn privileges (non-token related)
- G. ☐ Motivation to earn money
- H. ☐ Coping skills
- I. ☐ Sense of belonging to the group (membership)
- J. ☐ Small group interaction skills
- K. ☐ Large group interaction skills
- L. ☐ Peer tutoring
- M. ☐ Other (please specify) _____

14. The activity I regarded as being "most beneficial" in question 1 of this section, provided an opportunity for the development of work-related skills in the area(s) below (please check all that apply):

- A. ☐ Attendance
- B. ☐ Punctuality
- C. ☐ Acceptance of supervision
- D. ☐ Task completion
- E. ☐ Expected level of quality work
- F. ☐ Ability to function on the job
- G. ☐ Independence during work-related tasks
- H. ☐ Work endurance of four or more hours
- I. ☐ Ability to identify work skills
- J. ☐ Formulation of a job resume
- K. ☐ Arrangement and completion of job interview(s)
- L. ☐ Completion of job application(s)
- M. ☐ Money management
- N. ☐ Other (please specify) _____

SECTION IIB. REHABILITATIVE ACTIVITIES

This section will gather descriptive information on the types of activities you have found to be least beneficial in promoting successful future full or part-time paid employment to discharged clients. Please complete the following questions by either writing brief descriptive answers or checking your selection(s):

1. "Least beneficial" rehabilitative activity: _____
2. Type of rehabilitation center: _____
3. Location of center (city/town): _____
Urban (); Suburban (); Rural ()
4. Type of client population (diagnoses): _____

5. Age range of clients: _____
6. Number of clients attending activity: _____
7. Number of staff supervising activity: _____
8. Number of OTR staff supervising activity: _____
9. Does/did your rehabilitation center provide follow-up services:
Yes () No ()
10. If follow-up services are/were provided, for what length of time are/were they provided: _____
11. What percentages of clients were able to obtain a full or part-time paid employment position? _____
12. Materials/resources used in this activity: _____
13. The activity I regarded as being "least beneficial" in question 1 of this section, did not provide an opportunity for intrapersonal and interpersonal skill development in the area(s) below (please check all that apply):
 - A. () Hygiene and grooming
 - B. () Identification of strengths and weaknesses
 - C. () Concentration on tasks
 - D. () Intrinsic motivation to become healthy/self-sufficient
 - E. () Motivation to earn tokens
 - F. () Motivation to earn privileges (non-token related)
 - G. () Motivation to earn money
 - H. () Coping skills
 - I. () Sense of belonging to the group (membership)
 - J. () Small group interaction skills
 - K. () Large group interaction skills
 - L. () Peer tutoring
 - M. () Other (please specify) _____
14. The activity I regarded as being "least beneficial" in question 1 of this section, did not provide an opportunity for the development of work-related skills in the area(s) below (please check all that apply):
 - A. () Attendance
 - B. () Punctuality
 - C. () Acceptance of supervision
 - D. () Task completion
 - E. () Expected level of quality work
 - F. () Ability to function on the job
 - G. () Independence during work-related tasks
 - H. () Work endurance of four or more hours
 - I. () Ability to identify work skills
 - J. () Formulation of a job resume
 - K. () Arrangement and completion of job interview(s)
 - L. () Completion of job application(s)
 - M. () Money management
 - N. () Other (please specify) _____

SECTION III. INTERACTIVE TREATMENT STYLE

Please place a check beside the interactive style that best characterizes the one that you use with clients in a psychosocial community vocational rehabilitation center:

- () Formal: Clients generally refer to you on a last name basis. You see clients on an appointment only basis, except in a crisis or emergency situation. Discussions are led by therapist and generally proceed according to an established or understood format.
- () Informal/Non-intimate: Clients generally refer to you on a first name basis. Interaction occurs both during scheduled groups as well as spontaneously. Information sharing occurs on a reciprocal basis, with therapist sharing practical advice but not personal detail or contact.
- () Informal/Intimate: Clients generally refer to you on a first name basis. Interaction occurs both during scheduled groups, as well as spontaneously. Information sharing occurs on a reciprocal basis, with therapist sharing practical advice as well as some degree of personal preferences. Therapist may frequently display affection in the form of non-sexual contact (hugs, pats on the back, etc.)
- () Other: (please specify) _____

SECTION IV. LEADERSHIP STYLE

Please place a check beside the leadership style that best describes the one you most frequently use during treatment:

- () Work/therapy groups are organized and led by therapist.
- () Work/therapy groups are organized by therapist and primarily led by clients.
- () Work/therapy groups are organized and led by clients.
- () Other (please specify) _____

SECTION V. THEORETICAL MODELS/FRAMES OF REFERENCE

Please place a check beside each theoretical model or frame of reference that you utilize during treatment:

() Clubhouse	() Occupational performance
() Humanistic	() Occupational behavior
() Behavioral	() Human occupation
() Developmental	() Adaptive response
() Psychodynamic	() Other: _____

THANK YOU FOR YOUR ASSISTANCE WITH THIS SURVEY.

APPENDIX C

COVER LETTER

A campus of The California State University

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059 • 408/277-2981

July 20, 1987

Dear Occupational Therapist:

I am currently conducting a survey on occupational therapy in community mental health centers located in the state of Massachusetts, in partial fulfillment of requirements for the Master of Science degree in occupational therapy. This study hopes to determine which types of psychiatric facilities/programs, treatment styles/interactions, rehabilitative activities, and theoretical models/frames of reference used by community psychiatric occupational therapists are most likely to promote gainful (paid) full or part time employment of former clients.

The questionnaire will require 15-20 minutes to complete. Your time and effort in completing this questionnaire are greatly appreciated. If you are unable to complete part of the questionnaire, please send it back regardless. Data from this questionnaire may be used for presentation or publication. Return of the questionnaire implies consent to use the data for these purposes. I have enclosed a self-addressed stamped envelope for your convenience. Please return this questionnaire within 3-4 days from the date you receive it.

Sincerely,

Beth Epstein OTR
Beth Epstein OTR
165 Crescent St.
Northampton, MA. 01060

APPENDIX D

FOLLOW-UP POST CARD

Follow-up Post Card

Dear Occupational Therapist:

I would very much appreciate the return of my questionnaire on vocational rehabilitation in the area of community mental health. Due to the small sample size of 25, it is imperative for me to get a higher return if my study is to be seen as valid. Please take a few moments to return the questionnaire and send it back immediately, even if incomplete.

Sincerely, Beth Epstein OTR
165 Crescent St.
Northampton, MA 01060