INCORPORATING PSYCHIATRY AND OCCUPATIONAL THERAPY CONSULTATION

As part of the assessment process, the Core Team engages the occupational therapy consultant (OT) in a consultative screening, and together they develop a plan for the OT's involvement going forward. This may include, but is not limited to, the OT providing a consultative assessment; recommendations to the family, Core Team, and Family Team; and/or coaching to the family.

As agreed upon with the OT, the Core Team engages the OT to assist with assessing and addressing youth and family processing patterns and environmental factors that contribute to presenting concerns as well as developing individualized interventions that focus on establishing pro-social habits, such as healthy attachment, parenting skills and routines, using occupations of the family and of childhood to enhance and promote self-regulation and relaxation, and developing strategies for managing symptoms that are associated with the use of problematic behaviors (e.g., stress, anger, anxiety). The Core Team may also coordinate with the OT to provide training/coaching to the Family Team to support their implementation of the occupational therapy recommendations.

The Core Team engages in an ongoing assessment of the need for psychiatric consultation with the Core Team and the Family Team. The Core Team consults with the psychiatry consultant as needed to assist with diagnosis, clinical formulation, and intervention planning, especially when addressing clinical complexities or when improvements have plateaued or high-risk behaviors are present.

Please see the following matrices for additional information related to incorporating psychiatry and occupational therapy consultation:

- Engaging Youth and Family
- Continuity with Higher Levels of Care
- Assessing Risk, Safety Planning, and Supporting Families through Crisis
- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Strengthening Wellbeing through Respite
- Conducting a Comprehensive Collaborative Assessment
- Providing Therapeutic Interventions

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Engages OT in consultative screening for every youth/family during the initial assessment. » Explores with the OT and youth/family whether an OT consultative assessment is needed. » Coordinates with the OT and collaterals so that the OT consultation includes all necessary settings such as home, schools, community centers, hospitals, and group home.	» Provides incomplete information to the OT when obtaining a consultative screening and/or determining the need for consultative assessment. Fails to provide the full assessment or pertinent portions such as the early developmental history, trauma history, or other history that will enrich OT's consultative screening/assessment. » Limited or narrow understanding of the OT role. Underestimates the usefulness of the OT role. Provides the family with minimized definition/explanation of OT role. » Solicits the OT for a narrow scope of work (e.g., only to discuss safety planning). » Suggests a limited need for the OT consultant to coordinate with only one collateral, or setting, rather than considering all collaterals and settings together. » Communicates limited information about OT consultative screening/assessment recommendations to family, Family Team, and/or other collaterals.	» Neglects to engage OT for screening consult during initial assessment. » Provides family with no explanation or inaccurate explanation of OT's role. » Discounts OT consultation as needed/viable resource to the Core Team, family, and Family Team. » Insists Core Team has the answers/knows what to do without ever consulting the OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Throughout provision if Continuum services, consults with the OT proactively and when there is a new disruptive/maladaptive behavior or current approach to maladaptive behavior isn't working, especially when there are possible or established concerns relative to: sensorimotor, sensory modulation, learning, social and cognitive development, or other factors persistently interfering with and impacting youth's engagement in meaningful participation in social relationships, education/vocation, eating, sleeping, daily living, leisure, activities of daily living (ADLs) and instrumental activities of daily living (IADLs).	» Engages OT "reactively" and not for proactive support of screening, assessment, and treatment planning. » Requests a specific type of OT screening (e.g., a sensory profile) rather than engaging the OT in a general consultative screening. Considers limited areas of consultation (e.g., sensory only) rather then the full spectrum in which OT can consult. » Seeks consults inconsistently throughout the course of treatment. » Doesn't include OT in identifying and overcoming barriers to engaging youth/family (e.g., how cognitive impairment, communication disorder, or physical disability of family member may interfere with family engagement). » Focuses on obtaining OT consultation when there are issues with youth and doesn't consider OT consultation when there are issues in youth's environment and with family/household members.	» Considers need for OT consultation once only, not throughout the course of Continuum service provision. » Provides OT with historic information but not updated information regarding new behaviors and response to approaches. » Disregards the need to share supporting reports/ testing, such as psychological testing, with OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Incorporates and implements OT recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning. » Uses OT consultation to assist the Core Team's assessment and development of strategies to address environmental factors that contribute to disruptive and maladaptive behaviors. » Uses OT consultation to inform the development of interventions that can support youth's development of healthy attachment, affect-regulation skills, social skills, positive coping skills, daily routines, family rituals, participation in education, play, leisure, social activities, sleep, school/work, activities of daily living, and independent living. Prioritizes involvement of parent/caregiver/family in all OT interventions and prepares and supports them to take on these roles. » Uses OT consultation to educate family, Core Team, and Family Team members to support their understanding of factors contributing to current presentation.	» Incorporates recommendations into initial assessment, treatment plan, etc. but doesn't continue to modify them with additional recommendations over time. » Inconsistently implements OT recommendations. » Has restricted frame of how to utilize OT consult (e.g., applies it only to social skill development at school). » Isn't sure when to share information with OT or doesn't realize the need to keep OT informed. » Uses OT consultation to inform the development of interventions but misunderstands the intent behind "fun" activities the OT recommends (e.g., refers to them as rewards when the intent is to teach skills). » Uses OT consult as a last resort after all the Core Team interventions have failed. » Only partially integrates OT recommendations into interventions. » Encourages the family to implement OT recommendations but doesn't follow up to see how they are working.	» Ignores recommendations when in disagreement with them (rather then discussing them and coming to consensus). Doesn't integrate and/or document OT recommendations. » Dismisses OT theory of cause of maladaptive/disruptive behavior (e.g., refers to behaviors as intentionally manipulative in nature rather than serving a particular function). » Makes unilateral decision to utilize OT tools (e.g., uses weighted blanket for youth during family therapy because it worked for other youth) without consulting with OT about the specific youth's needs. Uses different interventions/tools then those recommended by the OT. » Doesn't encourage family to follow through with OT recommendations and/or minimizes or dismisses them in discussion with family. » Makes unilateral decision about the youth/family and/or their environment (e.g., being too unstable, chaotic, overburdened, etc.) to have OT involved at a given time without exploring this with the OT and the youth/family. » Fails to follow up or follow through on communications with OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Determines with OT how to include them/ their recommendations and updates in the Family Team meetings. Discusses how to use information from OT consultation to assist the Family Team in exploring and generating OT-informed options to address clinical complexities, especially when disruptive/ maladaptive behavior is persistent, improvements have plateaued, or high-risk behaviors are present. » As agreed upon with OT consultant, includes consultant in or presents information from them at Family Team meetings and ensures that they have the opportunity to be involved in ongoing treatment planning, review, and modification.	» Makes plan with the OT on how the Core Team will share OT recommendations but is unclear, incomplete, or vague when explaining them to the Family Team. » Overcommits the use of the OT consultant or OT-specific tool(s) and interventions to the Family Team without explaining that further OT consultation is needed to ensure that specific tools/intervention and their definitive usefulness are good options for the particular youth.	» Makes unilateral determination (without collaboration with OT) on how to update the Family Team regarding OT consultation. » Misrepresents OT (e.g., describes them as "fixers of all [the youth/family's] problems"). » Makes unilateral decision that the OT won't have time to attend Family Team meetings without first discussing it with the OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Evaluates and considers the need for psychiatry consultation when: » Youth/family reports side effects of medication or lack of targeted effect of current prescriber's treatment plan. » Youth has comorbid mental health and medical diagnoses. » Core Team's comprehensive assessment and OT consult have not identified the factors driving or maintaining disruptive/ maladaptive behaviors. » Risk mitigation and management concerns are present. » Assistance in focal treatment planning and recovery-oriented approach is needed. » There is a need to address/improve linkage with the youth's primary care physician or psychiatrist. » Youth does not have a psychiatrist and interventions have not strengthened, developed, or maintained desirable behaviors or reduced or eliminated complex, challenging behaviors related to the youth's mental health condition.	Uses psychiatry consultation for a limited scope of situations (e.g., only talks with the consultant if the youth doesn't have a treating psychiatrist/prescriber or only considers need for/seeks consultation when there is a crisis).	» Ignores or dismisses the potential contribution psychiatry consultation can make. » Obtains psychiatry consult in an attempt to coerce/ persuade family into a particular perspective. » Determines need for consultation but doesn't request one or isn't aware Continuum has access to one.

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COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Obtains psychiatry consultation (as needed) and presents a comprehensive youth/family presentation with specific questions for the consultant.	» Presents case to psychiatry consultant focuses only on the current presenting problem and omits history, or vice versa. » Poorly articulates consultation question(s). » Limits the consultation to the youth. Omits information or questions about family system interactions and family member concerns.	» Excludes outreach worker, peer mentor, family, or other pertinent Family Team members in consultation. » Gives a biased case presentation. » Gives case presentation lacking details the psychiatrist needs for an informed consultation (e.g., missing information on diagnosis, medications, needs, strengths, etc.).
» Determines with psychiatry consultant how to include them/their recommendations and updates in the Family Team meetings. Discusses how to use information from consultation to assist the Family Team in exploring and generating psychiatry-informed options to address clinical complexities, especially when a comorbid medical and psychiatric diagnosis exists, disruptive/ maladaptive behavior are persistent, improvements have plateaued, and/or high-risk behaviors are evident. » As agreed upon with psychiatry consultant, includes the consultant in or presents information from them at Family Team meetings.	» Makes a plan with psychiatrist for how the Core Team will share their consultation recommendations with Family Team members but is vague or unclear when explaining to the Family Team.	» Makes unilateral determination (without collaboration with psychiatrist) on how to update the Family Team regarding psychiatry consultation. » Makes unilateral decision that psychiatrist won't have time to attend the Family Team meeting, without first discussing it with the psychiatrist.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Incorporates and implements recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning. » Uses psychiatry consultation to explore how to make a better linkage to treating psychiatrist and/or determine when to coordinate a consultation between treating psychiatrist/ prescriber and psychiatry consultant. » Uses psychiatry consultation to assist treating psychiatrist in understanding the youth/family constellation and situation and incorporating key family/natural supports that best sustain or advance permanency for the youth. » Uses psychiatry consultation to help family explore readiness for psychiatry evaluation and treatment (help them consider the pros and cons of medication, address general questions, etc.). » Uses psychiatry consultation to assist in focal treatment planning and recovery oriented approach.	» Is aware of potential barriers to implementing consultant's recommendations but doesn't discuss these with the consultant. » Uses consultant inconsistently. » Makes poor use of psychiatry consultants because of lack of understanding of the role and scope of the psychiatry consult.	» Incorporates recommendations that aren't feasible for the family without first exploring feasibility with them. » Makes unilateral decision that consulting psychiatrist should not meet with youth/family because they are not treating the youth. » Describes/explains consultation to family in language that isn't familiar or meaningful to them (e.g., uses professional terms and acronyms without explaining them). Doesn't ask family if the explanation was clear. Ignores need to try and re-explain with different words. » Downplays consultant recommendations as insignificant given that they are not the treating psychiatrist.