Actions of occupational therapy in mental health for patients hospitalized in general hospitals: impact on occupational functioning

Ações de terapia ocupacional em saúde mental para pacientes internados em hospital geral: impacto sobre o funcionamento ocupacional

ORIGINAL ARTICLE

Solange Aparecida Tedesco[1], Luiz Antonio Nogueira-Martins[2], Vanessa de Albuquerque Citero[3]

http://dx.doi.org/10.11606/issn.2238-6149.v28i3p261-270

Tedesco SA, Nogueira-Martins LA, Citero VA. Actions of occupational therapy in mental health for patients hospitalized in general hospitals: impact on occupational functioning. Rev Ter Ocup Univ São Paulo. 2017 Sept.-Dec.;28(3):261-70.

ABSTRACT: *Introduction*: Occupational Therapy (OT) in mental health favors the care for the patient in situations of adversity due to hospitalization. *Objective*: To evaluate the impact of the OT approach on the occupational functioning, specifically on the dimensions of personal causation, values, interests, roles, habits, skills, and environment of inpatients at general hospitals under a consultation-liaison psychiatry service. *Method*: This is a longitudinal study that evaluated the occupational functioning of patients who presented difficulties with the hospitalization, before and after the OT intervention and the impact on the occupational functioning. We studied patients who went to at least five OT sessions. Data were obtained from records of the service and from the Self-Assessment of Occupational Functioning (SAOF) scale. *Results*: Means of all the occupational functioning dimensions were higher than baseline means ($p<0.05$) after the intervention. *Conclusion*: The OT approach in consultation-liaison psychiatry allows the dimensions that compose the performance systems of the general hospital inpatient to be improved.

KEYWORDS: Occupational therapy; Mental health; Evaluation; Referral and consultation; Institutionalization.

Tedesco SA, Nogueira-Martins LA, Citero VA. Ações de terapia ocupacional em saúde mental para pacientes internados em hospital geral: impacto sobre o funcionamento ocupacional. Rev Ter Ocup Univ São Paulo. 2017 set.-dez.;28(3):261-70.

RESUMO: *Introdução*: A Terapia Ocupacional (TO) em saúde mental favorece o cuidado ao paciente em situações de adversidade decorrentes da hospitalização. *Objetivo*: Avaliar o impacto da abordagem em TO sobre o funcionamento ocupacional especificamente nas dimensões de causalidade pessoal, valores, interesses, papéis, hábitos, habilidades e meio ambiente de pacientes internados em hospital geral provenientes de um serviço de interconsulta psiquiátrica. *Método*: Estudo longitudinal que avaliou o funcionamento ocupacional, antes e após a intervenção em TO, verificando o impacto sobre estratégias utilizadas para lidar com as dificuldades com a internação por, no mínimo, cinco sessões. Os dados foram obtidos dos registros do serviço e pela Autoavaliação do Funcionamento Ocupacional (SAOF). *Resultados*: As médias de todas as dimensões de funcionamento ocupacional após as intervenções foram maiores do que as médias iniciais ($p<0,05$). *Conclusão*: A abordagem em TO no contexto da interconsulta psiquiátrica possibilita a ampliação das dimensões que compõem diferentes sistemas do desempenho do paciente internado em hospital geral.

DESCRITORES: Terapia ocupacional; Saúde mental; Avaliação; Encaminhamento e consulta; Institucionalização.

This study is part of the doctoral dissertation *Ações de terapia ocupacional (TO) em saúde mental no contexto de um serviço de interconsulta psiquiátrica em hospital geral (HG)* (Actions of occupational therapy in mental health for patients hospitalized in general hospitals: impact on occupational functioning) developed in the Graduate Program of the Department of Psychiatry of the Federal University of São Paulo – Paulista School of Medicine (UNIFESP-EPM). The study is part of the research *Avaliação da implantação do núcleo de terapia ocupacional (NuTO) em saúde mental no programa de interconsulta psiquiátrica em hospital geral*. Institutional ethics committee opinion: approved CEP 1167/10 in August 20, 2010.

1. PhD in Sciences from UNIFESP and occupational therapist in the Department of Psychiatry at the UNIFESP-EPM. Professor of the Undergraduate Course of Occupational Therapy of the Centro Universitário São Camilo. E-mail: sotedesco@uol.com.br.
2. Associate Professor of the Department of Psychiatry of UNIFESP-EPM. E-mail: nogmartins.luizantonio@gmail.com.
3. Affiliated Professor and Coordinator of the Mental Health Service of the University Hospital – Department of Psychiatry, UNIFESP-EPM. E-mail: vcitero@uol.com.br.

Corresponding address: Solange Aparecida Tedesco. Universidade Federal de São Paulo. Departamento de Psiquiatria. Secretaria do Departamento de Psiquiatria. Rua Borges Lagoa, 570, 1º andar. Vila Clementino – São Paulo, SP, BR. CEP 04038-020. E-mail: sotedesco@uol.com.br.

INTRODUCTION

The study and the evaluation of occupational functioning is part of occupational therapy (OT) as a field of knowledge and as a practice. Occupational functioning comprises all activities performed by an individual in his or her occupation and construction of time, environment and culture for a routine[1,2,3].

Occupational functioning is a concept associated with the study of the Model of Human Occupation[4,5]. Multiple reference models for the application of OT procedures seek to delineate this concept, which focuses on the nature of the occupation and its role on the life of individuals, such as health, disruption of life projects, self-care and occupation in life, including actions aimed at maintaining these activities, even when facing adversities from hospitalization and treatment from illness. The actions performed by an occupational therapist during the health-disease process contemplate the integration of biological, social, psychological and cultural aspects, as well as understanding the value of this integration to the relational life and productivity of the target subjects[6].

Occupational functioning is conceived by the Model of Human Occupation[4,5] as a system of relations and exchanges between the person and his or her environment. The model considers occupation as inherent to the human condition and thus, the relation between acting and doing is established within the temporal, physical, social and cultural contexts[4]. The word "occupational" is used for every relation of a person with his or her areas of action, such as work, leisure and daily life activities. The OT procedures evaluate the relations between the person, the environment and the action. Therefore, the occupational functioning concept is consistent with the practice of occupational therapy because it comprises components such as self-care, productivity and leisure, and their relation to the roles, environment and values, among others. Performing pleasant and satisfying occupations provides the individual with an identity, a structure and a flexibility in social and functional roles[4]. Thus, understanding what motivates the occupations, which standards are established or adapted and how the activities are performed is the objective of studying this model. Three elements are used to study these actions: volition, habituation and performance capacity[5].

The Model of Human Occupation was developed as a specific attempt to synthesize the concepts of occupational behavior in a model of practice and research. Authors such as Barris et al.[7] are developing instruments for clinical evaluation, defining the identification of impairments on the performance structures of actions that support the occupations and the daily life activities of each individual as occupational functioning categories.

Literature on OT actions in mental health for inpatients at general hospitals describes experiences conditioned to consultation-liaison psychiatry services, which limits the referral criteria for specialized care. Morais, Santos, Cabrera et al.[8] describe the relation between the reasons to request OT and stimulating the inpatient during his or her hospitalization, promoting activities and focusing on the use of available time (especially idle time), assisting the inpatient to adapt to the illness, treatment and managing the psychosocial aspects. Similarly, Gomes et al.[9] showed that the criteria for a liaison psychiatrist to refer an inpatient to OT in mental health are the patient's inability to adapt to the hospital routine, the non-adherence to the proposed clinical treatment, the disruption of daily life by illness/hospitalization, and the manifested desire to undergo OT.

Consultation-liaison psychiatry consists of establishing a clinical network with multiple medical specialties to assist in patient care at general hospitals. The actions are developed by two specialized teams, one in mental health and the other in general health. Quality and integrated care for the inpatient in general hospitals are the main propositions, as well as modifying the structure from disease-centered care to a context-focused care[10,11]. Multiprofessional work in mental health enriches the consultation-liaison psychiatry services, reflecting the change from a biomedical paradigm to a biopsychosocial model. Integrative and interactive medicine practices and the technological development of the area also aid multiprofessional care[12].

Thus, this study evaluated the occupational functioning of patients of consultation-liaison psychiatry services referred by the liaison psychiatrist to mental health treatment, as well as the impact that OT actions cause on the occupational functioning after completion of a therapeutic process. The research hypothesis was that the relationship established during the process of OT in mental health at the general hospital can identify occupational functioning areas that could be improved, thus assisting the patient to adapt to the adversities from illness and hospitalization.

METHOD

This is a longitudinal study that compared the occupational functioning of inpatients of a general hospital before and after undergoing a therapeutic process in mental health. The study was conducted for two years (from 01/01/2002 to 12/31/2004), at the *Hospital São Paulo*, the general and university hospital of the *Escola Paulista de Medicina*, from 2002 to 2004, and approved by the Research Ethics Committee of the *Universidade Federal de São Paulo* (protocol nº 1167/10).

This study selected 45 out of a group of 139 patients. The selected patients were referred to OT treatments by the consultation-liaison psychiatrist and were attended by the OT at least five times during their hospitalization. The description of the 139 patients and the reasons why they were referred to OT are described in the Tedesco study[13]. We used the concept "complexity of care" as described in the European Consultation Liaison Workgroup[15] because of the lack of parameters for the minimum amount of OT sessions in mental health that would allow us to evaluate the impact of the intervention[14]. The concept regards the use of healthcare at hospitals and the number of unexpected nursing interventions and medical and paramedical consultations performed[13,15]. Thus, we defined at least five OT sessions to reevaluate the changes on the occupational functioning of the patient. The care method was used for the data collection process, i.e., the occupational therapist evaluated the patient and the hospitalization context when requested and designed a therapeutic process to improve daily life and the contexts together with the patient. The frequency that the interventions would be performed considered the medical condition of each patient, i.e., it could be daily, every two or three days and, in chronic cases, weekly.

The data were from the Psychiatric Consultation-liaison Service of the university hospital from 01/01/2002 to 12/31/2004. The records from this period allowed the service to be organized and clinical protocols in OT to be structured, as well as the development of an ongoing longitudinal study. The consultation-liaison psychiatrists attended inpatients when a physician from the clinical or surgical areas requested, if they identified any psychiatric and/or psychological need that involved the patient, his or her relationship with the medical staff or the relationship of the family with the staff[16]. The consultation-liaison service started to use OT in mental health in 2000 to expand the actions offered. This inclusion was based on the theoretical assumption[16,17] that OT would contribute to patient care, better structuring the occupational functioning and consequently creating a better relationship with the environment and the context. The liaison psychiatrist was responsible for requesting the services of the occupational therapist. The therapist performed a consultant role, providing specialized care for the patient. The occupational therapist was part of a specialization program in mental health of the Department of Psychiatry and was supervised by the researcher responsible for the program during the training.

The appointments were individual, starting with patient evaluation, followed by the development of an action plan that consisted of a relational field and therapeutic activities. The process ended with a final revaluation. Biopsychosocial care for hospitalized inpatients considered not only the interpersonal relations between the health professionals and the patient/family but also the adaptation to the illness, hospitalization and therapeutic procedures.

The data were collected from the files of the consultation-liaison service written by the liaison psychiatrist. The main measurement data were: sociodemographic characteristics of the patient (gender, age, schooling, marital status, employment); clinical data (hospitalization diagnosis, unit, psychiatric history); request data (reason for being evaluated by the consultation-liaison psychiatrist, reason for the referral to OT and result of the evaluation of the consultation-liaison psychiatrist; methods used and psychiatric diagnosis). The registry files and those of the OT program were also used as sources, comprising: (1) Psychosocial evaluation (illness and the hospitalization impacts on patient function, performance and routine; sequelae prior to the hospitalization; physical or psychosocial rehabilitation; social or family support during the hospitalization; illness and hospitalization impacts for the patient and the family; patient perception regarding his or her difficulties, limitations and needs during hospitalization); (2) Overall assessment of the situation (need to adapt in time, environment and activities; need of social, environmental, emotional and functional support; damage to self-care, autonomy and independence; difficulty of interpersonal communication); and (3) Evaluation of the occupational functioning, using the SAOF scale on the first and last appointments.

The occupational functioning of patients was evaluated by the Self-Assessment of Occupational Functioning scale – SAOF[18], which is based on the Model of Human Occupation[5] to evaluate the perception of a patient regarding the areas of occupational functioning. The scale was developed to establish the most vulnerable points of the overall functioning of the patient as priorities during treatment[8]. It also provides both qualitative information of these experiences and a score that shows the patient's opinion of his or her own potentials and limits in areas such as personal causation (self-perception of the individual), values, interests, roles, habits, skills and environment[13]. Tedesco et al.[20] adapted the instrument to facilitate its use in Brazil, nonetheless keeping the criteria of the original instrument (k=0.69). The reliability values for this study were satisfactory for both the individual use of areas of the SAOF (k=0.75) and for the use of all areas (k=0.65). These values suggest that the discussions of priorities for the therapeutic process and for the perception of ruptures between the inpatient and the therapist were collaborative.

The adapted version of the SAOF is composed by 35 items distributed in seven areas. Each item has three possible responses (1 ⇨ Yes; 2 ⇨ No; 3 ⇨ I do not know) and a page with definitions to help the therapist to clarify and define each of the categories of occupation functioning, thus standardizing the interpreting of the theory[13]:

1. **Personal Causation:** How the individual sees himself or herself and the expectations of succeeding or failing in the activities, including the self-perception of the capacity of self-control, decision-making and frustration;
2. **Values:** Important activities for the individual and established standards and targets;
3. **Interests:** Activities that the individual enjoys and has pleasure performing;
4. **Roles:** Functions performed in life, including knowledge and the performance of necessary behaviors and skills;
5. **Habits:** Routine acts, organization and execution of tasks in daily life;
6. **Skills:** Physical and mental abilities that assist in social expression, contacts and actions;
7. **Environment:** variety of locations where the individual spends time, including people, objects and social resources.

The categories "No" and "I do not know" were grouped for analysis purposes; thus, we used the categories of responses "Yes" and "No/ I do not know".

The occupational therapist evaluated the patient using the protocols described. The SAOF was applied on the first appointment and re-applied on the last appointment, before medical discharge. All appointments were individual. The process started with patient evaluation, followed by the development of an action plan of therapeutic activities and ended with a final reevaluation.

The central tendency values of the seven dimensions of the SAOF were described and the means were compared before and after the OT intervention by the Student's *t*-test for dependent samples[21]. The McNemar test was used to verify the changes on the patterns of the items of the scale between the phases of the process. All values obtained from the SAOF on both phases were used to create a radar chart. The area under the curve represented the performance of each of the dimensions of the SAOF and each of the seven dimensions represents one of the ends of the polygon. The homogeneity of the performances is shown by the form of the polygon. Finally, we analyzed the consistency of the items that compose each dimension of the SAOF.

RESULTS

From 139 referrals, 45 (32.4%) patients went to more than five OT appointments.

Table 1 shows characteristics of the referred patients separated between those who went to at least five appointments (45) and those who did not (94). Fifty-five members of the second group did not met the required number of appointments, 16 passed away and 23 were discharged from the hospital without reevaluation. Both groups were very different ($p<0.05$). Those who attended at least five appointments were predominantly women, of older age, had more years of schooling, mostly economically active, hospitalized in dialysis unit and referred to OT because of the "extended period of hospitalization." In addition, fewer were referred ($p<0.05$) because of the "difficulties of relation with the caregivers." Reasons for this include presenting psychiatric symptoms and many unexplained somatic symptoms. The OT evaluation diagnosed a greater need for adapting to the activities and fewer need of adapting to the environment and difficulty of interpersonal communication.

Table 1 – Distribution of the sociodemographic and clinical characteristics of the patient and of the aspects related to the psychiatric consultation-liaison due to referral of the patient to treatment in occupational therapy

	Referrals for OT (n=139)		Evaluation and Reevaluation (SAOF)				*p-value*
			Yes (n=45)		No (n=94)		
	n	%	n	%	n	%	
Women	90	65.2	35	77.8	55	59.1	0.031
Years of study ≥8 years	55	39.6	25	56.8	30	32.3	0.006
Active on the labor market	20	14.7	11	24.4	9	9.9	0.024
Clinical Data							
Unit							
- Dialysis	21	15.2	17	37.8	4	4.3	<0.001
- Hematology	16	11.6	7	15.6	9	9.7	0.0312
- Plastic Surgery	4	2.9	0	0.0	4	4.3	0.303
- Gynecology	5	3.6	0	0.0	5	5.4	0.173
Psychiatric history	37	26.6	16	35.6	21	22.3	0.099
Reason for referral from the consultation-liaison							
- Long period of hospitalization	76	60.3	37	82.2	39	48.1	<0.001
- Difficulties in clinical management	75	59.5	22	48.9	53	65.4	0.070
- Relationship difficulties with the caregivers	61	48.4	14	31.1	47	58.0	0.004
- Psychiatric symptoms	83	65.9	24	53.3	59	72.8	0.0027
- Patient with somatoform disorder	87	69.0	26	57.8	61	75.3	0.041
- Patient with difficulties to adapt to the illness and/or hospitalization	117	92.9	41	91.1	76	93.8	0.720
- Adaptation and orientation for the care and daily life activities	99	78.6	41	91.1	58	71.6	0.011

Table 1 – Distribution of the sociodemographic and clinical characteristics of the patient and of the aspects related to the psychiatric consultation-liaison due to referral of the patient to treatment in occupational therapy

	Referrals for OT (n=139)		Evaluation and Reevaluation (SAOF)				p-value
			Yes (n=45)		No (n=94)		
	n	%	n	%	n	%	
Occupational Therapy Evaluation							
Need to adapt to time	91	73.4	37	82.2	54	68.4	0.093
Need to adapt to the environment	92	74.2	27	60.0	65	82.3	0.006
Need to adapt to the making	103	83.1	43	95.6	60	75.9	0.005
Need of social support	57	46	21	46.7	36	45.6	0.906
Need of environmental support	92	74.2	30	66.7	62	78.5	0.148
Need of emotional support	113	91.1	40	88.9	73	92.4	0.526
Need of functional support	95	76.6	35	77.8	60	75.9	0.817
Damage to self-care	68	54.8	22	48.9	46	58.2	0.315
Damage to autonomy	72	58.1	26	57.8	46	58.2	0.961
Damage to independency	60	48.4	23	51.1	37	46.8	0.647
Difficulty of inter-personal communication	80	64.5	24	53.3	56	70.9	0.049
	Mean ± SD (min-max)		**Mean ± SD (min-max)**		**Mean ± SD (min-max)**		***p***
Age of the patient (years)	39±18.4 (3;86)		43.7±13.8 (10;66)		36.7±19.9 (3;86)		0.018
Number of appointments performed by the occupational therapist	8.0±6.6 (1;28)		13.5±5.8 (6;27)		5.1±4.9 (1;28)		<0.001
Occupational therapy duration (days)	Mean n=4		Mean n=12		Mean n=4		

These 45 patients were mostly women (77.8%, Table 1), with an average age of 43.7±13.8 years, 56.8% had eight or more years of study, 24.4% were economically active in the labor market and 53.3% were married. Out of all patients, 35.6% had psychiatric history. Regarding the unit of hospitalization, 37.8% were from dialysis and 15.6% from hematology. The main reasons for being referred to OT were "difficulty to deal with the illness and hospitalization," "need to adapt and orientation in the activities of daily living and care" and "long period of hospitalization." More than 80% of the patients expressed "need to adapt to activities," "need to adapt to time" and "need for emotional support." For these records, the patients went to a mean of 13.5±5.8 OT appointments that occurred on a mean period of 59 days.

Psychosocial evaluation verified that 91.1% of the patients showed some type of limitation during hospitalization. Out of all patients, 88.7% and 87.9% reported illnesses and hospitalizations, respectively, of great impact on their lives. Additionally, 67% reported social support during hospitalization.

Table 2. Odds ratio of a patient to be referred by the liaison psychiatrist for service in occupational therapy in mental health

Variables	Mean	Standard Deviation	Minimum	Maximum	t	*p*
Personal Causation						
Pre-intervention	0.30	0.23	0.00	0.83	14.76	<0.001
Post-intervention	0.61	0.18	0.33	1.00		
Values						
Pre-intervention	0.21	0.24	0.00	0.67	10.80	<0.001
Post-intervention	0.62	0.20	0.33	1.00		
Interests						
Pre-intervention	0.10	0.20	0.00	0.67	16.96	<0.001
Post-intervention	0.66	0.21	0.33	1.00		
Roles						
Pre-intervention	0.43	0.24	0.00	0.71	8.22	<0.001
Post-intervention	0.66	0.14	0.29	1.00		
Habits						
Pre-intervention	0.16	0.20	0.00	0.67	10.89	<0.001
Post-intervention	0.58	0.26	0.00	1.00		
Skills						
Pre-intervention	0.21	0.14	0.00	0.58	21.87	<0.001
Post-intervention	0.62	0.10	0.42	0.83		

When comparing the means of performance of the SAOF dimensions before and after the intervention (Table 2), all dimensions increased after the intervention ($p<0.05$). We observe that there is homogeneity on the performance of every dimension on the polygon associated with the reevaluation (Figure 1). The initial evaluation showed that patients would usually present little perception of their "Interests" and greater awareness of their "Roles." The reevaluation thus showed great improvement on the "Interests" dimension.

In the Environment dimension, which consists of a single item, we observed an increase from 17.8% to 55.6% in positive responses between both evaluations.

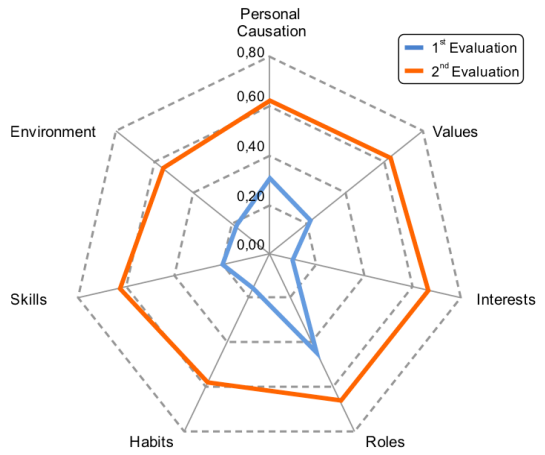

Figure 1 – Mean of the indicators by SAOF dimensions by evaluations

DISCUSSION

The patients referred by the consultation-liaison psychiatrists and treated with OT in mental health, being evaluated and revaluated for occupational functioning, presented improvements on every dimension evaluated.

There were significant improvements from the first to the second evaluation on the occupational functioning areas. Some strategies were changed, and others acquired on the activities with the therapist.

For the Habits (routine and daily), we observed that between the initial and the final evaluation, the satisfactory use of time was perceived by the patients (even during hospitalization). The most significant difference for the Roles area was the involvement in the current experience and the experiences as a relative. The dimensions of the Habits and Roles correspond to the internalized personal and social standards as well as organizing routines.

Every evaluation for the Skills dimension increased on the reevaluations and were related to the subject's subsystem of integrated performance as capable of organizing the ability to perform, narrate, relate and interact.

Considering the study of OT practices in mental health for inpatients at hospitals and the discussions of Galheigo and Antunes[22], we understand the completeness of care as the actual and multidimensional construction of support networks and social and relational maintenance of the subject as guides for the promotion of healthcare. Thus, establishing broader practices than those focused on health-disease is needed. The difficulties of the patients to deal with the illness and hospitalization and the need for adaptation and guidance regarding daily life activities and care are observed when analyzing all referrals from the consultation-liaison psychiatrist.

Concepts of a therapeutic process focused on the subject-environment relationship, social participation, health and well-being highlight the need of further evaluation of the narratives and experiences of the activities and the occupational roles of the subject. Occupational dysfunction does not exist when considering this perspective, but a perception of the subject about the disruptions that occur during the process of making and participating.

The areas that presented the greater improvements on occupational functioning between the applications are related to self-image, improvement on the expectations of success or failure and subsequent relation with the environment, improvement on the will to seek pleasure in certain objects, events or people and improvement on interrelated actions and flexibly organized components due to meeting a purpose or a target under favorable environmental conditions; these changes affected not only the awareness required to act on the environment, but the need for decision-making and solving problems[22,23,24].

The use of SAOF to evaluate occupational functioning allowed the dimensions that compose the different performance systems of an individual to be expanded. The concept of occupational roles (under the Roles dimension) involves the behaviors related to organizing the use of time and the participation of the individual in the social structure[22]. Thus, the roles related to environments outside the hospital, such as student and worker, were stable on both evaluations; however, the values for the roles related to the context and changed by the hospitalization, such as the performance as a family member and friend, varied on both evaluations.

The evaluation or the acquisition of function and dysfunction during health-disease processes (even at general hospitals), are different from the contextual factors (environmental and personal) and the relational processes that occur during occupational therapy and the activities performed in the therapeutic setting.

We cannot claim that the rupture processes experienced by the patients started during the hospitalization or were related to the clinical or psychiatric condition of the patient, or even to his or her emotional condition. The use of the SAOF only allowed us to correlate the occupational functioning and the OT process in mental health within a hospital context.

The SAOF is an instrument of easy application for the occupational therapist, and even if not all dimensions are applied, the instrument will still show the areas of occupational functioning that can change under intervention. We cannot know if the changes on the occupational functioning come from the OT intervention or from the psychiatric or clinical improvement, since this is still an unstudied aspect. However, we note that the SAOF dimensions presented the construct "occupational functioning" as a possible indicator of effectiveness to be studied. We could even understand the SAOF as a proxy measure for coping strategies. The research group from this study is currently performing prospective studies to investigate the association between SAOF and an instrument that evaluates coping strategies.

REFERENCES

1. Nelson DL. Occupation: form and performance. Am J Occup Ther. 1988;42(10):633-41. doi: 10.5014/ajot.42.10.633
2. Maximino VS, Tedesco S. Rotina, hábitos, cotidiano: no banal e no sutil, a trama da vida. In: Matsukura TS, Salle MM, organizadores. Cotidiano, atividade humana e ocupação: perspectivas da Terapia Ocupacional no campo da saúde mental. São Carlos: EDUFSCAR; 2016. p. 123 - 46.
3. American Occupational Therapy Association (AOTA). Estrutura da prática da Terapia Ocupacional: domínio & processo – 3a ed. traduzida. Rev Ter Ocup Univ Sao Paulo. 2015;26:1-49. doi: 10.11606/issn.2238-6149.v26iespp1-49.
4. Kielhofner G. Modelo de ocupación humana. Teoría y aplicación. 3a ed. Buenos Aires: Editorial Médica Panamericana; 2004.
5. Kielhofner G. Fundamentos conceptuales de la terapia ocupacional. 3a ed. Buenos Aires: Médica Panamericana; 2006.
6. Conselho Federal de Fisioterapia e Terapia Ocupacional. Resolução nº 408, de 18 de ago de 2011. Disciplina a Especialidade Profissional Terapia Ocupacional em Saúde Mental e dá outras providências [resolução na internet]. Diário Oficial da União, 24 nov 2011 [cited Dec. 14, 2012]. Available from: ftp://ftp.saude.sp.gov.br/ftpsessp/bibliote/informe_eletronico/2011/iels.nov.11/Iels220/U_RS-COFFITO-408_180811.pdf.
7. Barris R, Kielhofner G, Martin RMB, Gelinas I, Klement M, Schultz B. Occupational function and dysfunction in three groups of adolescents. Occup Ther J Res. 1986;6(5):301-17. doi: 10.1177/153944928600600504.
8. Morais LV, Santos JE, Cabrera CC, Ribeiro RPP. A vida cotidiana na obesidade morbida: um espaço para assistência de terapia ocupacional. Diagn Tratamento. 2002;7(4):18-21.
9. Gomes MG, Morais LV, Osório FL, Cabrera CC, Bertuso-Pelá EC, De Carlo MM, et al. Assessment of referrals to an OT consultation-liaison service: a retrospective and comparative study. Scand J Occup Ther. 2012;19(1):84-91. doi: 10.3109/11038128.2010.534504
10. Gitlin DF, Levenson JL, Lyketsos CG. Psychosomatic medicine: a new psychiatric subspecialty. Acad Psychiatry. 2004;28:4-11. doi: 10.1176/appi.ap.28.1.4.
11. Levenson JL. Psychosomatic medicine: future tasks and priorities for the new psychiatric subspecialty. Rev Bras Psiquiatr. 2007;29(4):301-2. doi: 10.1590/S1516-44462007000400002.
12. Cítero VA, Araújo Andreoli PB, Nogueira-Martins LA, Andreoli SB. New potential clinical indicators of consultation-liaison psychiatry's effectiveness in Brazilian general hospitals. Psychosomatics. 2008;49(1):29-38. doi: 10.1176/appi.psy.49.1.29
13. Tedesco S. Ações de terapia ocupacional (TO) em saúde mental no contexto de um serviço de interconsulta psiquiátrica em hospital geral (HG) [tese]. São Paulo: Universidade Federal de São Paulo - Escola Paulista de Medicina; 2013.
14. Lee SW, Kielhofner G, Morley M, Heasman D, Garnham M, Willis S, et al. Impact of using the Model of Human Occupation: a survey of occupational therapy mental health practitioners' perceptions. Scand J Occup Ther. 2012;19(5):450-6. doi: 10.3109/11038128.2011.645553.
15. Hansen MS, Fink P, Frydenberg M, de Jonge P, Huyse FJ. Complexity of care and mental illness in medical inpatients. Gen Hosp Psychiatry. 2001;23(6):319-25. doi: 10.1016/S0163-8343(01)00162-1
16. Cordeiro JR, Camelier A, Oakley F, Jardim JR. Cross-cultural reproducibility of the Brazilian Portuguese version of the role checklist for persons with chronic obstructive pulmonary disease. Am J Occup Ther. 2007;61(1):33-40. doi: 10.5014/ajot.61.1.33.
17. Roley SS, DeLany JV, Barrows CJ, Brownrigg S, Honaker D, Sava DI, et al. Occupational therapy practice framework: domain & practice, 2nd edition. Am J Occup Ther. 2008;62(6):625-83. doi: 10.5014/ajot.62.6.625.
18. Baron K, Curtin C. Self-Assessment of Occupational Functioning (SAOF). Chicago (IL): University of Illinois; 1990.
19. Tedesco SA. Estudo da validade e confiabilidade de um instrumento de Terapia Ocupacional: Auto-Avaliação do Funcionamento Ocupacional (SAOF) [dissertação]. São Paulo: Escola Paulista de Medicina/UNIFESP; 2000. http://repositorio.unifesp.br/handle/11600/16993
20. Tedesco SA, Cítero VA, Martins LAN, Iacoponi E. Tradução e validação para português brasileiro da Escala de Autoavaliação do Funcionamento Ocupacional. Rev Mundo Saúde. 2010;34(2):230-7. Disponível em: http://www.saocamilo-sp.br/pdf/mundo_saude/75/230a237.pdf.
21. Fletcher RH, Fletcher SW, Fletcher GS. Epidemiologia clínica: elementos essenciais. 5a ed. Porto Alegre: ArtMed; 2014.
22. Galheigo SM, Antunes JA. A caracterização da produção bibliográfica nas práticas hospitalares em terapia ocupacional no Brasil: uma revisão da literatura de 1990 a

2007. Rev Ter Ocup Univ São Paulo. 2008;19(2):91-9. doi: 10.11606/issn.2238-6149.v19i2p91-99.

23. Kielhofner G, Forsyth K, Suman M, Kramer J, Nakamura-Thomas H, et al. Self-Reports: Eliciting Client's Perspectives. In: Kielhofner G. A model of human occupation: Theory and application. 4th ed. Philadelphia (PA): Lippincott Williams & Wilkins; 2008. p.237-61.

24. Schindler VP. A client-centred, occupation-based occupational therapy programme for adults with psychiatric diagnoses. Occup Ther Int. 2010;17(3):105-12. doi: 10.1002/oti.291

Received: 08.10.17
Accepted: 12.01.17