All service users referred to HD Community team will, if needed, have access to a qualified Occupational Therapist (OT) who will identify their occupational performance needs. Where Occupational Therapy needs have been identified by the MDT, the OT will provide clinical interventions designed to improve the person’s social independence as well as their physical and mental wellbeing. Social, environmental, and sensory adaptations may also be recommended to improve independence and quality of life. When able, these goals will be created in collaboration with the service user using Occupational Therapy assessment tools, eg: Sensory Checklist and Model of Human Occupational Screening Tool (MOHOST) as a framework for Occupational Therapy formulation.

The OT will complete assessments with service users around their mental health, social, leisure and Activity of Daily Living needs. Areas of need identified during these assessment will then be implemented by the OT through 1:1 interventions that support the individual to achieve these goals, or signpost to the appropriate services. Occupational Therapy assessments will be used to inform accommodation needs and support service users to improve or maintain skills. Occupational Therapy interventions will be an integrated part of the MDT provision. The OT will take the role of lead professional where it is appropriate for them to do so.

Potential referrals for Occupational Therapy intervention highlighted below.

* developing and implementing coping strategies
* relaxation techniques and exploring sensory preferences
* assess and make recommendations to overcome restrictions to family, work, leisure and social roles

**Mental health strategies for wellbeing and participation**

**Social and leisure activities**

* identify important and meaningful recreational activities and consider activity adaptation
* signpost to community resources and groups
* task assessment - consider restrictions and implement task modification to support safe participation
* memory/concentration/planning strategies
* strategies to compensate for cognitive impairment in ADLs when participation can still be facilitated (memory/concentration/planning)
* recommendations for how family/carers can best support

**Community skills**

* advice on risk/ safety awareness when accesssing the community
* develop management strategies to participate in community life
* recommendations for carers in facilitating safe community access

**Cognitive functioning**

**Managing fatigue**

* sleep hygeine strategies and sleep routine
* energy conserving strategies and daily routine plans

**Domestic skills**

If required forward referral onto Adult Social Care/Community teams for intervention or equipment needs

**Optimising mobility and transfers**(falls prevention)

* joint working with Physiotherapy
* environmental hazards assessment
* identify environmental modifications or transfer needs
* falls action plan

**Bed mobility and sleep safety**(getting in and out of bed, falls from bed, postioning)

If required forward referral onto Adult Social Care/Community teams for intervention or equipment needs

* task/environment risk assessment
* identify environmental modifications or needs

If required forward referral onto Adult Social Care/ Community Teams for intervention or equipment needs

**Self care**(toileting, bathing/showering, dressing/grooming)

* maintaining skills through task adaptation and compensatory strategies
* identify environmental modifications or needs
* recommendations for family/carers

**Eating and drinking**

* joint working with Speech and Language Therapy; posture recommendations alongside Physiotherapist, task adaptation or compensatory strategies, trialling adaptive equipment/aids