Mental health, as an area of specialty in occupational therapy, is in trouble. With the exception of mental retardation, the percentage of occupational therapists working with psychiatric diagnoses has dropped precipitously from 16.0% to 11.8%, according to the American Occupation Therapy Association’s (AOTA) Member Data Surveys for 1986 and 1990. AOTA surveys also show that the number of certified occupational therapy assistants dropped from 25.5% to 16.5% between 1987 and 1991. This decline occurred despite the AOTA-sponsored SCOPE and FOCUS curricula of the mid-1980s, which were designed to stimulate and assist therapists in meeting the challenges of a changing environment (Robertson, 1986, 1988). A variety of articles have been published addressing different aspects of the problem, including the perceived competence of mental health therapists (Cotrell, 1990), students’ choice of specialty (Ezersky, Havazelet, Scott, & Zeitler, 1989; Page, 1987; Swinehart, 1990; Wittman, Swinehart, Cahill, & St. Michel, 1989), and recruitment and retention (Hischmann, 1990; Wittman & Gibson, 1990). It seems clear that with increasingly fewer therapists to provide field work placements for students the situation is becoming critical.

The Medical Model

I believe that one reason for this crisis is that we as occupational therapists have invested too long and too exclusively in a medical model of service provision and have failed to explore and exploit alternatives. Despite some shifts over the years, the medical approach continues to emphasize the diagnosis of pathology and the cure of symptoms through treatment applied to a passive patient (Mosey, 1985). In recent years, as medicine has shifted to a profit orientation, occupational therapy has been subjected to the pressures of funding sources that affect programs by defining which services are reimbursable. In addition, the marketplace has launched a spate of freestanding, for-profit psychiatric centers that hire occupational therapists, but often limit their roles to a standard treatment package. The medicalization of psychiatry (Fine, 1986), which has led to a heavy reliance on psychotropic drugs and a tendency to limit inpatient treatment to a brief period of titration of medications, has also affected occupational therapy. Thus, external forces have limited the scope of our practice, and, so far, we have failed to overcome them.

The Community Mental Health Act of 1963 (Schulberg & Killilea, 1982) and the subsequent deinstitutionalization of patients with mental illness promised a new approach, providing resources for persons with mental illness in their own communities. In this context, many therapists over the years have developed innovative community programs; however, the majority of therapists have remained hospital-based in inpatient or partial hospitalization programs. Meanwhile, in community mental health centers, the employment of occupational therapists dropped from 2.4% in 1982 to 1.1% in 1990 (AOTA, 1991).

In long-term settings such as state hospitals and Veterans Administration centers, the patient population continues to dwindle as elderly patients die and the young persons with mental illness who might have replaced them in the past now remain in the community (Fine, 1986). While these public institutions compete for tax dollars, occupational therapists must compete with other activity disciplines for opportunities to serve within them. Employment of occupational therapists in psychiatric hospitals decreased from 7.4% in 1982 to 4.6% in 1990 (AOTA, 1991). These figures refer to both public and private psychiatric hospitals; the proliferation of for-profit psychiatric centers began in 1982, so it is apparent that occupational therapists are losing out in the public sector as well.

Alternatives to the Medical Model

Clearly, occupational therapists have been open to nonmedical models. (A model, as the term is used here, refers to a concept of practice that drives a particular mode of service provision. The Model of Human Occupation [Kielhofner, 1985] is not a model in this sense. Although the Model of Human Occupation is not a medical frame of reference, it is, at present, most often applied within the medical framework of hospital or institutional settings.) An example of a nonmedical model is the educational model, within which pediatric occupational therapists have established a well-developed role. Currently, 18.6% of occupational therapists work in school systems (AOTA, 1991). Allen (1990) advocated another example, a Consequences Model. In her theory, Allen acknowledged the medical etiology of cognitive disabilities and the effec-
tiveness of medical treatment in acute conditions, but conceptualized residual cognitive disabilities within a nonmedical consequences model, which defines ways of adjusting to permanent losses of function (Allen, 1990). Still another model, the social model, offers a promising alternative to a hospital-based medical approach for mental health occupational therapists.

A Social Model: Psychosocial Rehabilitation

The social model looks for causal factors, such as social relationships, environmental barriers, and societal stressors (including discrimination and poverty) that may contribute to a person’s dysfunction. Change occurs through supportive social relationships and social advocacy (Albee, 1986). Psychosocial rehabilitation combines this model with the rehabilitation model, which is familiar to occupational therapists. However, occupational therapists in both physical disabilities and psychosocial settings have tended to remain closer to the hospital where treatment began than to the community where rehabilitation can be tested. It might be useful to conceive of a continuum that begins with medical treatment, is followed by various phases of rehabilitation, and culminates in a social model that supports optimum functioning in a community setting. It is the “social” in psychosocial rehabilitation that springs rehabilitation from its medical ties.

Psychosocial rehabilitation is a community-based mode of service provision that has been developing for almost 40 years. It began with Horizon House in Philadelphia, which was founded in 1953 as an ex-patients’ club. When Congress passed the Alcohol Abuse, Drug Abuse, and Mental Health Amendments of 1984 (Public Law 98–509), it included a provision permitting and encouraging community mental health centers that receive federal block grant funds to provide community-based psychosocial rehabilitation services as one of five required services (Stockdill, 1985). Soon after, the International Association of Psychosocial Rehabilitation Services (IAPRSRS) adopted the following definition of psychosocial rehabilitation:

Psychosocial rehabilitation provides for the mentally ill to provide experiences which improve ability to function in the community. The philosophy emphasizes personal sense, practical needs and usually includes vocational and personal adjustment services geared toward the prevention of unnecessary hospitalization. The psychosocial rehabilitation setting is purposefully informal to reduce the psychological distance between staff and members as active participants in program planning. Members are continually encouraged to assume productive citizenship roles both within the psychosocial rehabilitation facilities and in the broader community which is viewed as an integral part of the total psychosocial rehabilitation setting. (IAPRSRS, 1985, p. 1)

Psychosocial rehabilitation agencies offer at least two of the following four services: (a) social/recreational, (b) vocational, (c) residential, and (d) educational (IAPRSRS, 1985). Occupational therapists will find the first two areas especially familiar. Social/recreational services encompass group experiences that foster basic social skills, such as conversation, hobbies, personal grooming, cooking, and physical exercise. Interpersonal skills relating to positive self-image and caring for others are also developed, as are symptom-reducing and problem-solving skills, such as taking medications on a regular basis, stress management, and coping skills. Vocational rehabilitation includes prevocational work activity designed to develop such skills as following instructions, taking initiative, being punctual, and maintaining concentration (IAPRSRS, 1985).

Currently, social workers are the dominant professionals in psychosocial rehabilitation—not surprising in a social model of service provision. Wintersteen (1986) contended that “social work is the only, or the most important, profession that deals with the long term—mentally ill . . . the conceptual framework and nearly a century of experience in helping clients with the complexities of social interaction give social work a track record that places it in an optimal position to provide leadership in this developing field” (p. 332). In the article, Wintersteen also promoted a rehabilitation model for social workers.

I would argue that occupational therapists, already familiar with a rehabilitation model, need only to adopt a social perspective in order to make an equal contribution. Yet occupational therapists are rarely recruited by psychosocial rehabilitation agencies, and very few may be found working there. In a national survey of such agencies, Newman (1991) found that only 11% of the 212 reporting agencies employed at least one occupational therapist, whereas 71% employed at least one social worker. Of a total of 3,952 workers, only 24 (0.6%) were occupational therapists (this number includes 7 certified occupational therapy assistants), whereas almost 21% of the total were social workers (Newman, 1991).

Most psychosocial rehabilitation workers (approximately 48%) are paraprofessionals (Newman, 1991). Of the 1,885 paraprofessionals surveyed, 59% were undergraduates, 40% had baccalaureate degrees, and 1% had graduate degrees (Newman, 1991). Within the field there is the perception that specific training of psychosocial rehabilitation workers is needed, whether in preservice graduate curricula or in postemployment in-service training (Parks, 1988). That the potential for ready-made psychosocial rehabilitation specialists may be found in the holistic training of occupational therapists and occupational therapy assistants appears to be a well-kept secret.

Without naming psychosocial rehabilitation per se, a number of recent articles have urged occupational therapists in mental health to look to the community for new opportunities (Adams, 1990; Bonder, 1987; Ethridge, 1986; McConchie, 1989). Others have described occupational therapists working in community-based programs (Raffaele, 1990; Ruben, 1990; Silverman & Gusich, 1990; Teske, 1986). Identification of occupational therapy with psychosocial rehabilitation may provide a means to revive our participation in the mental health field.

To achieve full participation in psychosocial rehabilitation, we must embrace a social model as a mode of occupational therapy service provision. We should seek ways to incorporate a social model into occupational therapy practice and into occupational therapy education at all levels, including continuing education. Although there may be few parallels, it might be instructive to study the development of pediatric occupational therapy’s participation in the educational model.

A second crucial step is to delineate clearly and then communicate the aspects of occupational therapy expertise that could be especially useful in psychosocial rehabilitation. Listed below are three of these:
1. **Emphasis on functional outcomes**. Function in the community is the ultimate goal of psychosocial rehabilitation. In both practice and communication, by keeping a focus on functional outcomes as defined by Uniform Terminology (AOTA, 1989) we can clarify our and others' perceptions of our role. (see Dunn & McGourty, 1989)

2. **A developmental perspective**. Other disciplines recognize the importance of age, interests, and experience when matching people and tasks and when structuring groups. Occupational therapists not only do this, but also uniquely apply their knowledge of the sequential, hierarchical, and interdependent nature of the sensorimotor, cognitive, and psychosocial aspects of skill development.

3. **Activity analysis**. Occupational therapists look at task elements, environmental factors, and the required performance components when matching a person to a task or when making environmental adaptations to ensure successful outcomes.

**Summary and Conclusion**

Although the number of occupational therapists working in mental health has dwindled, the number of people who need our services has not. In our tendency to cling to a medical model of service provision, we have allowed the scope and content of our services to be limited to what has been supported within this model. A social model that stresses functional adaptation within the community, exemplified in psychosocial rehabilitation, offers a promising alternative. A strongly proactive stance is needed if occupational therapists are to participate fully. Occupational therapy can survive without mental health specialists, but a large and deserving population could ultimately be deprived of a valuable service.

**References**


**Related Reading**


---

*The American Journal of Occupational Therapy*