LETTERS TO THE EDITOR

OTRs in Community Mental Health—An Endangered Species?

The figures for occupational therapy personnel employed in community mental health centers from 1977 to 1986 quoted in AOTA's Ad Hoc Commission's report Occupational Therapy Manpower: A Plan for Progress (AOTA, 1985) and clarified in a Letter to the Editor by Silvergleit (1987) are thought-provoking in relation to our own articles on related topics (Neeman & Neeman, 1983, 1987). We learn that, while the total population of OTRs plus COTAs employed in community mental health centers did not change during this decade and stood at around 700, the percentage of OTRs decreased steadily to a low of a mere 1.6% of total mental health personnel in 1986 from 4.3% 10 years earlier. In other words, the OTRs in this habitat were an "endangered species" in 1977, but will be extinct unless this manpower trend is reversed, and reversed before it is too late. This also affects the COTAs in community mental health, because OTRs are needed at least in their role as consultants to the COTAs; in the absence of OTRs, COTAs will presumably have to continue working under supervising professionals other than occupational therapists, which is less than ideal.

If OTRs in community mental health institutions are to be saved, this manpower demography must be reversed; but that requires a knowledge of the cause-effect determinants for their endangered status. Is it the developing occupational therapy manpower shortage drains OTRs from these institutions, and if so, what makes them noncompetitive? Is it a matter of supply and demand of professionals, or is it "technological obsolescence," i.e., displacement of the highly skilled and compassionate therapists, who continue the early tradition of "moral treatment" by seeking help from the seemingly more cost-effective psychopharmacologist? As a professional in a field related to the latter, I can see that this notion has internal validity, but as a devoted OT spouse, I hate to think so! I am curious about the causes of the OTRs' decelerating trend line in community mental health.

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References

Entry Level Education Inadequate for Practice in Pediatrics

As clinicians involved in student supervision, staff development, and occupational therapy education, we are alarmed at the number of graduates who are applying for jobs in pediatric facilities without affiliations or with minimal training in this area. We feel quite strongly that the minimal course requirement (usually one semester) given by most BS and basic MA programs in child development and specifically pediatric treatment/pathology is not sufficient to enable beginning therapists to function optimally and independently in a pediatric setting. By not requiring an affiliation in pediatrics, we are fostering the assumption that pediatrics does not have a body of knowledge, skills, and personal and professional issues specific to it. Furthermore, these students feel they can be trained on the job. Consequently, these graduating students require an unofficial period of affiliation in evaluation, reporting, validating observations, etc., while they are being paid to function at a higher level. This puts quite a burden on a staff expecting the supervision requirements for a beginning therapist and not an "affiliating student."

In dealing with other professionals, these inexperienced therapists are often not able to articulate their findings and treatment approaches with confidence or clarity, and they are seen as being less competent than other beginning personnel. They often require extensive supervision (which may not be available) to validate and build self-confidence in their skills.

Often these graduates take high-paying per diem positions in school systems and preschool programs without being directly supervised or with minimal supervision and peer contact. We feel that monthly supervision consisting of review of paperwork and possibly treatment plans is insufficient quality control.

Likewise, courses in specific treatment techniques do not substitute for adequate, personal, and direct supervision. These programs and other facilities hire these untrained
Therapists with the assumption that they are knowledgeable in the treatment of this population, they are often limited to hiring graduates with their experience to fill their funding requirements.

As an educator and a former academic educator, we recognize the difficulties of teaching a clinical profession in an academic setting. It is imperative that we require students wishing to treat a specific population to gain clinical experience in this area before they can be hired. It appears irresponsible to allow a student with one course in pediatrics and without awareness of the depth of skill he or she is lacking to treat a child with disabilities. Parents would have no way of knowing that the therapist treating their children had no hands-on experience and only limited supervisory experience. If occupational therapy standards for areas like pediatrics decline, the quality of our profession will be directly affected as well as the opinion of other professionals toward us whose standards of educational requirements are higher.

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Therapists in Mental Health Need to Become More Visible

In response to Bette Bonder’s article, “Occupational Therapy in Mental Health: Crisis or Opportunity?” which appeared in the August 1987 issue of the journal (pp. 495-499), we take exception to the strategy that advocates relinquishing the mental health area of practice that was most stressed by AOTA in its formative years and that remains a primary area of concern.

The mental health field is plagued by misunderstanding, the chronicity of the illnesses dealt with, the inability of patients to pay for treatment, and low salaries for mental health professionals which are compounded by inadequate government support and insurance coverage.

The plan to reduce beds in state hospitals has shifted the emphasis from treatment in large centralized residential state-funded institutions to smaller, diverse, locally funded centers with housing dispersed about the community. As patients left the large state hospitals to connect with community mental health systems, positions ideally suited for occupational therapists were filled by others with less training who were willing to accept the responsibility for developing new programs for less pay. Potential positions for occupational therapists were lost. It is now up to us to regain those positions and upgrade them to our professional standards.

Most of the general public has no idea what occupational therapy is, and the situation is only slightly better within the medical professions. Among occupational therapists there is animosity between those working with physical disabilities and those working in mental health that dates back to the 1960s when the use of crafts as a treatment medium came to be considered almost an act of heresy because some felt their use damaged the image of the profession.

Steps toward solutions of the problems are as follows:

1. A united stand within the profession about treatment approaches.
2. Increased research into and public education of benefits of occupational therapy in mental health.
3. Education of medical professionals at all levels from the local hospitals to the American Medical Association.
4. Education of the general public to make occupational therapy a household expression.
5. Education of legislators about occupational therapy and its benefits and importance in mental health.

6. Familiarizing high school students with occupational therapy and the career opportunities it offers.
7. Advocating publicly the career opportunities in occupational therapy.
8. Opening new areas of private practice.

If there is sufficient demand from the legislators, insurance companies will respond positively.

Mental health therapists basically need to do what occupational therapists did when they first entered the public schools: educate and work. Through perseverance these therapists have become a viable force in the public school systems. Occupational therapists and occupational therapy assistants in the mental health field need to follow their inspiring example.

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Author’s Response

I hope I did not leave readers with the impression that I support the option of eliminating occupational therapy in mental health. This elimination is, however, a possibility that has been discussed within the profession and that may, as the writers note, occur naturally if nothing is done to prevent it.

The writers have accurately identified some important actions that must be taken to strengthen the field. I hope that therapists like them will go further by determining the steps that must be taken to accomplish these broad goals, and will then act on these plans.

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