Mental Health: An Endangered Occupational Therapy Specialty?

Many writers have made us aware of the critical decline in occupational therapy practitioners specializing in mental health practice (Cottrell, 1990; Friedland & Renwick, 1993). Before World War II, the majority of occupational therapists and therapy assistants practiced in mental health, but by 1990, the percentage decreased to 11.8% (American Occupational Therapy Association [AOTA], 1991). Several factors may have contributed to this decline, such as low pay (Wittman & Gibson, 1990), ambiguity of the occupational therapist's role in mental health (Ebb & Haiman, 1987), lack of research concerning the practice of psychosocial occupational therapy (Bonder, 1987), and limited work opportunities outside conventional mental health settings, such as home care and contract work (McFadden, 1987). Negative experiences also may have contributed to the decline. Two studies found that because of poor psychosocial Level II fieldwork experiences, less than 20% of occupational therapy students were likely to choose mental health practice (Atwater & Davis, 1990; Christie, Joyce, & Moeller, 1985).

However, the biggest hindrance to the growth of mental health occupational therapy may be the stigma of mental illness. The public generally believes that prognosis are poor for psychiatric diagnoses and that persons with psychiatric problems are somewhat inferior in their competence (Hargrove, Fox, & Goldman, 1991).

Role Blurring

The AOTA Mental Health Task Force identified role blurring as a negative factor influencing mental health practice (AOTA, 1982). Additionally, role blurring has been frequently identified by researchers as a major factor that negatively influences student practice preferences in fields related to mental health.

Role blurring is not new to occupational therapists. In mental health practice, role blurring occurs when activity therapists and recreation therapists duplicate traditional occupational therapy activities. Although we may use similar treatment modalities, the philosophical assumptions, professional values, and beliefs of occupational therapy are unique and cannot be replaced by any other discipline. Treatment methods unique to occupational therapy include task-oriented and developmental groups. Research has proven the usefulness of occupational therapy intervention in conjunction with psychotherapy in treating various psychiatric disorders (Higdon, 1990).

Additionally, role blurring is not unique to mental health practice. In physical disabilities practice, role blurring occurs when physical therapists also work on positioning, bed mobility, transfers, and use of neurodevelopmental techniques. In school-based practice, special education teachers and speech pathologists often work on the same special physical and cognitive-perceptual needs as do occupational therapists.

Role blurring occurs as specialty areas develop within professions. Enhancing the functional level of clients in their immediate environment is the ultimate goal of all members of the mental health rehabilitation team. From a team perspective, the occupational therapist's contribution specifically addresses the client's occupational performance as well as the client's environment that supports his or her performance. Our focus is on helping...
clients to achieve optimum function in their daily living skills (i.e., self-care, work, and leisure). This unique domain of concern means that occupational therapy personnel and their services cannot be replaced easily by social workers or recreation therapists. By not employing occupational therapists, mental health rehabilitation agencies deny clients an effective, scientifically proven, and valuable service.

Steps Toward a Possible Solution

Various solutions to increasing the number of mental health occupational therapists have been recommended. These solutions include:

- Involving experienced mental health occupational therapists in recruitment (Ebb & Haiman, 1990)
- Exposing students to good mental health role models (Scott, 1990)
- Recruiting students who have expressed a preference for mental health practice (Swinehart & Feinberg, 1990)
- Providing support groups for occupational therapists practicing in mental health (Burnett-Beaulieu, 1982)
- Lobbying for support for mental health occupational therapy services, including reimbursement (Friedland & Renwick, 1993; Johnson, 1983)
- Creating more occupational therapy schools
- Increasing faculty members’ salaries and creating new roles, such as teaching functional skills for living in the community (Price, 1993).

In addition to these solutions, I suggest that the steps outlined in the following sections be considered.

Efficacy Studies

Of the number of efficacy studies done in occupational therapy, those on mental health are relatively few (Gibson, 1984). More efficacy studies could enhance inclusion of occupational therapy mental health practice in health care reform proposals. We need studies on the effect of specific occupational therapy intervention techniques in the treatment of various psychiatric disabilities, such as schizophrenia and multiple personality disorder (Suto & Frank, 1994; Waid, 1993). We also need studies on geropsychiatry (Sholle-Martin & Alessi, 1990) and child psychiatry (Trace & Howell, 1991). Such research efforts will not go unnoticed by the legislators, mental health community, and the general public.

Influencing Occupational Therapy Students

Providing occupational therapy students with excellent fieldwork experience can serve as a strong motivator for their choosing the mental health specialty. Studies by Wittman and colleagues (1989) and Cusick, Demartia, and Doyle (1993) found that fieldwork was a major factor influencing students’ specialty choice. Studies by Mitchell and Kampfe (1990, 1993) on coping strategies used by fieldwork students stress the collective role of clinical supervisors, academic fieldwork coordinators, curriculum directors, and faculty members in helping fieldwork students become excellent practitioners. Mental health clinical supervisors can assist fieldwork students by being supportive and acknowledging students’ difficulties, stresses, and fears. Clinical supervisors in other practice areas should use language that conveys mutual respect for the various areas of occupational therapy practice, and they should not discourage students from pursuing mental health fieldwork or practice. Instead, the supervisor needs to respect a student’s interest while stressing the importance of meeting all the clinical criteria necessary to become a therapist.

Factors that influence practice preferences are not easily understood. Research focused on admission criteria to occupational therapy educational programs may help clarify these factors. For example, a study by Swinehart and Feinberg (1990) examined the relationship of the admission criteria of one occupational therapy program to practice preferences at the time of application and revealed no existing biases relative to future practice choice among accepted, alternate, and rejected groups of applicants. However, recalculation of the admission criteria revealed that if admission were based solely on grade point average, more applicants preferring psychiatric practice would have been accepted into the program. Further studies are warranted to gain more understanding about various factors that influence practice preferences. For example, one might study whether students with a more positive attitude toward persons with psychiatric disabilities are more likely to prefer mental health practice to physical disabilities practice upon completion of their studies. Also, one might examine the impact of student learning styles and personality traits on practice preferences.

Mandatory Mental Health Fieldwork

Several occupational therapy educational programs do not require mental health fieldwork. This sends a message that mental health practice is not important. The areas of mental health and psychosocial dysfunction play an important role in the continuing development of the occupational therapy profession, just as they did in the early days of our profession. It is our duty, therefore, to maintain respect and provide continuing support to mental health practitioners. Lack of nearby mental health fieldwork placement sites or shortage of mental health occupational therapy supervisors are not genuine reasons to abandon mental health fieldwork. Some educational programs are providing mental health placements for their students by using a progressive fieldwork model. For example, the New York University fieldwork team is developing such a model, with equal cooperation from area organizations, occupational therapists, and other occupational therapy schools (McCready, 1994), by using nontraditional fieldwork sites such as a city-funded shelter for formerly homeless geriatric clients with psychiatric conditions. In this model, students are carefully matched to placement sites. Even if
Mental health fieldwork sites are not located near an educational program, occupational therapy students can be told in advance of the requirement so that they can plan for travel and finances. Fieldwork coordinators can develop potential fieldwork openings by establishing active contacts and progressive programs with various mental health facilities.

I believe that mental health fieldwork should be mandatory in all occupational therapy educational programs. Providing holistic treatment to all our clients means attending to their psychosocial well-being as well as their physical needs. Mental health fieldwork can help prepare a student for this task.

Mental Health Priority at AOTA

AOTA is striving to increase the number of occupational therapists working in mental health, but we, the therapists, must make it happen. Committed effort by AOTA's Mental Health Task Force and the Mental Health Special Interest Section Standing Committee to investigate every possible reason for why fewer occupational therapists and therapy assistants choosing mental health would serve to enhance awareness in occupational therapy practitioners not working in mental health.

Personal Commitment

Although our national organization is making great efforts to improve the mental health crisis, we occupational therapists must think and act as one to provide solutions. Some steps we can take individually include rereading our history, respecting our peers in different specialty areas because we are equal and not a hierarchy, eliminating unfounded remarks (especially in front of students and mental health colleagues), reminding ourselves about the inseparability between sensorimotor and psychosocial components of the occupational performance domain, thinking globally in terms of improving the respect for our profession, and acting locally by collaborating with each other to bring up the morale of the mental health specialty area.

Conclusion

Occupational therapy practitioners are unique among the rehabilitation professionals in using holistic approaches in treating clients, and we must continue to show this in our theory and practice. In my experience in non-mental health practice, I have encountered some therapists who easily forgot the psychosocial components while focusing only on the sensorimotor components. In my opinion, this is wrong and unfortunate. Occupational therapists must treat clients holistically, not just the discrete physical disability that reimbursement sources may require. Clients and their physical, psychosocial, and cognitive needs are intricately and inseparably related. Instead of dichotomizing occupational therapy practice, we need to integrate physical, psychosocial, and environmental components during evaluation and treatment of clients (Friedland & Renwick, 1993).

Comprehensive evaluation and treatment cover all areas of occupational performance. For example, treatment of clients with AIDS (acquired immune deficiency syndrome) includes the physical manifestations of their illness as well as their cognitive, psychosocial, and environmental needs. As the issue of quality of life and the incorporation of prevention and health promotion models are emphasized in today's health care, the role of mental health occupational therapy becomes imperative.

There are factors beyond our control that contribute to the decline of mental health occupational therapy, such as deinstitutionalization and the comprehensive focus on an organic basis for disease. However, lack of involvement by occupational therapists not practicing in mental health in influencing policy is a factor that we can change. We need to respect our mental health colleagues and support them in their efforts to gain respect from the mental health community. We can show our support by acknowledging and treating our clients physical and psychosocial needs.

Occupational therapy may survive if we neglect mental health practice but at the expense of a valuable service to a large and ever-increasing population of persons with psychiatric conditions (Kleinman, 1992). We must give more emphasis to psychosocial rehabilitation of clients if we want to retain mental health therapists. Occupational therapy curricula also must give more importance to the psychosocial rehabilitation model and biopsychosocial frames of reference (AOTA, 1982; Bailey, 1990).

By these arguments I am not ignoring the realities facing mental health occupational therapy practice, including the proliferation of for-profit psychiatric centers, the pressures for delivering strictly reimbursable services in psychiatry, and the effects of national health care reform. External factors may limit the scope of mental health practice, but a conscious effort to reestablish a strong mental health occupational therapy practice is necessary for the future of our profession.
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