Occupational Therapy in Mental Health: Crisis or Opportunity?

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For at least a decade, concern has been expressed about the status of occupational therapy in mental health. Increases in the number of new jobs and clinicians have not kept pace with growth in other practice areas. Although growing criticism of the practice of deinstitutionalization and an increased focus on cost-effectiveness have recently become major public policy trends in mental health practice, the psychological and nursing professions have responded creatively in order to expand their influence and practice. This paper relates changes in the delivery of mental health services to the systematic study of policy development and careful planning needed to help occupational therapy accomplish the same goals.

Over the past 10 years, concern has been growing about the fate of occupational therapy in mental health. In 1975, Ethridge (1976) noted that the profession would be forced to change as public policy in mental health changed. In 1976, an American Occupational Therapy Association task force on mental health reported serious problems in that sphere of practice ("Report," 1976). The task force noted that the number of occupational therapy personnel in mental health was on the decline at a time when the rest of the profession was growing. Thus, some professionals speculated that occupational therapy in mental health would disappear entirely as a result of unclear role delineations, increased competition from other professionals for decreasing funding, and changes in the health care system.

An initial review of data describing occupational therapy practice in mental health appears to support these concerns. A survey conducted in 1984 by the AOTA Division of Continuing Education found that few occupational therapists in mental health were employed outside of inpatient facilities and that only 36.1% of the respondents reported being reimbursed by third-party payers for their services. The 1985 report of the AOTA Commission on Manpower showed that, while overall employment of occupational therapists increased by more than 75% between 1977 and 1982, the number of occupational therapists in community mental health centers was reduced by half. Similarly, while occupational therapists reported increases in other areas of patient treatment, their involvement with patients with psychosis or neurosis dropped dramatically.

These figures suggest that occupational therapy in mental health has not kept pace with other areas of practice, and to some, these findings indicate a change of crisis proportions. Concern has been expressed about the viability of occupational therapy in mental health, and one strategy advocates giving up this practice area entirely. Less extreme recommendations include a change in function from direct treatment to assessment or consultation only. The 1984 Strategic Integrated Management System of the AOTA ranked "Changes in the Mental Health and Service Delivery System" as fifth in importance to the profession out of 11 items. In fact, the current situation may not be a crisis but a continuation of the change Ethridge (1976) discussed. He noted that legal and administrative issues were becoming increasingly important in the delivery of mental health services and that the focus of service delivery was moving from the institution to the community. As early as 1975, Ethridge called for both improved research and education in occupational therapy along with innovations in practice to keep up with changes in programming.
Change has been rapid in all areas of health care, and mental health has not been immune. However, these changes may actually represent an opportunity for the expansion and improvement of occupational therapy services in mental health. By exploring that possibility, first examining how policy is made in mental health and then how other professions have responded to the upheavals in health care, methods by which occupational therapy might make the most of emerging trends may be discovered.

Public Policy and Mental Health

Changes in policy in mental health management in the 1960s and 1970s are well documented (Mollica, 1983). The 1963 Community Mental Health Act brought about a dramatic shift in care focus; large numbers of patients were discharged from state hospitals, presumably to receive care in community-based facilities. This law was passed during a time period characterized by both idealism and belief in the unlimited potential of the United States. Deinstitutionalization seemed a humane and caring policy to mental health workers and lawmakers. It was thought that community living would be more pleasant and less restrictive to the individual. Shadish (1984) noted that "policies are implemented to the extent that they are consistent with extant social structures and ideologies" (p. 725). Thus, it may be said that deinstitutionalization was a logical outgrowth of the times.

However, while political administrations may create new policies, their continuation on a long-term basis is tenuous (Fairweather, Sanders, & Tornatzky, 1974). Although there is some evidence that noninstitutionalization is effective when individuals have adequate community support (Kiesler, 1982), the rigorous investigation of the outcomes of treatment approaches and policy decisions is relatively new to the whole mental health field (Banta & Saxe, 1983). Even if they had chosen to use it, politicians during the height of the community mental health era frequently did not have access to data on which to base decisions regarding program development. Instead, they judged the effectiveness of programs on the basis of a poorly defined concept of access (Mollica, 1983). The nature of the programs to which patients actually had access was of little importance.

Shadish (1984) suggested that most policy is the result of interacting factors related to special interest group concerns in a particular area. He described a situation where a half-way house designed for discharged state hospital patients was ignored in favor of a nearby nursing home. Shadish suggested that this change was the result of strain between professionals, who needed to maintain their status; the community, which wanted to avoid the stigma of having a mental health facility in their area; and the government, which needed to reduce costs. The patients themselves, who had the least power, were given the least consideration in this decision. Shadish indicated that the patients' welfare is frequently considered least important in policy decisions and noted that "advocating therapy in policy simply because it is effective, or even cost-effective, ignores the complexity of policy implementation" (p. 731).

Public policy is not static (Pardes, 1983). Changes may reflect new economic conditions, emerging social values, or political considerations. Careful attention to political rhetoric often provides clues about shifts in policy. The current disapproval of the community mental health movement was foreshadowed by statements made during the Nixon administration (1968-1974), and became more clearly evident during the Carter administration (1976-1980) (McGinnis, 1985).

Current trends in policy reflect some of the failures of deinstitutionalization (O’Connor, 1983). Considerable attention has been given to the plight of the street people, and to the dramatic increases of mentally ill residents in nursing homes. The move to nursing homes is one of many shifts in the locus of service provision (Mills & Cummins, 1982) and by itself is thought to reflect the inadequacy of the deinstitutionalization policy.

Another shift in location of service is evident in the growth of employee assistance programs, in which industry offers on-site care to its employees (VandenBos, 1983). This shift suggests a change in health care values from tertiary care to prevention, holistic health, and early intervention (McGinnis, 1985).

At the same time, there are pressures for the continuation of existing institutions. New functions are emerging for state mental hospitals (Goldman, Taube, Regier, & Witkin, 1983) and partial hospitals (Klar, Frances, & Clarkin, 1982). Special populations, including alcoholics and patients hospitalized against their will, have been targeted for state hospitals. Simultaneously, outpatient services are expanding, and partial hospitals are becoming more specialized.

Public policy related to mental health is still in flux and lacks the clarity of philosophy evident during the community mental health era. The most obvious trend, however, is toward cost containment (Freytman, 1985). The control of government funding is shifting from the federal level to the state and local level, increasing the diversity of service provided (Andviks & Mazade, 1983). Both government and private insurers continue to increase funding for outpatient care but not for inpatient care, because inpatient care is far more expensive (DeLeon, Pallak, & Heffernan, 1982). Research money is decreasing and areas being
funded have become more narrowly defined, thus creating increased competition among providers of care for available funding (Andrulis & Mazade, 1983).

A further problem in current policy planning relates to the dearth of information about the efficacy of treatment. Accountability has become a key word in the 1980s, and professionals are hard pressed to demonstrate the efficacy of their treatments (Klerman, 1983).

Mollica (1983) summarized the situation thus:

As political reforms were translated into political action, political solutions replaced clinical definitions of treatment and outcome lack of clinical criteria for the evaluation of public programs is now plaguing states that are beleaguered by serious financial constraints and public skepticism about the way government dollars are spent. (p. 371)

Effects of Policy Change on Mental Health Professionals

As mental health policy undergoes rapid and dramatic change, professionals are confronted with several different and occasionally conflicting pressures. One pressure often felt is the need for self-preservation. Each profession wishes to survive and, if possible, to prosper. At the same time, professionals are concerned about the individuals they serve and about the communities of which they are members.

Nursing has responded to these pressures through concerted research, public relations, and lobbying efforts (Fisher, 1985). These activities have brought positive results from the perspective of the nursing profession, as the government is now considering funding a special institute for nursing research.

Psychology is another field that has grappled with conflicting pressures created by changing policies. Much of what has been said about the status of psychologists sounds familiar: "Psychologists have not been systematically involved throughout the various stages of the political process until most recently" (DeLeon, VandenBos, & Kraut, 1984, p. 933); "You cannot achieve major goals by just reacting in crisis situations" (Dorken, 1983, p. 1211). "For whatever reasons, the cadre of psychotherapy researchers has been relatively small in psychotherapy, psychiatry, and related fields, and the volume of research inadequate" (Klerman, 1983, p. 934); "Psychologists and other nonphysicians often bemoan what they consider second class status at hospitals" (Mikel, 1982, p. 1350). In recent years, psychologists have fought fiercely for recognition and third-party reimbursement, and the battle over licensure has been an ongoing struggle (Kilburg & Ginsberg, 1983).

The psychological profession's reaction to these concerns, which so closely resemble those of occupational therapy, has been to take a proactive stance through research and lobbying efforts (Dorken, 1983). This is reflected in specific actions taken by the American Psychological Association (APA) and its affiliated groups, which include state associations.

One example of lobbying efforts concerned the "sunset crisis" (Kilburg & Ginsberg, 1983). Many states require periodic review of licensure for various professions and then abolish those licensure laws thought to be ineffective in protecting the public. Several state legislatures began to consider discontinuing the practice of licensing psychologists (Kilburg & Ginsberg, 1983). In Florida, the psychology licensure law was allowed to lapse. APA and the state psychology associations immediately raised funds from their membership to fight for retention of licensure. This action resulted in the strengthening of current laws, and in no other state did psychology lose its licensure.

A second example of the APA proactive stance is the drive by psychologists to obtain hospital privileges (Bersoff, 1983; Tanney, 1983). Psychologists argue that their services would be cost-effective because they would increase competition and challenge the medical monopoly on hospital practice (McGuire & Frisman, 1983). These arguments are succeeding in several states.

Furthermore, psychologists are exploring new areas of practice (Mills & Cummins, 1982; Pion & Lipsey, 1984). As traditional academic and hospital positions decrease and cost containment and other trends change the nature of practice, psychologists are moving into business and industry and community organizations and assume policy-making positions. In addition, lobbying efforts by APA have increased (DeLeon, VandenBos, & Kraut, 1984) and a push for efficacy studies has been intensified (Klerman, 1983). Finally, psychologists have taken an active and occasionally adversarial role in dealing with policies of third-party payers, resulting in sometimes caustic, but productive, court battles (Resnick, 1985). In the final analysis, what has been achieved in the fields of nursing and psychology may prove instructive for occupational therapists who practice in mental health.

Implications for Occupational Therapy

Occupational therapy literature demonstrates a recognition of the numerous changes in society and in health care delivery and discusses the need to plan systematically for those changes (Gilfoyle, 1984; VANDAMM, 1981). However, this literature is not consistent in predicting the effect of these changes on occupational therapy practice. Some authors predict that new practice areas will develop, particularly in mental health (Diasio, 1980), while others express concern about the profession's future as a whole (VANDAMM, 1981).

What the literature does not specify are ways to adapt to the emerging trends in mental health. The
American Occupational Therapy Association (AOTA) has made some inroads towards coping with current trends, in part by recognizing them as an area of focus in its strategic plan. At this point, however, AOTA's activity has been predominantly reactive, or, when it has been proactive, the efforts have been fragmented. The recent mental health symposium ("Mental Health," 1984) and the resultant research proposals are among the most important efforts of the Association and the Foundation, but specific, coordinated, and sustained action is required to adequately address existing problems.

The first step is to obtain accurate information regarding the current situation. The AOTA Manpower Report (AOTA, 1985) suggested that occupational therapy in mental health is holding its own or declining in a period of growth for the rest of the field. The data are unclear, however, because the survey instrument did not reflect changes already in motion. It is possible that mental health therapists have already begun to move into new areas of practice, such as home health, private practice, or other types of facilities.

In mental health practice as a whole, current personnel changes are difficult to assess. Deinstitutionalization has not had the desired effect. Community mental health agencies are being criticized, and the entire mental health system is in flux. Not only must occupational therapists understand their own situation accurately, they must also carefully monitor emerging trends. This means a careful review is required of new legislation at the federal, state, and local levels; occupational therapists must then attend and testify at legislative hearings, and they must actively lobby for the interests of both clients and the profession.

In other words, occupational therapists must not only become aware of trends, but also make a concerted effort to influence policy. This requires an understanding of the process by which policy is developed and calls for a plan for intervention. Wilkinson (1983) recommended that "to achieve a political objective, the problems that interfere with its attainment must be clearly delineated, goals established, strategies chosen, and a time set for the beginning of the 'movement'" (p. 876).

Banta and Saxe (1983) noted that policy is generally made on the basis of the best available evidence. Thus, good research and efficacy information is vitally important. In planning research, the interests of federal agencies should be noted. In 1984, for example, the National Institutes for Mental Health funded research on cognition, personality (particularly, correlates of personal competence and control of antisocial behavior), family issues, and the processes of emotional and social development (Silver & Segal, 1984). All of these are areas in which occupational therapists have interest and expertise. An involvement in research in these areas both responds to government priorities and increases the profession's visibility. Thus, research is an important component of a plan for change.

Marcos and Gil (1983) recommended force field analysis as a means to plan for change. Force field analysis is a method of exploring factors that have a negative and positive influence and developing methods for maximizing the latter while minimizing the former. Some of the possible restraining forces of occupational therapy in mental health are a lack of qualified practitioners, an absence of data to support claims of efficacy, and, perhaps, a lack of professional self-confidence. Enabling forces include a theory base that for years has espoused the now-popular trends toward holism and concern for function (Fidler, 1981; Rogers, 1982; West, 1984); a professional association that has begun to respond to current events by encouraging research and efficacy studies, through lobbying efforts, and by augmenting strategic planning; and a well-educated, concerned group of practitioners.

As with most changes, however, there are choices to be made. Is occupational therapy in mental health in the midst of an insoluble crisis, or can therapists follow psychologists' example and use this occasion to expand their realm of influence? Can changes in practice be developed in a positive direction, or will occupational therapy in mental health disappear? Can mental health occupational therapists move into new areas of practice, such as employee assistance programs, boarding homes, and community centers, or will they remain bound to the existing arenas of inpatient practice?

Change inevitably brings uncertainty, but it may also bring opportunity. Duhl (1982) noted that mental health practice is caught between the old vision of society and an emerging vision of a new and "better" society, in which technology brings us closer to an understanding of human function but, at the same time, is less tolerant of deviation from the norm. As he pointed out, "mental health practitioners can influence the new paradigms that emerge by the ways they choose to work with their patients and in their communities. Thus, through our visions, we can create the future" (p. 693).

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