Mental health reform in the western developed world has resulted in new models of care and changed work practices for all mental health professionals. Occupational therapists, as with other mental health professionals, have been required to assume new roles and responsibilities. Literature from the United Kingdom has reflected concern about this new way of working. The aim of this exploratory study was to examine the current work practices of and issues faced by Australian mental health occupational therapists. One hundred and forty-eight respondents (74%) answered an occupational therapy practice in mental health questionnaire.

The results from this survey suggest that there are two quite distinct groups of occupational therapists working in mental health settings in Australia. One group works as rehabilitation therapists in traditional activity-focused work roles. The other group works as case manager therapists and employs a much broader spectrum of clinical and support roles. The issues facing therapists include the development and maintenance of a clearly defined role, generic case management versus discipline-specific roles, recruitment and retention, the need for research and evidence-based practice, professional standing, and education and professional development.

The concerns over the role of occupational therapy in mental health were similar to those in previous British studies. The implications of these findings include a need for education and training at the undergraduate and postgraduate levels to equip mental health occupational therapists with both discipline-specific and generic skills.

A Survey of Australian Mental Health Occupational Therapists

Chris Lloyd, Robert King and Hazel Bassett

Introduction

The reform of Australian mental health services has had a significant impact upon the staff working in these services. There has been an emphasis on developing a generic skill base in order to assume broad-spectrum mental health professional roles and to provide community-based care. Policy statements have emphasised continuity of care, the provision of accessible and high quality services and the development of intersectoral collaboration (Australian Health Ministers 1992). Case management has been identified as an effective approach to service delivery to ensure continuity of care across inpatient and community settings and access to a range of services (Queensland Health 1996) and is now the expected role of community mental health practitioners.

Despite this expectation, the types of work roles and practices that Australian occupational therapists are assuming or whether they are spending less time on discipline-specific tasks as opposed to generic tasks is not known empirically. Except for anecdotal evidence, little is known of the issues that face occupational therapy as a profession since the introduction of mental health reform. It is unclear whether work practice issues raised in the British literature are similar for Australian occupational therapists. The purpose of this research project was to examine the work practice profile of occupational therapists and the issues that concern them.

Literature review

Changed work practices and service reform

With the shift to community-based care and new models of practice, there has been a move towards providing both discipline-specific and generic work within multidisciplinary teams. This has highlighted the need for extending and refining staff skills relevant to community mental health practice (National Mental Health Strategy Evaluation Steering Committee 1997). Staff are now required to work more autonomously than had previously been expected and to perform a broader range of roles. They are expected to have a variety of skills, which are shared by all mental health workers (Deakin Human Services Australia 1999). Case management has been identified as an essential part of service delivery (Lehman 1999). Notwithstanding weak

evidence for clinical efficacy and relatively high cost (Marshall et al 2000), case management improves continuity of care and is a mandated model of public mental health service delivery throughout Australia (Queensland Health 1996).

Profile of occupational therapists in mental health

Craik et al (1998a) conducted a survey of 137 British occupational therapists (response rate 68.5%) to determine the profile of mental health practitioners, their responsibilities, professional development and employment situation, and their opinion of the issues facing occupational therapists. The results found that mental health occupational therapists spent between 25% and 74% of their time on occupational therapy specific tasks as opposed to generic tasks. Sixty-seven per cent believed that they carried out non-occupational therapy tasks. Less than half of the respondents reported receiving any training for these tasks.

Preparation for practice

In the United Kingdom, Craik and Austin (2000) conducted a study to gain the opinions of practitioners and occupational therapy educators about occupational therapy in mental health. The results indicated that the majority of practitioners considered their pre-registration education to be sufficient or partially sufficient. The lack of fieldwork placements and of good role models for students were noted by the educators. The value of practitioners being certain of the unique approach of occupational therapy was highlighted. The educators identified the need to focus on community and primary care, occupational therapy specific contributions, research and stronger professional identity, support and supervision.

The extent to which university education prepares graduates for the requirements of the workplace has become an important issue. Adamson et al (1998) surveyed 144 Australian graduates using a purposive sampling procedure to determine their perceptions regarding the adequacy of their undergraduate programmes in equipping them for the workplace. The results found that the graduates perceived significant gaps between their training and work preparation and the reality of being employed in the workplace. Basic undergraduate courses in occupational therapy insufficiently prepare entrants for mental health practice because their education is generic (Deakin Human Services Australia 1999). Continuing professional development is seen as important for the maintenance of competency and standards of practice amongst occupational therapy mental health practitioners (Craik et al 1999, Ford et al 1999). However, the lack of resources for additional training is a problem (Sweeney et al 1993, Ryrie et al 2000).

Fieldwork is an integral part of the education of occupational therapists. Cusick et al (1993) surveyed 181 Australian undergraduates to examine the factors influencing student practice preference. The results indicated that occupational therapists' career choice was influenced by their fieldwork placement experience. Students who found mental health attractive liked the less structured environment and the greater opportunity for creativity. In the United States of America, Sladyk (1994) has suggested that the negative attitudes about mental health shown by educators and physical occupational therapists put pressure on students not to consider mental health as a career choice.

Intervention media and work tasks

According to de Jonge and Vanclay (1989), concerns have been raised as to the identity of the profession and the legitimacy of the media being used by Australian occupational therapists. In their study involving 40 occupational therapists in the greater Brisbane area, respondents were asked to report their usage of a specified list of treatment media and the characteristics of their client group. They found that the media chosen were daily living tasks, discussion groups and social/recreational activities. The limitations of this study included the small sample size and the fact that the respondents were all from one geographical area, which may limit the generalisability of the results. In a British study involving 137 respondents, the most frequently used interventions were leisure, counselling, anxiety management and creative activities (Craik et al 1998a). Work rehabilitation did not feature highly in the interventions chosen by occupational therapists. Meeson (1998a) found a diverse pattern of intervention choices in a study of 12 British community mental health occupational therapists. Supportive counselling, anxiety management and problem solving about aspects of clients' daily lives were the most frequently selected interventions. The practice context influenced the intervention choice of therapists, particularly policy, the organisation of services, the division of labour within the team and the resources at their disposal.

Role blurring

Occupational therapists increasingly function in multidisciplinary teams with limited contact with profession-specific departments. This leads to less formal and informal supervision and less availability of role models than in the past (Barnitt and Salmond 2000). Role blurring is a significant feature of working in community mental health (Paul 1996). All team members, whatever their background, undertake similar types of work. Galvin and McCarthy (1994) claimed that this pressure towards interchangeability of team members' roles was driven partly by the need to keep pace with the number of referrals and to fulfil all the other roles and functions expected of the team.

Issues for occupational therapists in mental health

Craik et al (1998a) also explored the issues that British occupational therapists working in mental health considered as important for the profession. Four main clusters were identified and included the nature of the clinical work, interpersonal aspects, the challenge of the work and the need for flexibility and creativity. Future issues in mental

health were perceived as being the loss of occupational therapists from leadership, management or supervisory roles, recruitment and retention, educating others about the role of occupational therapists and the need for research and evidence-based practice.

Need for research and publication

The use of evidence-based practice is being encouraged in all health delivery, including mental health service provision (Australian Health Ministers 1998). A number of writers in the profession have urged occupational therapists to adopt evidence-based practice (Alsop 1997, Taylor 1997) because of this increased emphasis on outcomes. However, two reviews of the literature (Mountain 1997, Craik 1998) found a scarcity of articles on mental health. Craik (1998) considered it lamentable that among those published there was a lack of research, a lack of a clear definition of the profession and a lack of information on the scope of practice. Craik et al (1998b) identified the need for more research as a major issue for the profession and highlighted the importance of published evidence on which occupational therapists could base their practice. Fowler Davis and Bannigan (2000) conducted a study to identify the key priorities for research by British occupational therapists working in mental health. Four main themes emerged from this research: core skills, professional role and identity within the multidisciplinary team, effectiveness and evidence-based practice, and client-centred practice.

Aims of the study

This study focused on practitioners in mental health and aimed to:

1. Determine the profile of occupational therapists practising in mental health in Australia
2. Determine the types of clinical role and work activity carried out by occupational therapists
3. Determine the degree of generic and discipline-specific work carried out by occupational therapists
4. Identify the future issues of importance to occupational therapists in mental health.

Method

Participants

The participants were members of OT Australia (the Australian Association of Occupational Therapists). The questionnaire was posted to them in the Association's newsletter.

Design and instrumentation

In the light of limited research in this area and the constraints of time and resources, the survey methodology was selected for this study. The study design was a cross-sectional survey. The questionnaire consisted of three sections.

The first section collected demographic information from therapists, including age, gender, qualifications, time worked in mental health and time in current position. It also included questions concerning the amount of time spent in administrative, supervisory and clinical work. It explored the breakdown of the clinical role between generic services and specialist rehabilitation.

The second section took the form of three open questions which asked what had attracted the therapist to work in mental health, what he or she saw as the three main issues for occupational therapy in the future, and any other comments that he or she wished to make. This section was based on the Craik et al (1998a) study.

The third section consisted of 40 statements concerning specific work practices. The therapist was asked to rate how often he or she engaged in each work practice using a Likert scale. The divisions on the Likert scale were frequently (at least once a fortnight), sometimes (several times a year), rarely (once or twice a year) and never (never performed this task in regular practice).

The scale items were based on consultation with a reference group of occupational therapists working in mental health, on published competency standards for occupational therapists in occupational therapy specific or generic roles (Ford et al 1999) and on an item pool used in related studies on mental health worker competency and case manager self-efficacy conducted in the Department of Psychiatry at the University of Queensland (King et al 2000, King et al 2002). This generated a list of task activities that reflected current work practices in mental health.

Following piloting with a group of occupational therapists working in mental health, the initial item pool was refined to produce the final version. The results of the psychometric investigation of the scale are reported below.

The qualitative data were collected for each question and coded. Through a reduction of these codes into larger categories, themes were identified (Wheeler and Holloway 1996). Each response was then noted for analysis of frequency and coded with regard to the themes. An independent reviewer then reviewed the responses and coding of themes. The final review and analysis of these findings are discussed below.

Results

Demographic characteristics of respondents

The respondents were 131 female and 16 male occupational therapists (plus one who did not specify gender), resulting in a response rate of 148/200 (74%). It was estimated that 200 members of OT Australia were employed in mental health (personal communication from OT Australia).

A disproportionate number of respondents (39%) were from Queensland, suggesting a state bias that possibly reflected the origin of the study. Other respondent characteristics are set out in Table 1.

Table 1. Respondent characteristics (n = 147)*

	Median age	Months of mental health experience	Months in current job	% with postgraduate qualifications
Female, n = 131	37	85	36	25%
Male, n = 16	34	57	22	25%

*One respondent did not specify gender.

Work profile of respondents

Of the 148 respondents, 12% were employed in primarily administrative roles, a further 14% described their work as being equally administrative and clinical and the remaining 74% had a primarily clinical role. Thirty-four per cent were engaged primarily in case management, while a further 18% indicated that they were engaged equally in case management and specialist rehabilitation. Forty-nine per cent indicated that they were mostly engaged in specialist rehabilitation work.

Occupational therapists' work practices scale

The 40-item scale was investigated using factor analysis (principal components with varimax rotation). This analysis yielded four factors containing a minimum of five item loadings of 0.5 or higher. These factors were then investigated for reliability using Cronbach alpha as a test of internal consistency. The results of this analysis are set out in Table 2.

The psychometric properties of these four factors were investigated to determine their suitability as subscales. Reliability, as measured by internal consistency, for the first three subscales was high (alpha = 0.91, 0.86 and 0.82 respectively). The fourth subscale had marginal internal consistency (alpha = 0.67) but was judged to be acceptable for use in further analysis. The four subscales are referred to below as, respectively, (1) *Generic Clinical*, (2) *Specialist Rehabilitation*, (3) *Group Work* and (4) *Service Planning*.

Table 2. Factor structure (principal components, varimax rotation), item loading and internal consistency for the occupational therapists' work practices scale

Factor 1 (Generic Clinical)	Factor 2 (Specialist Rehabilitation)	Factor 3 (Group Work)	Factor 4 (Service Planning)
Home visiting (0.67)	ADL interventions (0.71)	Special needs groups (0.55)	Service needs assessment (0.51)
Support for family and carers (0.52)	Functional assessments (0.72)	Anxiety management groups (0.76)	Collaborative service plans (0.51)
Advocacy for clients (0.63)	Community orientation/ access with clients (0.59)	Depression management groups (0.77)	Vocational assessments (0.62)
Visiting clients in hospital (0.60)	Planning and using activities (0.56)	Leisure and recreational groups (0.55)	Relapse prevention plans (0.58)
Advocacy for treatment change (0.71)	Occupational analysis and lifestyle redesign (0.70)	Psychoeducation groups (0.66)	Community development and consultation (0.52)
Arranging doctors appointments (0.78)	Community living skills training (0.76)	Social skills training groups (0.62)	
Supportive counselling (0.56)	Assessing occupational performance (0.75)	Early intervention and prevention groups (0.66)	
Intake and triage (0.52)	Activity analysis (0.67)		
Mental state examination (0.70)			
Crisis intervention (0.78)			
Arranging accommodation (0.74)			
Family psychoeducation (0.58)			
Medication education (0.64)			
Help with finances (0.61)			
Arranging hospital admission (0.79)			
Attending case presentations and reviews (0.50)			
Alpha = 0.91	Alpha = 0.86	Alpha = 0.82	Alpha = 0.67

Four items did not have a loading of 0.5 or higher on any of the four major factors. These were working with comorbidity, employment interventions, collaborative goal setting and developing artistic skills and pleasure. These items were not included in subsequent analysis.

Work practice profiles of occupational therapists in mental health

The work practice profiles of occupational therapists in mental health settings were investigated by exploring the relationships between demographic and work-related data and subscale scores. The only significant relationship between subscale scores and demographic variables was in the area of *Specialist Rehabilitation*, for which higher scores were associated with less experienced ($r = 0.42$, $p < 0.01$) and younger ($r = 0.38$, $p < 0.01$) respondents. The work-related data were simplified by classifying the respondents as having either a significant case management role (51%) or a significant specialist rehabilitation role (49%). T-tests were then used to compare mean scores for the two groups on each of the four subscales. The results of this analysis are set out in Table 3. The form of scoring for the scale means that low scores indicate high activity and high scores indicate low activity.

It can be seen that there were significant differences between the two groups on each of the subscales. The respondents with a case management focus had lower scores on the *Generic Clinical* subscale than did the respondents with a predominantly specialist rehabilitation role and the former also had significant lower scores on the *Service Planning* subscale. By contrast, the respondents with a specialist rehabilitation focus had lower scores on the *Specialist Rehabilitation* roles and the *Group Work* subscales (see Table 3).

The differences in work role between the case managers and specialist rehabilitation therapists are further illustrated by considering the 10 highest frequency work roles identified by each group. High frequency work roles for the two groups are set out by order of frequency in Table 4; lower scores denote higher frequency.

Table 3. Relationship between subscale scores and the two groups' work profile

Factor	Role	N	Mean	SD	t	Sig.
Generic Clinical	Case manager	71	26.00	6.54	11.39	<0.01
	Rehabilitation therapist	63	41.38	9.06		
Specialist Rehabilitation	Case manager	68	16.44	5.42	2.92	<0.01
	Rehabilitation therapist	67	13.80	5.12		
Group Work	Case manager	71	19.92	5.64	3.56	<0.01
	Rehabilitation therapist	65	16.65	5.01		
Service Planning	Case manager	70	9.90	3.13	2.85	<0.01
	Rehabilitation therapist	67	11.39	2.99		

Table 4. High frequency work roles for case manager therapists and rehabilitation therapists

Case managers	Rehabilitation therapists
Attending case presentations (1.14)	Collaborative goal setting (1.26)
Supportive counselling (1.15)	Planning and using activities (1.28)
Collaborative goal setting (1.21)	Supportive counselling (1.42)
Home visiting (1.24)	Attending case presentations (1.50)
Advocacy for clients (1.31)	Activity analysis (1.54)
Mental state examination (1.43)	OT functional assessments (1.65)
Service needs assessment (1.50)	Service needs assessment (1.75)
Advocacy for treatment change (1.56)	Helping with ADLs (1.76)
Arranging doctors appointments (1.64)	Leisure and recreation groups (1.85)
Medication education (1.64)	Community orientation and access (1.90)

Scores in brackets are mean scores for each sample where 1 = frequent (at least once a fortnight); 2 = sometimes (several times a year); 3 = rarely (once or twice a year); and 4 = never (never performed this task in regular practice).

This listing reveals four items in common (attending case presentations, collaborative goal setting, service needs assessment and supportive counselling) but six items for each group that were distinctive. Case managers were more actively involved in the full spectrum of clinical service delivery whereas rehabilitation therapists focused much more specifically on clients' activities of daily living.

Qualitative results

The responses to the open questions were diverse. Only 4 (3%) of the 148 therapists who participated in the survey did not answer the open questions. Of the 144 (97%) therapists who answered the open questions, 139 gave more than one response to each question.

The question concerning what had attracted them to the area of mental health yielded 344 responses, which when examined formed five main clusters. These were work practice (71%), in particular the creativity, flexibility and diversity of the occupational therapy role in mental health and the fact that it was seen as more rewarding, interesting and challenging than other areas of practice; the diverse nature of the client population (12%); interest in the area of mental health (7%); employment opportunities (5%); and positive student fieldwork placements (5%).

The second open question concerned what issues the therapists saw as being important for the future of occupational therapy in mental health. There were 400 responses for this question and they fell into seven main clusters. The largest cluster (27.75%) concerned occupational therapy skills in mental health. Of particular concern was the use of core skills and being recognised by other professionals as bringing unique skills to the multidisciplinary team. This is reflected in the statement:

> Things get confusing and roles blur. We do have valuable things to offer clients.

The second cluster (19.5%) was related to the first and concerned the specific role versus the generic case manager role. The respondents were divided on the issue. One comment was:

> We need to embrace case management and case coordination rather than devaluing this role as this is the majority of the work and is the way of the future.

Nevertheless, other therapists were obviously not comfortable, as reflected in the comment:

> Generic skills are important and necessary but more important is the need for specialist occupational therapy skills to be used and promoted.

The third cluster (19%) concerned recruitment and retention. The issues raised included burnout, high workloads and career structures. The importance of positive student placements was raised in the light of recruitment. However, it was commented that positive fieldwork placements were scarce:

> Heavy demanding caseloads make therapists unwilling to take students. In turn, students get poor placements or no mental health placements at all. This means that students are turned off the area when it comes to finding employment after graduation.

The fourth cluster of responses (13%) focused on research and evidence-based practice. The respondents who commented on this area stated that without research and published evidence of effective occupational therapy, the profession would lose its standing as one of the core mental health professions. This is reflected in the comment:

> Research or perish!

The fifth cluster of responses (10.75%) dealt with the standing of mental health within the profession. The respondents believed that occupational therapists needed to build more respect for the profession among other occupational therapists. It was stated:

> I am sick of being devalued by other occupational therapists not working in mental health.

The sixth cluster (5.25%) focused on education and professional development. The respondents raised the need for continuing training activities being made available to therapists in the area of mental health occupational therapy as well as improving the quality and quantity of mental health education in undergraduate courses. This is reflected in the comment:

> University courses do not incorporate enough mental health related topics. It is one area of OT that we learn through work experience or employment.

The final cluster (4.75%) dealt with the lack of funding and resources in the area of mental health and the difficulties experienced by occupational therapists in accessing these limited funds.

Discussion

Interpretation of quantitative data

The response rate at 74% was good and comparable to the survey by Craik et al (1998a) of 137 British practitioners which achieved a 68.5% response rate. As was expected, the demographic profile of the respondents revealed that the majority were female. Of interest was the high percentage (43%) who were over 36 years of age. It is usually thought that the occupational therapy workforce is young and relatively inexperienced, as was found in the Craik et al (1998a) survey. The therapists in this survey tended to be older and had more experience of working in mental health. They had worked in mental health for 7 years on average and in their current position for 3 years on average. Thirty-six per cent of the respondents stated that they had postgraduate qualifications but it is not known whether this was in occupational therapy or in a related field. The questionnaire did not address training; the Craik et al (1998a) survey did and found that 91% of the practitioners had received additional training, some of which was occupational therapy specific but much of which was generic.

The findings from this study reveal a number of similarities with previous studies (de Jonge and Vanclay 1989, Craik et al 1998a, Meeson 1998a) about the choice of interventions used by occupational therapists. This was most evident in the areas of supportive counselling, daily living tasks, activities and the use of leisure. It was interesting to note that, as was found in the Craik et al (1998a) survey, employment interventions did not feature as a part of regular practice. It is difficult to find an explanation for this trend. Employment interventions have a long association as being a core part of occupational therapy. Unlike the findings of Craik et al (1998a) and Meeson (1998a), anxiety management did not feature as a frequently used intervention choice. This was not surprising given the emphasis on major mental illness and associated high levels of disability that is characteristic of Australian public mental health services. Consistent with previous research, a significant number of the respondents were involved in non-occupational therapy tasks (Craik et al 1998a). However, in this study the non-occupational therapy tasks were specifically related to generic clinical and support work, which is a part of the case management role. These tasks included service needs assessments, advocacy for treatment changes, arranging appointments with doctors, mental state examinations and medication education.

The quantitative data suggest that there are now in Australia two distinct groups of occupational therapists working in mental health settings. One group, which tends to be younger and less experienced, is engaged in more traditional specialist rehabilitation activities, such as occupational therapy functional assessments, service needs assessments, activities of daily living, group work and community orientation and access. It is most likely that these occupational therapists are working in hospital environments in acute or longer-term care. The second group is somewhat older and more experienced and is probably working in community settings. This group is engaged in a much broader range of activities, many of which are not traditionally associated with occupational therapy roles. These findings provide support for the study conducted by Meeson (1998a), which found that it was the practice context which influenced the choice of interventions used by occupational therapists. Given the direction of mental health policy and service development in Australia, the authors would anticipate a likely increase in the second group at the expense of the first group.

Many of the work activities undertaken by the second group require skills that do not form part of core education and training in undergraduate programmes, for example mental state examinations and medication education. Craik et al (1998a) had previously pointed out that many therapists were performing non-occupational therapy tasks for which they had not received education or training or which were not within their professional competence. This raises important questions about the focus of education and training for occupational therapists and possibly the need for specialist postgraduate training and accreditation, in order to address the skills required for undertaking generic as well as occupational therapy specific service provider roles in current mental health service provision.

In addition to the substantive findings, the quantitative study successfully developed a new tool for measuring the work activity of occupational therapists in mental health settings. This tool has good psychometric qualities, especially for three of the four subscales, and appears to have a good capacity to discriminate the work activities of occupational therapists employed in different work roles. This measure has potential for application in future studies of the occupational therapy workforce. The authors think that there is sufficient equivalence between occupational therapy work roles in Australia and the United Kingdom for international and comparative national studies, with only minor modifications to take into account local terminology.

Interpretation of the qualitative data

It is interesting that the findings of this study reflect to some degree the findings of the Craik et al (1998a) study. The nature of the work in the field of mental health is the major attraction for occupational therapists. However, the respondents were concerned that occupational therapy should maintain a clearly defined role in mental health and felt that the specific role versus the generic role will continue to be an issue. They believed that occupational therapists need to promote their specific skills within the multidisciplinary team. The need to define and promote core skills within the multidisciplinary team has previously been reported in the literature (Craik et al 1999, Craik and Austin 2000). Many therapists felt that the profession needs to define its role if it is to survive in today's changing world of mental health service provision.

It is of no surprise that the respondents were polarised on the issue of case management considering the quantitative results of the survey. This polarisation has serious ramifications for the future of occupational therapy in mental health. Under Australian government policies, mental health workers are required to undertake generic work within a multidisciplinary team framework. Holding on to discipline-specific roles and traditional professional boundaries does not reflect the new paradigm in mental health care. There is an urgent need for occupational therapists to look at how they are able to achieve a balance between performing generic roles and discipline-specific skills if they wish to maintain a profile in mental health. Therein lies the profession's greatest challenge: to do things differently to effect a change towards best practice.

The above ties into the issue of recruitment and retention. Many respondents recognised that occupational therapy, as a profession, needs to examine this area in mental health. Of great concern to the therapists was the perceived lack of senior therapists, the lack of entry positions for occupational therapists, high caseloads, burnout and reduced availability of supervision. The rural therapists, in particular, expressed concern about the lack of experienced therapists with whom they could confer and the fact that they were often not supervised or supervised by

someone who did not understand the philosophy of occupational therapy.

Another issue that the respondents recognised as being important for the future was that of research and evidence-based practice. This has been a finding similar to a number of other studies (Craik et al 1998a, Craik et al 1999, Craik and Austin 2000, Fowler Davis and Bannigan 2000). All areas of health are being called upon to justify their interventions and occupational therapists are no exception. In the area of mental health, little research has been done concerning occupational therapy specific interventions and outcomes. The therapists believed that the standing of occupational therapy would only improve with research and evidence-based practice.

An interesting issue raised by this research was how occupational therapists working in mental health are viewed by occupational therapists working in other areas. This negative viewpoint about mental health practice has previously been reported in the American literature (Sladyk 1994). It is also likely that the poor status of the profession will have a significant impact on the future of occupational therapy in mental health, particularly in the area of recruitment and retention.

Finally, education and training is an area of concern for occupational therapists. A number of the respondents commented on the lack of mental health in undergraduate courses. They believed that there was a need for universities to revisit the mental health component of their education. The lack of adequate mental health coursework appears to reflect a worldwide trend (Sladyk 1994, Craik and Austin 2000). This supports the findings of the study by Adamson et al (1998), where graduates felt that they were not adequately prepared for the practice environment.

Limitations of the study

There are a number of limitations to this study which may limit the generalisability of the results. The respondents were members of the professional association and it is not known how non-members might have responded. This may influence the results because being a member of the professional association may indicate a greater commitment to the profession and a willingness to be involved in the issues facing the profession. As such, the respondents may not be representative of other practitioners.

Owing to the absence of a database of occupational therapists working in mental health, it was not possible to contact potential respondents directly, nor was it possible to follow up non-respondents which may have had an impact upon the number of returned responses. A further limitation was that the location of the workplace, whether it was hospital or community based, was not identified. This meant that it was difficult to determine which work activities were associated with specific work settings.

Finally, while the scale used to measure occupational activity was found to be reliable and had face validity, it is not possible to be completely confident that self-report of work activity provides an accurate measure of actual work activity.

Future research

It would be of interest to know in greater depth the work practice profile of occupational therapists in mental health, their expectation of their work role and how they are adjusting to this changed work environment. It is suggested that future research be undertaken with a larger sample size and include non-members of the professional association and that a comparative study be undertaken.

Conclusion

The findings from this study revealed that generic case management is the primary work role of Australian mental health occupational therapists, although a significant proportion of occupational therapists still continue to carry out specialist rehabilitation roles. Specific work activities endorsed as occurring with high frequency tended to be generic and carried out by occupational therapists in a case management role. More traditional specialist occupational therapy activities were endorsed as occurring frequently but less so than generic work and were mainly carried out by occupational therapists in a rehabilitation role.

The study also indicated a number of issues that are viewed as having an impact on the role of occupational therapists in the area of mental health, both now and in the future. The predominant issue focused on the need to develop and maintain a clearly defined role in mental health. Closely related to this were issues about generic versus discipline-specific roles, recruitment and retention, the need to adopt evidence-based practice and conduct research, the standing of the profession and the importance of having a greater focus on mental health in undergraduate education and postgraduate training.

This study shared a number of similarities with studies conducted in the United Kingdom, notably in the choice of occupational therapy interventions and with the increased predominance of non-occupational therapy specific tasks. It could be expected that, in both countries, generic as well as occupational therapy specific service provider roles will continue to evolve. At this stage it is unclear as to how well the profession will respond to the different demands being placed on practitioners in mental health settings.

The findings reported here have clear implications for the education of occupational therapists. In order to maintain relevance to contemporary mental health practice, professional education must equip occupational therapists to practise with a broad repertoire of skills in multidisciplinary teams while maintaining a distinctive professional focus and identity. While the results suggest that new graduates and less experienced therapists are more likely to be working in more traditional specialist roles, it is important that graduates have a clear understanding of the work roles and requirements of therapists who are employed in community mental health settings. In particular, therapists must be equipped for the assessment and collaborative service planning work that is central to case management.

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