The aim of this research was to conduct a cluster analysis on data from 40 community mental health occupational therapists to determine if subgroups of therapists had differing referral prioritisation policies. A Ward's cluster analysis showed four clusters to be present.

These four subgroups of occupational therapists were found to differ according to several factors: the percentage of role dedicated to specialist occupational therapy or generic work, satisfaction with the balance in these roles, the number of hours worked, the number of professionally trained team members and the presence of referral prioritisation policies. The subgroups were named the aspiring specialists, the satisfied specialists, the satisfied genericists and the chameleons (those not set in applying a consistent or specific policy).

The policies that led to mainly generic working gave greatest importance to clients who were potentially violent or at risk of suicide. The policies that led to more of an occupational therapy role gave particular importance to the reason for referral and the client's diagnosis.

The College of Occupational Therapists has recommended that the majority of casework should be focused on specialist occupational therapy interventions (Craik et al 1998): most of the participants in this study were not meeting this recommendation. Although some aspired to being more specialist, the pressures to work generically may have been affecting referral policies.

Generic and Specialist Occupational Therapy Casework in Community Mental Health Teams

Priscilla A Harries and Ken Gilhooly

Introduction

There has recently been a debate in the British occupational therapy literature as to the optimal type of casework for occupational therapists working in community mental health teams (Parker 2001, Corrigan 2002, Dunrose and Leeson 2002, Forsyth and Summerfield-Mann 2002, Harries 2002, Stone 2002). One of the issues of the debate is how much time should be given to generic casework and how much time should be given to clients who primarily have difficulties in occupational performance.

Three patterns of working have been described in the literature: generic casework, specialist occupational therapy casework and a mixture of the two. Some occupational therapists are working solely as a generic case coordinator, a role that has been considered by some to be the most effective method of providing services to the client (Parry-Jones et al 1998). This role began in the early 1990s, when it became government policy that a single professional should be responsible for the management of a client's needs (Department of Health 1990). Taking a generic role is a common expectation in many community teams (Brown et al 2000).

Unfortunately, generic working has had some drawbacks. In theory, each professional can refer to the other team members when needed but, owing to workload pressures, this does not always occur. Therefore, team members do not necessarily feel skilled in meeting all the needs of the client and they may have to work outside their areas of expertise (Brown et al 2000). Team members recognise that they must not focus on their own areas of professional interest but on the needs of the client. These needs must lead the orientation of the service provision. In relation to generic working, role stress and role confusion have been commonly reported (Parry-Jones et al 1998).

Some occupational therapists work only as occupational therapy specialists, therefore accepting only occupational therapy type referrals. This type of casework may include case coordination, but only if the client's main needs can be met by occupational therapy.

Finally, some occupational therapists hold a mixed generic and specialist caseload. From the data collected prior to the cluster analysis, this appeared to be the most common method of working (Harries and Gilhooly 2003). The professional body for occupational therapists recommends that, in this type of mixed caseload, occupational therapists

should spend the majority of their time on specialist occupational therapy interventions (Craik et al 1998). This suggestion has been necessitated because occupational therapy services are in short supply. If too much time is spent on generic work, there will be clients with unmet occupational therapy needs. If there were larger numbers of occupational therapists in each team, as there are community psychiatric nurses, there would be less problem in extending the role to generic work. However, there is usually only one occupational therapist in a team so there is limited flexibility (Harries and Gilhooly 2003).

One key way in which the generic-specialist caseload balance becomes operationalised is through the process of referral acceptance. The occupational therapist's referral prioritisation policy determines which clients are taken onto the caseload. Research on occupational therapists' referral policies has already been conducted with 40 occupational therapists in Britain to identify individual referral prioritisation policies (Harries and Gilhooly 2003); demographic and practice data were also collected in this study. It was found that half the occupational therapists' generic caseloads were too large and it appeared that the greater the generic responsibilities the lower was the level of work satisfaction (rho = -0.35, p = 0.039). The profession is correct in thinking that occupational therapists are under pressure to take too much generic responsibility. Those occupational therapists that are dissatisfied are at a higher risk of leaving their posts and possibly the profession, a situation that the profession can ill afford (Craik et al 1998).

According to Harries and Gilhooly (2003), the three most important pieces of referral information used by the 40 occupational therapists to prioritise referrals were reason for referral, history of violence and diagnosis. Post hoc analysis showed that use of the history of violence information was the only cue that correlated with the percentage of time spent on generic cases (r = 0.28, p = 0.047). Suicide risk and physical aggression were given the highest ratings within this cue. Therefore, the occupational therapists with a greater generic focus were more likely to take a referral of a suicidal or aggressive client than the occupational therapists with a focus on occupational dysfunction. If the policies of some therapists were leading to an unsatisfactory caseload balance, then the use of the information about violence needed to be examined in greater depth. Using the results of the 40 occupational therapists, research was required to identify if there were any subgroups of occupational therapists that had differing referral policies. Were any of these policies leading to the caseload balance that the profession advocates?

The aims of this research were, therefore, to use cluster analysis to identify any subgroups of occupational therapists that were using differing referral prioritisation policies and to examine the factors influencing their policy use. Of particular interest would be whether the subgroups were differentiated by the balance of specialist versus generalist casework and the levels of satisfaction with this balance.

Method

In order to understand the data on which the cluster analysis was conducted, it is first important to provide the details of how the data were obtained. This is a prerequisite to describing the cluster analysis methodology and results (Brenner and Fox 1999, Lustig and Crowder 2000). Additional details of the methodological approach and the results can be found in Harries and Harries (2001) and Harries and Gilhooly (2003).

Participants

A sample of 40 experienced occupational therapists working in community mental health teams had been recruited via the Special Interest Group for Occupational Therapists in Mental Health for the referral prioritisation policies study (Harries and Gilhooly 2003). To obtain a random sample, letters were sent to the first 100 occupational therapists on its mailing list. In order to recruit experienced clinicians, potential participants were required to be at Senior Occupational Therapist grade or above. To ensure that they had formed some stability in their prioritisation policies, they had to have worked for at least one year in their current post. Finally, only those occupational therapists who would accept direct occupational therapy referrals were invited to respond. It was on these 40 occupational therapists' policies that the cluster analysis would be conducted.

Occupational therapists from England, Scotland and Wales had participated. Seventy-five per cent were at Senior I/Head IV grade, 80% were working full time and 70% had worked as an occupational therapist for more than 6 years. Seventy per cent of the work was being carried out in urban settings, with 15% in suburban settings and 15% in the countryside. The majority of the work was in deprived areas.

Almost 50% of the participants had felt that their caseloads were just the right size and the other 50% that their caseloads were too large; 5% had felt that their caseloads were a little small. Ninety-five per cent had a generic role, the percentage of which ranged from 100% to 5% (mean 53%). Half of these participants had felt that their generic role was too large and half that it was the right size. All but one of the participants had an occupational therapy role. The occupational therapy roles ranged from 100% to 0% of their work (mean 52%). Half had felt that theirs was just the right percentage, with the other half being equally divided between feeling that their occupational therapy role was too small or too large.

All but one of the participants had a coordinator (key worker/case manager) role. The number of clients for whom the participants coordinated care ranged between 2 and 67, with a mean of 19 clients (equivalent to 64% of their caseloads). Thirty per cent of the participants were key workers for only occupational therapy type referrals and 88% of the participants ran groups.

Procedures

The prioritisation policies to be entered into the cluster analysis had been derived from the following procedures.

The 40 participants had been asked to prioritise individually a set of 120 referrals: 90 referrals plus 30 repeated referrals (to check for consistency). They did this by putting a mark on a line at the foot of each referral. One end of the line was named low priority and the other end was named high priority (a visual analogue scale). Nine types of information (cues) varied in the referrals. These were the referrer and the client's gender, age, diagnosis, living situation, length of history, reason for referral, level of support and history of violence.

Additional demographic and practice data were systematically collected through the use of a questionnaire. The demographic data included such information as the participants' length of time in community practice and the weekly hours worked. The practice data included such information as the staffing in the team and the decision-making pathways used. The responses were coded and divided into parametric or non-parametric data according to standard statistical requirements. These data could then be used to correlate participants' working situations; for example, the type of catchment area and the prioritisation policies. Following analysis, the participants were sent by post their own and their colleagues' results (coded to protect confidentiality). The participants were offered the opportunity to contact the researcher to discuss their results.

Up to 2 hours from each of the 40 participating occupational therapists was required. An honorarium of £15 each was provided on completion of participation. A full information sheet had been provided to these expert occupational therapists before consent was obtained. Anonymity was assured for all the participants involved in the study. All the participants' information was coded prior to the data collection and the names and codes held separately, thereby assuring confidentiality. Ethical approval from the relevant university department had been obtained.

Consistency and agreement

An individual's consistency in using his or her policies was identified by correlating the ratings on the original and repeat referrals. Pearson's correlation coefficient for the 40 occupational therapists ranged from r = 0.29 to r = 0.96. The mean consistency (r) was found to be 0.74. A correlation score of zero indicates no consistency in policy use (the individual would give two identical referrals completely different priorities), whereas a correlation score of one indicates the use of a completely consistent policy (same priority rating given to identical referrals).

The agreement of participants' ratings on the original 90 referrals was identified using Kendal's coefficient of concordance (W). This is an appropriate statistical test to calculate a group agreement correlation. For the 40 participants, the agreement was found to be 0.367 (W), p = 0.0001. (No group agreement on how referrals should be prioritised would give a correlation score of zero. Complete group agreement on how referrals should be prioritised would give a correlation score of one.) As individual consistency of policy use was far higher than group agreement on policy use, cluster analysis could potentially identify clear subgroups with differing policies.

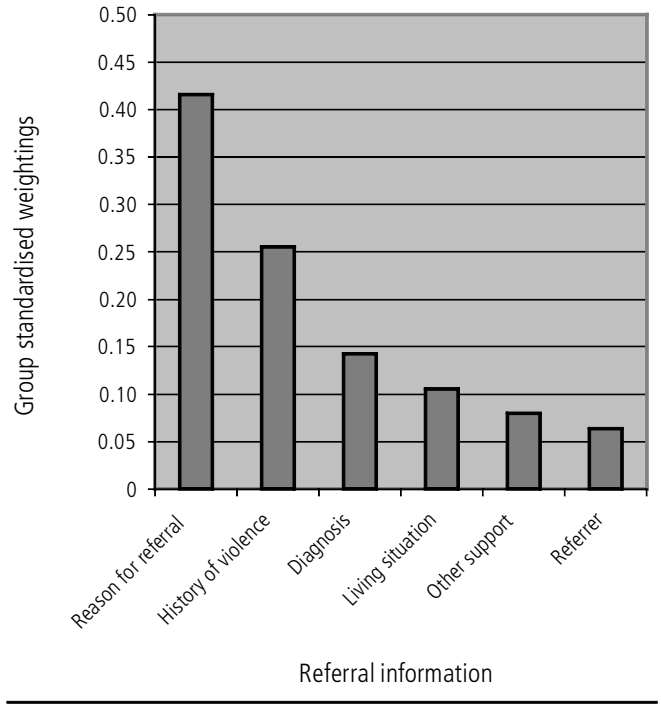
Prioritisation policies

To analyse the cue use for each participant, multiple regression analysis was used. This test allows the prediction of one factor from the knowledge about others. For example, can children's test scores be predicted from their heights and ages? Each item of knowledge can influence the prediction to differing degrees, that is, differing amounts of weight can be attributed to the respective pieces of information. Thus, in the referral prioritisation study, standardised regression coefficients (beta weights) derived from multiple regression analysis indicated the influence that each piece of referral information had had on the referral prioritisation, such as the bearing that the diagnosis had or the bearing that the reason for referral had. The larger the regression weight, the larger was the impact of the cue.

The tacit (objective) standardised regression coefficients were sent as feedback, in a graphical form, to all the participants. The heights of the columns in the graphs indicated the importance given to the different types of referral information. The cues were defined as being used if their regression coefficient was significantly different from zero ($p<0.05$). These regression coefficients (beta weights) were the data to be entered into a cluster analysis to identify subgroups of differing policies.

As a group, the importance placed on different types of referral information was analysed. The mean cue weights for the total sample (N = 40) were calculated by regressing the average standardised rating for each referral onto the cue values. Of the nine cues, six were of significance (Fig. 1). The reason for referral was given the most weighting (ß = 0.42, p = 0.0001), followed by history of violence (ß = 0.255,

Fig. 1. Importance given to types of referral information by 40 experienced occupational therapists.



p = 0.0001), diagnosis (ß = 0.14, p = 0.0001), living situation (ß = 0.11, p = 0.001), support available (ß = 0.08, p = 0.008) and the referrer (ß = 0.06, p = 0.033). The three referral cues that were not significant were gender (ß = 0.03, p = 0.38), age (ß = -0.04, p = 0.23) and length of history (ß = -0.009, p = 0.75). Fig. 1 illustrates the mean cue weights of these six cues used by the 40 occupational therapists.

Analysis of variance (ANOVA) was then used to examine the means of the levels of cues that each individual had used; for example, how each different diagnosis had been prioritised. ANOVA is needed to examine means when there are three or more groups; for example, five types of diagnosis. (T-tests are used for two groups.) Of particular interest was the level of cue with the highest mean, indicating that it had been given the highest priority. For the cue reason for referral, 68% of the participants had prioritised the most severe occupational dysfunction described. This level had included both physical and psychological dysfunction and requested a functional assessment. None of the participants had prioritised requests to monitor changes in medication or to help family dynamics where the individual's occupational dysfunction was not impaired. Eighty-three per cent had prioritised suicidal history (aggressive to self) over those who were physically or verbally aggressive and 88% had prioritised schizophrenia over those with other psychotic or neurotic disorders. For the cue describing living situations, 93% had prioritised those living alone over those living with family or in group homes. With regard to available support, 100% had prioritised no support as the highest level of cue over those seeing a counsellor or having a day centre place. Seventy-two per cent had prioritised referrals from psychiatrists over those from general practitioners or colleagues.

Cluster analysis

Cluster analysis was then used to identify the subgroups of occupational therapists with differing policies. The method of cluster analysis chosen for this study was Ward's (1963) method. It has been shown to be a more effective method of clustering than other methods (Blashfield 1976, Mojena 1977). It is also recognised as an appropriate method for discovering groups of judges within a data set (see, for example, Cooksey et al 1990).

Ward's method of cluster analysis is a type of 'hierarchical' cluster analysis. These hierarchical methods are used to discover the natural number of clusters present in the data (Everitt 1974). This differs from non-hierarchical cluster analysis which specifies, *a priori*, how many clusters to group data into. In the social sciences, a researcher is often interested in discovering the natural groupings that may occur in the research data (Dillon and Goldstein 1984). Ward's method gradually builds up groupings, according to similarity using the error sum of squares, to make a sequential aggregation of groupings, starting with all individuals and, finally, making one large group. The results of these agglomerative methods are displayed in a dendrogram showing the succession of fusions. The number of clusters has to be identified visually from the dendrogram. Confirmation of the number of clusters can be identified by the change of angle ('elbow') in a scree line plot.

The ultimate purpose of using the cluster analysis was to allow the clusters to be examined according to relevant issues of interest. For example, mean cue weights could be plotted for each cluster to identify the cues most responsible for differentiating the clusters. The clusters could also be checked against other relevant data to examine external validity (Cooksey 1996). For example, the participants' demographic data could be examined to see if variations in treatment settings, caseload balance or expertise could be

Fig. 2. Dendrogram of occupational therapists' beta weights using Ward's (1963) method.

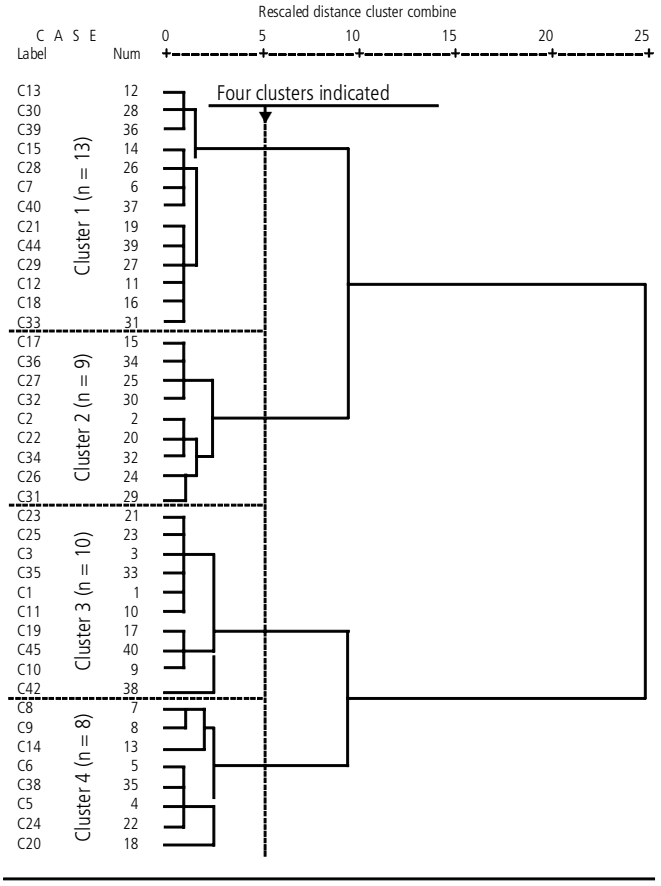


Fig. 3. Beta weights: inverse scree plot of distance versus number of clusters.

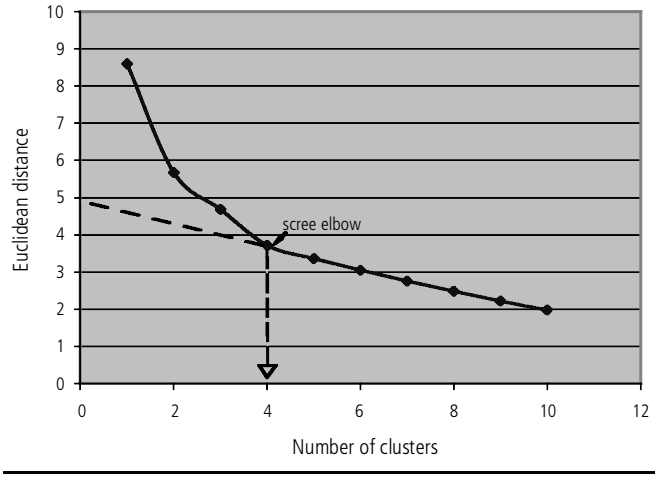


Table 1. Descriptions of clusters formed by Ward's analysis on beta weights: mean scores and percentages

Characteristics	Cluster 1 (n = 13)	Cluster 2 (n = 9)	Cluster 3 (n = 10)	Cluster 4 (n = 8)	Clusters that differ significantly (Mann-Whitney U test)
% of time in OT role	44%	63%	42%	59%	2>1,3
% of time in generic role	56%	37%	56%*	41%	2<1,3
% of OTs who feel generic role is too big	69%	44%	20%	44%	1>3
No. of psychiatrists in team	1.5	2.4	1.9	1.9	2>1
No. of community support workers in team	2.3	1	1.5	1.4	2<1
Teams with prioritisation policies	31%	70%	67%	63%	1<2
OTs with prioritisation policies	39%	20%	70%	25%	3>2
No. of team referrals	26	48	45	32	2>1
No. of hours worked each week	36.5	30.6	34.1	31.2	2<1
Mean consistency (Pearson's) in applying policy on the 30 repeated referrals	0.82	0.71	0.78	0.55	4<1,3

*Participant 25 in cluster 3 did not total the percentages of time in role to 100%.

associated with the clusters of prioritisation policies. Any patterns that supported the groupings would add external validity to the cluster groupings.

Results

Initial examination of the Ward's cluster analysis dendrogram suggested that four potential clusters were present (Fig. 2). A scree graph confirmed that this was the correct number of clusters to interpret (Fig. 3). Therefore, there were four main types of referral prioritisation policy used by the 40 occupational therapists. In order to identify any differences in the cue weights used to separate the clusters, the mean cue weights were plotted for the four clusters (Figs 4-7). These four types of policy were then validated against patterns in the demographic data to identify any reasons that these participants had been grouped together.

The demographic characteristics that differed significantly ($p<0.05$) using the Mann-Whitney U test are shown in Table 1. Both the key factors of interest – the size of the generic role and the level of satisfaction with this role – were found to be statistically significant between some of the clusters. The demographic data did not vary significantly between the clusters in relation to the participants' age, grade, type of catchment area, length of waiting list, size of caseload, percentage of caseload with a care-coordinator role, number of community psychiatric nurses in team, number of social workers in team, general facilities, location, transport and equipment, whether the team was full and whether they had sufficient staff when the team was full.

Using the demographic and practice characteristics of each cluster, statistically different results were most notable between cluster 1 and cluster 2. Compared with cluster 1, the participants in cluster 2 had less of a generic role ($U = 28$, $p = 0.038$) and more of an occupational therapy role ($U = 27$, $p = 0.33$), worked fewer hours ($U = 28.5$, $p = 0.035$), had a greater level of expertise in the team (number of psychiatrists $U = 23.5$, $p = 0.014$, and number of untrained community support workers $U = 26$, $p = 0.026$), received a greater number of team referrals ($U = 23$, $p = 0.027$) and were more likely to have a team prioritisation policy ($U = 30$, $p = 0.049$).

The participants in cluster 3 differed significantly in that they had spent more time in a generic role in relation to those in cluster 2 ($U = 18.5$, $p = 0.028$). They were also more satisfied than those in cluster 1 with the time they spent in a generic role ($U = 31$, $p = 0.034$). Cluster 3 also had a greater number of participants with their own referral prioritisation policies compared with cluster 2.

The participants in cluster 4 were only differentiated by their low level of consistency when applying their policy on identical referrals.

The participants in cluster 1 were labelled the aspiring specialists, those in cluster 2 the satisfied specialists, those in cluster 3 the satisfied genericists and those in cluster 4 the chameleons.

Fig. 4. Weighting given to referral information by cluster 1 (aspiring specialists, n = 13).

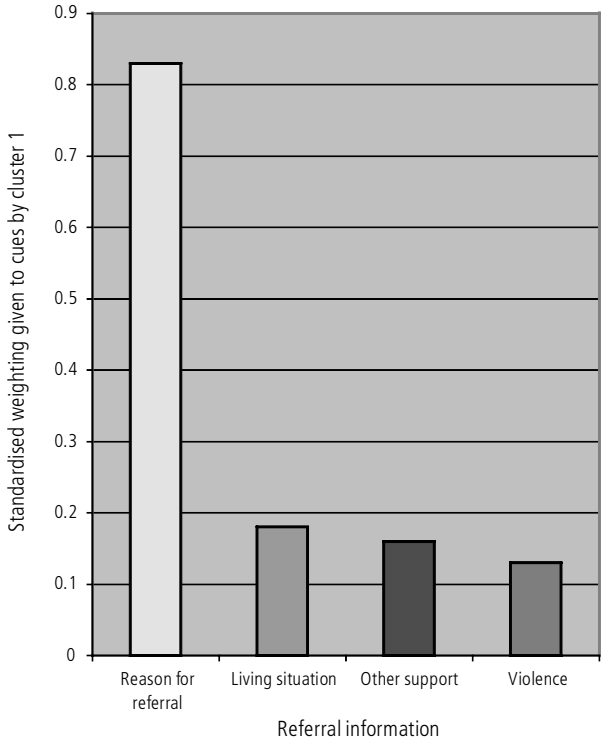


Fig. 5. Weighting given to referral information by cluster 2 (satisfied specialists, n = 9).

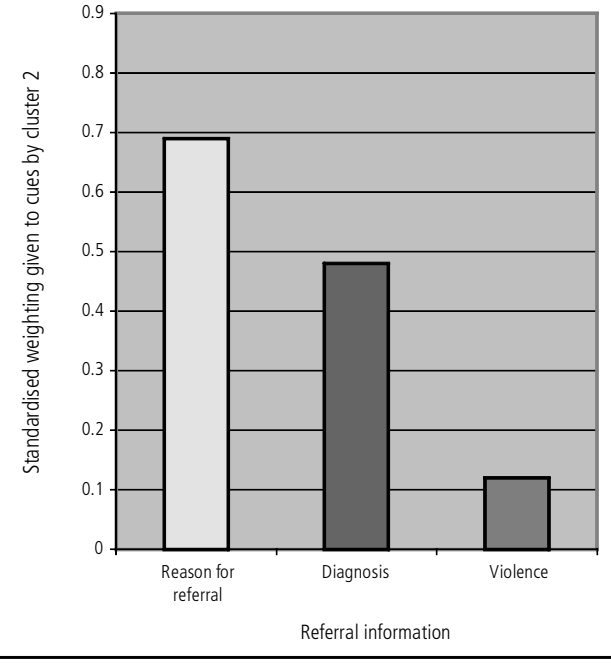


Fig. 6. Weighting given to referral information by cluster 3 (satisfied genericists, n = 10).

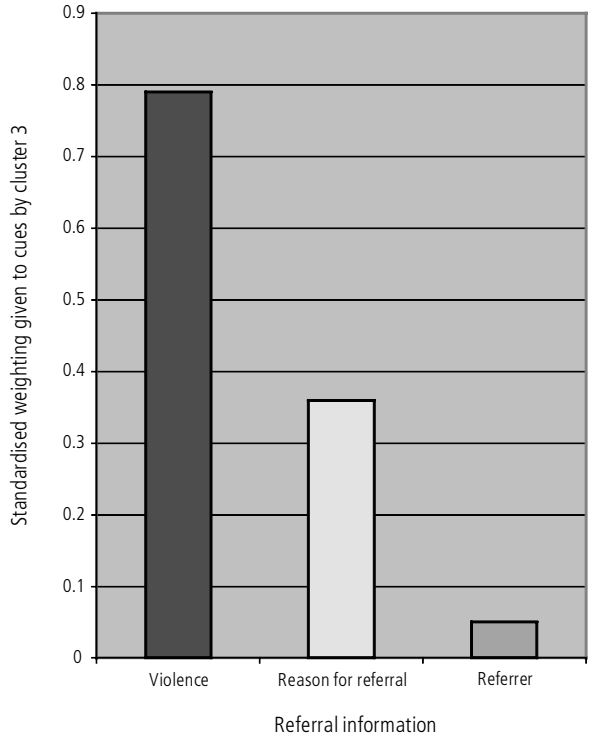
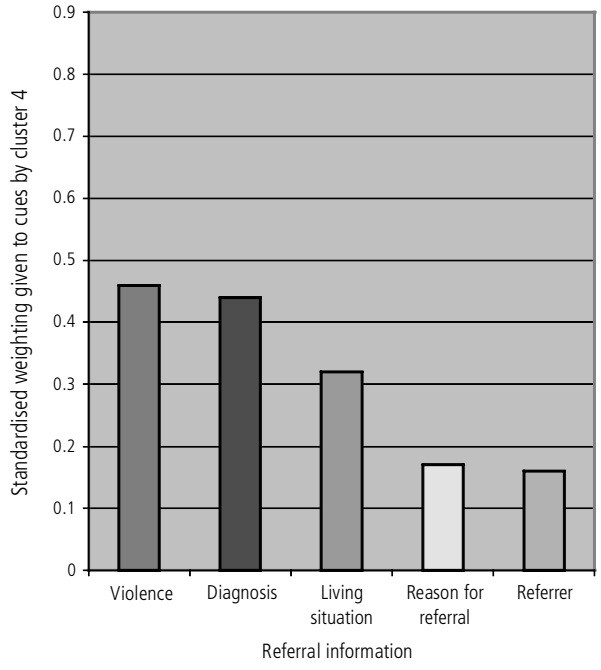


Fig. 7. Weighting given to referral information by cluster 4 (the chameleons, n = 8).



The aspiring specialists (cluster 1)

The aspiring specialists (n = 13) were characterised by full-time staff who, compared with the satisfied specialists, were taking a greater percentage of generic cases (56%). Compared with the satisfied specialists, their teams were less professionally qualified (fewer psychiatrists and more untrained community support workers).

The aspiring specialists took the same percentage (56%) of generic cases as the satisfied genericists. However, 69% of the aspiring specialists were dissatisfied with this situation compared with only 20% of the satisfied genericists. The aspiring specialists sought to take a greater occupational therapy role.

The aspiring specialists placed high importance on the cue reason for referral (ß = 0.83). The client's living situation, other support and history of violence were also used (statistically significant to a level of <0.05), but given much less importance.

The satisfied specialists (cluster 2)

The satisfied specialists (n = 9), compared with the aspiring specialists, were characterised by part-time staff, who were being referred a greater number of cases and whose caseload held a greater percentage of professionally focused cases. Their teams were more professionally qualified (more psychiatrists and fewer untrained community support workers).

The satisfied specialists placed high importance on the reason for referral (ß = 0.69) and moderate importance on diagnosis (ß = 0.48). The level of violence was considered by only two of the nine members of the satisfied specialists. In addition, the diagnosis cue was the cue that differed the most between the aspiring specialists and the satisfied specialists ($t = -6.923$, $df = 19$, $p = 0.0001$).

The satisfied genericists (cluster 3)

The satisfied genericists (n = 10) had a mainly generic role and were the most satisfied with their role. The participants in this cluster were the most likely to have their own prioritisation policy.

The satisfied genericists placed high importance on the history of violence (ß = 0.79). Moderate importance was placed on the reason for referral (ß = 0.36). The referrer was considered but given minimal importance.

The chameleons (cluster 4)

The chameleons (n = 8) had the flattest graph: they used the most cues and gave no particular emphasis to any one cue.

The chameleons placed low to moderate importance on five cues. The highest of these were history of violence (ß = 0.47) and diagnosis (ß = 0.45), with reason for referral being given low importance. Of the 40 participants, the chameleons tended to have the lowest consistency scores. Indeed, the chameleons had the lowest mean consistency score of the four subgroups (mean r = 0.5). Their consistency scores were significantly lower than those of the aspiring specialists ($t = 3.397$, $df = 19$, $p = 0.003$).

Since the chameleons had the lowest weighting for reason for referral, a hypothesis was considered that consistency might be positively correlated with the use of this cue. A post hoc correlation was therefore conducted on the results of the 40 participants to examine the relationship between consistency scores (using Fisher's scores to correct for non-normality of distribution) and the weightings given to the reason for referral cue. This relationship was found to be significant ($r = 0.348$, $p = 0.028$, $N = 40$). Those participants who were least consistent in applying their policies were less likely to use the reason for referral cue.

In order to examine how each cluster had used the levels of each cue, for example, how the different types of diagnosis had been prioritised, ANOVAs were used to identify mean scores of levels of cue for each cluster. This was done by analysing each cluster's mean standardised ratings (composite judgements) with the 90 standardised profiles. The levels of each cue were found to be similar between clusters. It was not so much the content of the cues that altered policy, but the importance placed on the cue itself that determined the priority a referral was given.

Discussion

Four subgroups were identified out of the 40 occupational therapists in the original study. Not all these participants may have been optimally clustered because Ward's method tends to produce clusters of equal sizes. It is therefore possible that, in some data sets, small groups of unusual data can be grouped in large clusters; consequently, a small radical faction may not be appropriately represented. However, the subgroups could be clearly differentiated by demographic and practice factors, which adds external validity to the findings. There are several key points of interest.

The satisfied genericists

A quarter of the sample was happy to have a strong generic role. This original sample was taken only from those therapists who took direct occupational therapy referrals, so some occupational therapists in purely generic roles may not have participated in the study. The percentage of satisfied generic therapists may, therefore, be even greater than that reported here.

This may be progressive in terms of team working, but these therapists are not working as their professional body would wish. The professional body for occupational therapists has recommended that occupational therapists spend the majority of their time on specialist occupational therapy interventions (Craik et al 1998). However, the satisfied genericists in the study have chosen to take up the call of generic work and have generally found their niche. Owing to limited professional supervision, they are probably in closer contact with their team than they are with their occupational therapy colleagues. Their allegiance may well be with their team more than with their profession.

In the 1980s, only 10% of community mental health teams had a manager (Onyett 1997); now the large majority of teams have managers who have taken a strong role in the allocation of cases (Onyett 1997). Indeed, some managers see specialist working as a form of professional protectionism (Parker 2002). This attitude may have led to greater pressure to consider generic working and therapists may have had less individual choice in the matter.

The aspiring specialists

The largest cluster comprised those participants who wished to have a greater occupational therapy role. They had the same mean percentage of generic cases as the satisfied genericists, but they were generally unsatisfied with this role. They worked the longest hours of the four subgroups and may have been under pressure from their teams to take too many cases, especially generic ones. It has been recognised that strong professional leadership is needed to maintain a professional focus (Craik et al 1999). Each professional group values differing approaches to

maximising health. Health achieved through occupation is most highly valued by occupational therapists. Team managers are rarely occupational therapists and it can, therefore, be difficult to get professional support for the occupational therapy perspective.

The teams of this cluster were the least likely to have a prioritisation policy. In fact the occupational therapists themselves were more likely to have a prioritisation policy than their teams were. So perhaps, rather than being under pressure to work in a certain way, they lacked guidance and were, therefore, having to set the goals themselves.

This cluster also, however, had different referral prioritisation policies to those of the other clusters. They gave the greatest weighting to the reason for referral cue. This would have helped them to take an occupational perspective because the opportunity to identify an occupational need is most likely to be contained in this information. However, unlike the satisfied specialists they did not give importance to the diagnosis cue. Had they given greater importance to the diagnosis cue, they might have been more likely to give priority to clients with schizophrenia (the top weighted level of the diagnosis cue by 88% of the 40 occupational therapists). Clients with schizophrenia often have difficulties around self-care, concentration, motivation, use of time, occupational deprivation and limited socialisation. These difficulties commonly benefit from an occupational perspective (Creek 1990).

The satisfied specialists

The occupational therapists in this cluster were working in well organised, highly professional teams. This cluster had the most trained professionals and usually had clear team prioritisation policies (70%). The difference that this type of able team can indeed make to the effectiveness of the occupational therapist's role has indeed been acknowledged in the recent professional debate (Stone 2002). The occupational therapists in this cluster were able to take the greatest occupational therapy role and they were even keen to increase this. They were usually not working full time so may have had a little more time to reflect. However, their hours were still substantial (mean 30.6 hours per week) and they were therefore making a significant and apparently satisfying contribution to the team. They may have been less in need of their own prioritisation policies (20%) because they were happy with the strong policies of the team, which tended to support professional training.

The chameleons

Although the sample comprised experienced occupational therapists, many in this cluster did not seem to have found their feet in terms of both a specific policy to apply and when to apply it. The methodology of incorporating a large number of scenarios with repeated profiles did allow for this group to be recognised. It is common for studies to use only a few scenarios for participants to make decisions upon (Reich et al 1998), but it is risky to use only a small number of scenarios if generalisations about policy are to be made. The judgement analyst values sampling the environments as much as sampling the participants (Cooksey 1996). Both are needed to give a representative picture.

For the chameleons, there were no particular referral cues that were highly valued. This made it difficult for them to have a fixed policy. Like those in the total sample, they were under pressure to take too many generic referrals and 44% of them felt that their generic workload was too large. Having a clear policy may help them to manage their caseload more effectively and reduce workload responsibilities. Nevertheless, the participants in this cluster were working in keeping with the professional body's ideal, that is, focusing mainly on the occupational perspective. They were able to hold an occupational therapy role in 59% of each of their caseloads.

Improving effectiveness

As mentioned above, in order to promote an occupational therapy perspective, careful attention must be paid to the reason for the referral and the client's diagnosis when prioritising referrals.

The cue that perhaps needs less attention in prioritisation is the history of violence. This cue was valued most highly by the generic therapists and less so by the specialists and aspiring specialists. It contains information relating to suicidal or aggressive intent. This type of information would certainly indicate a priority for the team because of the risk that the client may harm himself or herself or others. The client is certainly a priority, but various members of the team can undertake a risk assessment. The social worker, the psychiatrist and the community psychiatric nurse may be in a better position to take decisions about using a section of the Mental Health Act to allow a client to be hospitalised or about considering the use of medication. An occupational therapist may more appropriately use his or her skills in assisting clients with occupational dysfunction when the acute crisis has passed. The satisfied specialists in the study appeared to be opting for this method of prioritising new referrals. The appropriate use of services is paramount to ensure that clients get their needs met effectively (Department of Health 1999).

It is interesting that, in the education and training of undergraduate occupational therapists, the violence cue is often over-valued when prioritising referrals (Harries et al 2002). Education about each profession's skills can help occupational therapy students to recognise that they do not have to take all suicidal or aggressive clients themselves. Occupational therapists need to learn how to make their level of casework manageable and their contribution effective.

There is certainly pressure from many community mental health teams for occupational therapists to be generic workers. Long waiting lists of individuals in severe need may cause managers to allocate cases without due consideration for matching need with team members' skills. Through follow-up discussions, it is apparent that some occupational therapists have managed to promote the

effectiveness of their occupational therapy contribution whilst others have reluctantly fallen in with the expectation that they join the generic workforce. By promoting knowledge of effective prioritisation policies, ideas can be generated and practice continually developed.

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