This research sought to investigate the self-perceived competence of mental health occupational therapists in Queensland. The research is a post-hoc analysis of survey results that formed part of the 1995 Professional Development Strategy for Adult Mental Health Services for the Queensland Health Mental Health Unit. A sample of 55 occupational therapists was compared with other professionals in relation to both general self-efficacy and efficacy in specific competencies. The devised scale for measuring self-efficacy was found to have a high level of internal reliability.

The results indicated that the general self-perceived competence of occupational therapists for the whole sample was comparable to that of other professional groups, but that in the community-based sample it was significantly higher than that of social workers or nurses. In addition, occupational therapists in community settings had significantly higher general self-perceived competence than occupational therapists in hospital locations. Greater length of experience in mental health was strongly predictive of higher levels of competence for occupational therapists than for other professionals.

The results suggest that occupational therapists have adapted well to the demands of multidisciplinary community practice. The possible reasons for these results, and the implications for competency-based recruitment and training, are presented.

The Competence of Mental Health Occupational Therapists

Amanda Jane Greaves, Robert King, Peter Yellowlees, Susan Spence and Chris Lloyd

Introduction

In Australia, policy statements guiding the delivery of mental health services since the adoption of the National Mental Health Policy and Plan (Australian Health Ministers 1992) have emphasised continuity of care, the provision of high quality accessible services and the development of intersectoral linkages and collaboration (Queensland Health 1996).

The roles of mental health professionals have undergone significant changes in recent years. Major trends in the policy climate, including the move toward deinstitutionalisation and community-based care, the increased focus on cost-effectiveness and accountability, the rise of consumer-based health care (Thorner 1991) and the recognition of consumer rights and self-determination (Lloyd et al 1998), have had a significant impact on mental health practice.

Mental health professionals working in community settings are required to provide generically based case management services in addition to discipline-based services. Generic case management roles include the development, monitoring and review of the individual management plan; the provision of education and support for illness, treatment and medication management; support and education to carers and families; and the coordination and facilitation of access to a range of interventions. The National Standards for Mental Health Services (Commonwealth Department of Health and Family Services 1997) further stipulated the involvement of consumers and carers in service planning and evaluation, health promotion and community education, the protection of consumer rights, cultural awareness and documentation. The move to community-based services has eroded the structured roles and identities of hospital-based staff and lessened the emphasis on professional departments (Harries 1998). Community-based workers are also required to work more autonomously than in the institutional setting.

These changes in service delivery and the new demands of the generic case manager role raise questions about the competence of mental health professionals working within the new frameworks, particularly those working in community settings where these changes may be more pronounced. The measurement of competence is fundamental to the consideration of factors affecting client outcomes and for informed recruitment and staff development practices.

Literature review

Challenges for occupational therapy

The challenge for occupational therapists in mental health has been described by Lloyd et al (1998) as being that of

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keeping their unique identity while extending their role and encompassing more non-traditional tasks. The holistic philosophical base of occupational therapy and its emphasis on functional independence, rehabilitation and environmental adaptation form a strong base for community practice (Learnard and Devereaux 1992) and are consistent with the principles of case management for those with severe psychiatric disability.

While there may be core aspects of occupational therapy that are congruent with contemporary models of mental health service delivery, there is also evidence of significant areas of limitation. Krupa and Clark (1995) suggested that occupational therapists may be less well prepared in their base education and training to carry out tasks such as crisis management, health education and counselling, family interventions, resource and service development, advocacy and lobbying. They further described a need for occupational therapists to develop their knowledge and skill base in these areas through on-site resources, support, hands-on training and formal educative processes. These needs are likely to affect new graduate occupational therapists in particular, a group that by its nature lacks well developed practice skills (Adamson et al 1998). Community settings with high levels of role ambiguity and higher levels of autonomy and responsibility are likely to be especially challenging for new graduates.

Professional identity

The need for occupational therapists to maintain a strong and adaptive sense of professional identity in the face of pressure generated by changes to mental health policy and practice is clear. Case management is now an expected role of community mental health practitioners (Queensland Health 1996). 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).

Gaitskell (1998) pointed out that the lack of a clear professional identity may cause insecurity and difficulty in critical self-appraisal. Yau (1995) suggested that unless occupational therapists felt professionally competent and had a clear understanding of their practice, role conflict and role confusion would become pressing problems.

Recent Australian research has revealed that occupational therapists are polarised over the issue of case management and the provision of generic skills and has shown the impact that this has had on discipline-specific skills and, subsequently, professional identity (Lloyd et al 2002). Evidence from the United Kingdom (Craik et al 1998, Taylor and Rubin 1999) indicates that occupational therapists lack both a unifying theoretical base and a clear definition of the profession. Together, these are factors with the potential to affect adversely the self-efficacy of occupational therapists, especially in community mental health settings.

Self-efficacy and competence

Self-efficacy refers to personal judgements of one's capacity to organise and implement actions in novel or unpredictable situations (Bandura 1982). Self-efficacy has been strongly linked to a range of attributes relevant to professional functioning. High levels of self-efficacy are associated with higher performance accomplishments, while judgements of self-efficacy determine how long a person will persist in the face of obstacles or challenges (Gage and Polatajko 1994). Cherniss (1991) proposed a central role for professional self-efficacy in the development of career commitment.

Most importantly, self-efficacy can be considered an index of actual competence (Stajkovic and Luthans 1998). Bandura (1982) provided a conceptual link in his argument that self-efficacy beliefs influence the initial decision to perform, expend effort and persist in a task. A bi-directional model for the link between perceived and actual competence has been proposed by Henry and Coster (1997). Factors that mediate the relationship between self-efficacy and action may include situational constraints and disincentives, unclear task requirements, and inadequate tools and resources for task execution (Bandura 1982).

An American study of 95 occupational therapists practising in mental health found a high level of perceived competence for the performance of professional tasks (Cottrell 1990). This study found that 90% of the respondents perceived their ability to adapt their role to a changing practice setting and mental health system as good or excellent.

Aim of the study

The study aimed to examine the self-efficacy of occupational therapists working in various mental health settings and to investigate the factors that might affect the development and maintenance of self-efficacy in the occupational therapy professional group.

Method

Design

The study took the form of a secondary analysis of data obtained from a survey conducted by the University of Queensland for the Queensland Health Mental Health Unit in 1995. A questionnaire, the Mental Health Workers Core Competencies Scale (King et al 2002), was administered to Queensland Mental Health employees as part of this survey to provide information about their training needs.

Sample

The sample consisted of eight professional groups; however, the reporting of results is restricted to the six groups carrying out broad-spectrum clinical and case management functions, namely occupational therapy, nursing, social work, social work associates, psychology and psychiatry (Table 1). A total of 1542 replies were obtained, a response rate of 51%.

Survey instrument

The Mental Health Workers Core Competencies Scale (MHWCCS) is a 27-item self-report scale in which

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Table 1. Sample statistics – discipline and location

Location	Discipline: Occupational therapy	Psychology	Nursing	Social work	Social work associates	Psychiatry
Acute inpatient	15	9	563	9	0	32
Extended inpatient	9	13	264	7	2	6
Community	23	52	219	52	14	42
Other	8	10	100	7	2	21
TOTAL	55	84	1146	75	18	101

respondents are invited to indicate their level of self-rated competence in a wide range of professional skills, both clinical and non-clinical, in contemporary mental health services. Scale items were generated by a multidisciplinary panel formed by a consultancy group commissioned by Queensland Health to identify the core competencies required by mental health practitioners. The scale also made use of items developed and piloted by author K with a cohort of mental health professionals engaged in multidisciplinary postgraduate study.

The items covered areas such as knowledge and understanding of mental illness and clinical interventions, related legal, ethical and policy issues, the ability to provide case management services, the ability to conduct generic and discipline-specific diagnosis and treatment, the ability to involve family, carers and consumers, the provision of education to others, networking, teamwork, service evaluation, human resource management issues, information management and quality assurance. The respondents rated how competent they felt on each item, from 1 (high level of competence) to 4 (not competent), and also indicated on a similar scale how much training they felt they needed in relation to each item.

The scale was found to have high levels of internal reliability (Cronbach's alpha coefficient = 0.93). The scale appeared to have face validity because the items reflected the areas of competence specified within relevant policy and in literature relating to best practice in mental health service delivery, and the items were also reviewed by a sample of relevant academic, clinical and management staff and consumers. No other similar scale was available to determine the concurrent or criterion validity. Factor analysis did not suggest the existence of underlying subscales, which was consistent with the high Cronbach alpha finding.

Data analysis

The scale data were analysed using multivariate analysis of covariance to compare total self-rated competence scale means for discipline and work location groups. This form of analysis was chosen because the scale total approximated interval data with normal distribution. This analysis was supplemented by a comparison of ranks using Mann-Whitney U tests for individual item scores where the data were clearly ordinal in quality.

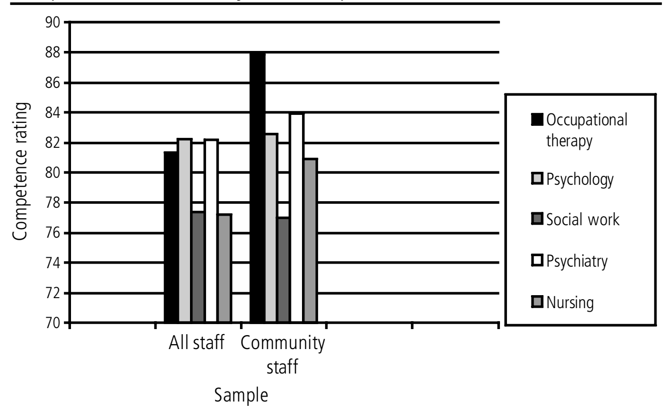
Results

Two-way analysis of covariance was conducted to investigate the effect of work location (hospital versus community) and discipline (occupational therapy, nursing, social work, psychology and psychiatry) on self-rated competence, after taking into account the length of experience (covariate). The length of experience in mental health practice was a highly significant covariate ($F = 83.3$, $df = 1$, $p < 0.01$). Main effects were found for both location ($F = 8.3$, $df = 1$, $p<0.01$) and discipline ($F = 7.4$, $df = 4$, $p<0.01$).

The interaction effect between profession and work location approached but did not reach significance ($F = 2.2$, $df = 4$, $p = 0.07$). However, when the sample that worked in community settings was examined separately, it was found that occupational therapists had the highest self-perceived competence of any discipline ($F = 4.14$, $df = 4$, $p<0.01$). Post-hoc comparisons using Bonferroni corrections revealed that occupational therapists reported significantly higher competence than social workers (mean difference = 9.84, SE = 2.73, $p<0.01$) (see Fig. 1). This difference was not evident in other locations, including extended inpatient, acute inpatient, and those who worked across a range of settings.

When individual item scores for the community sample were investigated using the non-parametric Kruskal Wallis test, occupational therapists scored significantly higher than all the other professional groups in their understanding and

Fig. 1. Disciplinary differences in self-efficacy: comparison of the self-perceived competence of all disciplines in the total sample and community sub-sample.



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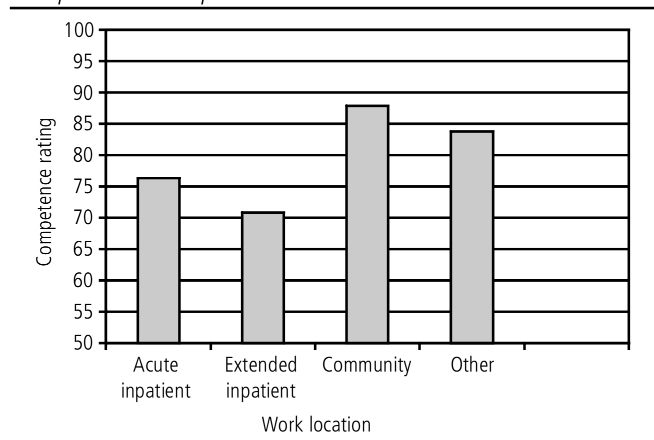
appreciation of the specialist skills of other professionals in the mental health team (chi square = 14.92, df = 4, p<0.01) and their ability to build a team (chi square = 36.71, df = 4, p<0.01).

Total self-rated competence scores for occupational therapists were investigated using one-way analysis of variance across work settings (acute inpatient, extended inpatient, community and mixed). The differences were significant (F = 7.0, df = 3, p<0.01), with those working in the community having higher self-perceived competence than those working in extended inpatient and acute inpatient settings (Fig. 2). Analysis of item scores, using Mann-Whitney U test, revealed that the items on which community-based occupational therapists scored significantly higher than their counterparts in other settings tended to reflect the generic nature of their work tasks. The items referred to case management (z = 4.11, p<0.01), triage of referrals (z =3.12, p<0.01), knowledge of the legal framework for mental health service delivery (z = 4.13, p<0.01) and networking with community practitioners and service providers (z = 3.57, p<0.01).

Fig. 2. Occupational therapy self-efficacy: the self-efficacy of occupational therapists in four locations.



Discussion

Overall, the self-efficacy and, therefore, possibly the competence of occupational therapists in mental health in Queensland was comparable to that of the other professional groups in the whole sample, and relatively higher than that of some other professional groups in the community setting. These findings are inconsistent with much of the available literature and seem to refute the suggestion that a crisis of professional identity may be negatively affecting the self-perceived competence of the profession (Paul 1996, Gaitskell 1998).

The reasons for such high levels of self-perceived competence may be found in occupational therapy education and training: their functional and rehabilitation based training may well equip occupational therapists to work with the everyday functional issues posed as problems by clients with serious mental illness. Similarly, Cottrell (1990) suggested that basic and continuing education may provide occupational therapists with the knowledge, skills and attitudes needed to perceive themselves as competent mental health practitioners. It is also possible that the occupational therapists entering the mental health field are those with higher levels of self-perceived competence, either through successful fieldwork placements in mental health or other life experiences, and who are able to work more autonomously and creatively. Lloyd et al (2002) found that over 70% of therapists in their Australian sample were attracted to the mental health field owing to the diversity, flexibility, autonomy and creativity of the work. Similar findings were reported in the Craik et al (1998) study of British mental health occupational therapists. Further research on these factors and on the influence of state-specific factors related to education and training or health care service delivery is needed to determine their influence and allow for the generalisation of these results.

The presence of discipline-based differences in self-efficacy in community settings, with occupational therapists scoring significantly higher than nurses and social workers, seems to indicate that occupational therapists have made a successful transition to mental health settings, incorporating generic tasks into their case management approaches. The broad psychosocial rehabilitation knowledge base of occupational therapists appears to have provided an effective foundation for the development of the wide range of professional roles required in mental health rehabilitation and case management.

The specific strengths identified in the occupational therapy professional group sample as being more pronounced in the community setting, including multidisciplinary, teamwork and human relations skills, may be part of the occupational therapy core performance knowledge and skill base. However, it was notable that there was a greater experience effect for occupational therapists than for the other professions. This suggests that the core professional education and training received by occupational therapists in Queensland and/or the specific attributes brought to the profession are consistent with a high level of learning on the job. Occupational therapists in community settings appear to have been able to expand their skill base to include generic tasks, such as triage and case management, to the degree where they rate themselves highly in these areas.

The second significant finding was that occupational therapists who worked in community mental health settings had significantly higher self-efficacy than occupational therapists who worked in acute inpatient or extended inpatient mental health settings. This finding may relate to the generic nature of the questionnaire, which measured skills and competencies that are not required by occupational therapists in inpatient settings. In these settings, occupational therapists are more likely to function in discipline-specific roles, using competencies and skills not represented on the questionnaire. It is also possible that higher levels of self-efficacy are linked to factors related to the community environment, such as greater autonomy and the increased likelihood of seeing positive results of interventions with clients who are not as ill as those in inpatient settings.

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Limitations of the study

It is difficult to know how far the findings would generalise beyond the study sample. While there are similarities in contemporary mental health practice in different parts of the English-speaking world and a broad equivalence in occupational therapy education and training, the impact of local work environment and training characteristics is an unknown factor.

Caution is also required as a result of the nature of the study. While the total study sample was large and the response rate above 50%, post-hoc analysis can capitalise on chance factors and a cautious interpreter of the results of the statistical analysis might conclude that there were not differences between the groups (that is, neither main nor interaction effects). The authors think that such a conclusion is unwarranted and that the ANOVA results were affected by inequality of variance among the different groups.

A replication of this study is required in order to obtain a better picture both of occupational therapy self-efficacy in other locations and of the generalisability of professional differences in self-efficacy in community settings.

Conclusion

This study has highlighted the high levels of self-perceived competence that exist amongst occupational therapists working in public mental health services in Queensland. Occupational therapists working in community settings rated their efficacy higher than did any other professional group and there were statistically significant differences between the efficacy scores of occupational therapists and those of nurses and social workers. These results suggest that, contrary to some earlier reports, occupational therapists have adapted well to the demands of the multidisciplinary community-based approaches to service delivery that characterise contemporary public mental health practice. This conclusion is reinforced by evidence that self-efficacy for occupational therapists is strongly linked to work experience, indicating that this professional group has a high capacity to learn new skills on the job.

While highlighting these issues, the study also raises many questions. No causal relations were established and the reasons for these results need to be investigated further. Further research is also needed to identify other factors, such as personality factors, which may influence self-perceived competence and were not included in this study. Furthermore, while in general self-efficacy has been found to have a robust relationship with work performance, the strength of this relationship declines as work tasks become more complex and when data are collected from naturalistic rather than laboratory settings (Stajkovic and Luthans 1998). Caution is needed both in generalising from the study sample and in presuming that self-efficacy implies task competence.

Notwithstanding the need for caution, the predictions of a declining role for occupational therapists in mental health may well be premature. Rather, it would appear that occupational therapists are responding to the many external pressures and changes in the service delivery environment by incorporating new skills and expanding their practice to produce high levels of competence. It is possible that the high self-efficacy of the profession derives from its underlying holistic and consumer-focused value base, enabling occupational therapists to maintain the strong and adaptable sense of professional identity so needed in the changing field of mental health service delivery. This does not mean that the profession should abandon a process of realistically evaluating threats and challenges; it might, however, best be done in the context of acknowledging the strengths and capacities of its members.

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