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Title:

Identifying educational priorities for occupational therapy students to prepare for mental health practice in Australia and New Zealand: Opinions of practicing occupational therapists

Short title:

Mental health education priorities

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Abstract

Introduction: The effective preparation of occupational therapy students for mental health practice is critical to facilitate positive consumer outcomes, underpin optimal practice and support new graduates' professional identity. This project was established to determine a set of "educational priorities" for occupational therapy students to prepare them for current (and future) entry-level practice in mental health, from the perspective of mental health occupational therapists in Australia and New Zealand.

Methods: The study included two phases. In Phase One, participants identified what they considered to be important educational priorities for occupational therapy students to prepare them for practice in mental health. For Phase Two, an "expert panel" was assembled to review and rank these using a Policy Delphi approach.

Results: Eighty-five participants provided educational priorities in Phase One. These were grouped into a total of 149 educational themes. In Phase Two, the expert panel (consisting of 37 occupational therapists from diverse locations and practice settings) prioritised these themes across three Delphi rounds. A final priority list was generated dividing educational themes into three prioritised categories: 29 "Essential," 25 "Important," and 44 "Optional"

priorities. Highest-ranked priorities were: clinical reasoning, client-centred practice, therapeutic use of self, functional implications of mental illness, therapeutic use of occupation, and mental health fieldwork experience.

Conclusion: The priority list developed as part of this project provides additional information to support the review of occupational therapy curricula across Australia and New Zealand to ensure that new graduates are optimally prepared for mental health practice.

Introduction

The overarching aim and responsibility of every professional preparation program in occupational therapy is to support graduates' attainment of competencies required for entry-level practice (e.g., Occupational Therapy Australia, 2010; Occupational Therapy Board of New Zealand, 2000) while meeting the minimum standards for education set out by the World Federation (Hocking & Ness, 2002). In addition to these general responsibilities, there is also a need to support the development of knowledge, skills and attitudes relevant for specific practice areas.

In order for university programs to effectively prepare occupational therapy students for mental health practice, there needs to be some consensus about the nature of the knowledge, skills and attitudes that are needed before graduation. Although a number of competency documents are available to support workforce development (e.g., National Mental Health Strategy, 2013; O'Hagan, 2001), these tend to focus on competencies that should be developed by all mental health professionals within the first two years of practice. In addition, the most specific document, *Australian Competency Standards for Occupational Therapists in Mental Health* (OT AUSTRALIA, 1999), which also focuses on competencies expected of more experienced occupational therapists, is now over 15 years old and may not reflect current practice demands.

Over the past two decades, substantial changes have occurred in the mental health sector in Australia, New Zealand and around the world. Although mental health reform has progressed differently in different jurisdictions, some common changes include: (i) greater focus on community-based treatment and support; (ii) a policy shift towards recovery orientation of services, (iii) expansion of the non-government and private sectors; (iv) focus on promotion,

prevention and early intervention and (v) an increased focus on social and economic participation of individuals living with serious mental illness (Gerrand et al., 2012; Lloyd, Waghorn, & Williams, 2008). All of these changes have influenced the range of duties and roles undertaken by occupational therapists. For example, the shift from hospital- to community-based models of care has seen a surge in the number of positions that are open to a variety of mental health professionals (e.g., “generic” positions such as “care coordinator”). Although there has been much debate in the literature about the various advantages and disadvantages of “generic” and “discipline-specific” roles of occupational therapists in mental health (e.g., Ceramidas, 2010), the proportion of generic positions continues to grow. Additionally, while recovery-oriented practice is well-aligned with the core principles of occupational therapy (Rebeiro Gruhl, 2005), support for the development of additional knowledge and attitudes is also required. Finally, changes within the mental health system have led to a stronger focus on promotion, prevention and early intervention and the social and economic participation of individuals living with serious mental illness (National Mental Health Strategy, 2013; O'Hagan, 2001). Programs such as Personal Helpers and Mentors, Disability Employment Services, Better Access to Mental Health care, headspace and beyondblue have increased the involvement of the private and non-government sectors in mental health service provision which presents new opportunities for occupational therapists (Kohn, Hitch, & Stagnitti, 2012; Waghorn, Lloyd, & Clune, 2009). These new and changing roles require graduating occupational therapists have knowledge and skills for generic mental health practice, along with a strong sense of what it is to be and practice as an occupational therapist to reduce the risk of graduates becoming overwhelmed or burnt out (Lloyd, King, & Bassett, 2002; Scanlan, Still, Stewart, & Croaker, 2010). This changing landscape of mental health service systems and practice prompted a call for the development of specific mental health occupational therapy educational streams in the United Kingdom (Bannigan et al.,

2011). Although this proposal was controversial, it does highlight the importance of reviewing occupational therapy curricula to ensure that mental health educational needs are being adequately addressed.

Previous studies have engaged with clinicians to explore specific educational needs in areas such as neurology and anatomy to prepare students for practice (e.g., McCluskey, 2000; Schofield, 2014). Such partnerships between academia and clinicians can assist in the identification of current and future needs of service users and assist in the preparation of graduates who can work effectively, thrive and lead changes in current mental health services.

Upon formation, the Australian and New Zealand Mental Health Occupational Therapy Academics (ANZOTMHA) network identified the need to review the range of skills and knowledge considered necessary to effectively prepare occupational therapists for mental health practice. The current project was established to answer the question: *What do occupational therapists working in mental health services across Australia and New Zealand consider to be the current (and future) educational priorities to effectively prepare student occupational therapists for entry level mental health practice?* In answering this question, it was hoped that this study would provide the foundation for curriculum review and renewal in occupational therapy programs across Australia and New Zealand.

Method

Design

This study was conducted in two phases. The aim of Phase One was to generate a list of potential educational priorities from a broad range of occupational therapists working in a

variety of mental health settings. Phase Two involved the establishment of an “expert panel” of occupational therapists to review and rank the educational themes suggested in Phase One using a “Policy Delphi” methodology (Crisp, Pelletier, Duffield, Adams, & Nagy, 1997; Reynes & Hahn, 2000). A summary of the overall process is provided in Figure 1.

< insert Figure 1 about here >

This study was approved by the Human Research Ethics Committee of the first author’s institution (Project number 2013/553).

Phase One

Participants

Participants for Phase One were recruited via information and paper-based surveys distributed during a workshop at the 2013 Occupational Therapy Australia National Conference as well as through advertisements placed in Occupational Therapy Australia newsletters, an invitation sent from New Zealand Association of Occupational Therapists to members, and information shared through other occupational therapy networks (e.g., OT4MH Facebook group).

Procedures

Data collection in Phase One was via a paper-based or online survey. Participants received an information statement and consent was implied through submission of the survey. The Phase One survey contained a section on demographic information and one other question: “Please list below what you consider to be the main educational priorities for occupational therapy students to prepare them for contemporary mental health practice (both now and into the

future).” There were sections for “occupational therapy specific” and “generalist mental health / generic” education priorities, each with space for up to 10 priorities. Participants were also requested to identify whether, from their perspective, each educational priority they identified was currently “met,” “partially met” or “unmet”. The Phase One survey was deliberately broad and open-ended to ensure the broadest range of potential priority areas would be identified. An extract from the survey is shown in Figure 2.

< Insert Figure 2 about here >

Analysis

In the initial stage of analysis, the first author reviewed each set of new priorities as they were received. Data saturation was reached when no new priorities were being identified. Then, the first author arranged the priority statements into groups (referred to hereafter as “educational themes”) using principles of inductive thematic analysis (Braun & Clarke, 2006). Where participants identified more than one educational priority in a single statement (e.g., “communication and counselling”), these were separated and grouped individually. The preliminary grouping scheme was independently reviewed by three other members of the research team. Groupings were agreed, or refined through discussion, until full consensus was reached among the four researchers.

Phase Two

Participants

The “expert panel” was established from Phase One participants who had provided consent to be considered for the Phase Two panel. To preserve the anonymity of Phase One responses,

identifying information collected in the “Phase Two opt in” consent form was collected and stored separately from Phase One responses.

In establishing “expert panels” for Policy Delphi projects, it is recommended to seek maximal diversity to ensure the broadest range of perspectives (Reynes & Hahn, 2000). To do this, we paid careful attention to the geographical diversity of the panel; the involvement of both managers and clinicians; professionals with a range of different years of experience in mental health practice; and clinicians working in diverse practice settings and with varied population groups.

Procedures

Phase Two followed the Policy Delphi Panel process adopted by Bissett, Cusick, and Adamson (2001) in their study to identify occupational therapy research priorities in mental health. Unlike other Delphi approaches, the aim of the Policy Delphi approach is not to achieve perfect consensus, but to generate a list of priorities that can then be used to inform decision making (Bissett et al., 2001; Crisp et al., 1997). This approach suited this project well, as the list of educational priorities was intended to inform curriculum planning in occupational therapy programs across Australia and New Zealand.

The Policy Delphi involved a total of three survey “rounds.” In Round One, the expert panel were presented with the list of educational themes generated from Phase One (in alphabetical order) and were requested to rate each one on a scale of 1 (“low importance”) to 7 (“high importance”) (Bissett et al., 2001).

Educational themes were ranked from most important to least important based on mean ratings from Round One and participants were asked to re-rate each educational theme in Round Two. The second round re-rating process allows for members of the panel to reconsider their responses in light of the opinions of other panel members (Crisp et al., 1997; Reynes & Hahn, 2000).

Following the close of Round Two, educational themes were again ranked in descending order of priority and grouped into four categories: (1) essential priorities (should be included in EVERY occupational therapy program); (2) important priorities (should be included in MOST occupational therapy programs); (3) optional priorities (could be included in SOME occupational therapy programs, e.g., in elective or extension units); and (4) themes to be removed from the final list. As Policy Delphi processes are designed to garner the expert panel's opinions about various different options (Reynes & Hahn, 2000), it was felt that this classification approach would support effective final decision making. The cut-points for each category were determined after reviewing the ranking and mean scores generated from Round Two. The cut-point for "essential priorities" was set at 5.75 as this was a logical point as it represented the highest 20% of the possible scoring range. The next cut-point for "important priorities" was set at 5.50 as there were a large number of educational themes with average scores clustered between 5.50 and 5.75. The final cut-point (between "optional priorities" and "themes to be removed") was set at 5.00 as there were a large number of themes with average ratings between 5.00 and 5.50 and due to the fact that "5" on the scale represented the first positive (non-neutral) point.

In Round Three, participants were requested to indicate if they agreed with the categorisation of each educational priority statement or if they believed that it should be re-categorised into

either the higher or lower category (an option of “not sure” was also provided). The final ranking and categorisation of priorities was generated using information from this final round. Where a large proportion of participants disagreed with the initial categorisation of an educational theme, this was changed in the final list. For these decisions, the *a priori* criteria set for “a large proportion of participants” were: (i) > 40% of participants suggesting that the theme should be categorised higher or lower and (ii) no participants suggesting that the theme should be re-classified in the opposite direction.

In each round, participants were also asked to report on a range of demographic variables which may influence their perceptions of educational priorities. The Round One survey was opened when the first participant accepted the invitation to participate and closed one month after the final participant accepted the invitation. The Round Two and Three surveys remained open for 30 and 24 days respectively. To ensure highest response rates were achieved, all participants received reminders at approximately two weeks and again at three days prior to the close of each round. Participants also had the opportunity to comment about each educational theme or the rankings / categorisation in each round.

Results

Participants

A total of 85 participants provided at least one educational priority area in Phase One of the study. Of these, 65 gave consent to be considered for inclusion in the expert panel for Phase Two. Using the criteria described above, a diverse range of participants was identified to be invited to participate in the expert panel for Phase Two. The final expert panel for Phase Two consisted of 37 members. Of these 37 members, 35 (94.6%) completed the Round One survey, 29 (78.4%) completed the Round Two survey and 28 (75.7%) completed the Round

Three survey. Demographic characteristics of participants in each stage of the study are presented in Table 1. This data was collected in order to present the diversity of participants involved in different aspects of the study.

< Insert Table 1 about here >

Phase One

In Phase One, a total of 1008 priority statements were identified (an average of 12 priority statements per participant). At the conclusion of the thematic analysis, these had been combined into 149 educational themes.

Phase Two

From Round One and Round Two ratings, participants identified “clinical reasoning / assessment formulation: combining occupational and psychiatric information to inform goal setting and intervention planning” as the most important educational theme. “Business skills / running a private practice” was rated as the least important educational theme.

Using mean ratings generated from Round Two responses, 28 educational themes were categorised as essential priorities; 22 as important priorities; 43 as optional priorities; and the remaining 56 as themes to be removed. From Round Three responses, the categorisation of a total of 10 priorities was changed. All of these changes involved moving educational themes from a lower category to a higher category. Those themes that were changed from one category to another are highlighted in Table 2. As part of this process, five educational themes were moved from the “to be removed” category back into the final priorities list: (i) eating disorders; (ii) Canadian Model of Occupational Performance and Engagement; (iii) mental health first aid; (iv) older person’s mental health and (v) research.

The final ranking and categorisation of educational themes is summarised in Table 2. The priority list contained 29 educational themes classified as essential priorities, 25 important priorities, 44 optional priorities and 51 educational themes were removed from the final list. Educational themes considered to be most important included: (1) clinical reasoning / assessment formulation: combining occupational and psychiatric information to inform goal setting and intervention planning; (2) client-centred practice and consumer engagement; (3) therapeutic use of self / therapeutic relationship / boundaries; (4) functional implications of mental illness; (5) therapeutic use of occupation and (6) mental health fieldwork experience.

Table 2 also contains information about how frequently each of these educational priority statements were identified in Phase One of the study as well as the overall “average” rating of whether this educational priority was considered “met” or “unmet” from Phase One information. In the group of 29 educational themes categorised as “essential priorities”, most were generally perceived as being “partially met” in current curricula. Those “essential priorities” considered to be “mostly met” were generally skills or knowledge applicable to a variety of settings (e.g., observational assessment / task and activity analysis; functional assessment of basic and instrumental activities of daily living and interviewing skills). Several themes were classified as “essential priorities” but were perceived as being “mostly unmet” in current curricula. These themes were: (i) mental health fieldwork experiences; (ii) risk assessment and management; (iii) professional self-care / resilience; and (iv) sensory approaches.

For reasons of space, “themes to be deleted” are not included in Table 2. A detailed summary of all themes, mean ratings for each round and changes in rank is available on request from the corresponding author.

There was also the opportunity to comment on each educational theme or its ranking in each Delphi survey round, but very few participants took up this option. Although there were too few comments to be formally analysed, participants' comments have been included in the discussion where they are considered to add to the understanding of the issue being discussed.

< Insert Table 2 about here >

Discussion

This study was designed to address one primary research question: What do occupational therapists working in mental health services across Australia and New Zealand consider to be the current (and future) educational priorities to effectively prepare student occupational therapists for entry level mental health practice? A robust priority-setting methodology, the Policy Delphi approach (Bissett et al., 2001; Reynes & Hahn, 2000), with input from an “expert panel” reflective of the breadth of occupational therapy practice in mental health, was employed.

In the context of this project, the use of practicing occupational therapists as our participants has both strengths and limitations. One of the strengths is that participants were working in a wide variety of settings, and would be able to draw on first-hand knowledge of roles, responsibilities and expectations of occupational therapists in practice. However, this is also a limitation as the opinions and perspectives of other key stakeholders such as consumers, carers and service leaders who are not occupational therapists were not sought. Although the input provided by participants in this study would have been informed by their knowledge of

the expectations of these stakeholder groups, direct input from these stakeholder groups is required to strengthen the basis for optimal curriculum review.

Additionally, curriculum reform cannot proceed based solely on a list of “things graduates should know about”. While educational priorities are an important basis for curriculum review, there are a broad range of other factors than need to be considered. These factors include educational considerations such as the understanding of the nature of knowledge, learning and teaching approaches and determining the optimal balance between conceptual understanding and technical skills (Biggs & Tang, 2011).

The list of educational priorities established as a result of this study serves as an essential foundation, to which other stakeholder perspectives can be added, for curriculum review in occupational therapy programs across Australia and New Zealand. The list of educational priorities can be used in a variety of ways by a range of groups: occupational therapy academics can examine how current curricula address the educational priorities identified; current clinicians can consider how well the priority list reflects the knowledge and skills required for entry level practice in their specific setting and other stakeholder groups (e.g., consumers; carers; service managers from a variety of mental health services) can review the list to examine if the educational priorities identified are consistent with their priorities for the education of the mental health workforce.

Although it is not the purpose of this paper to provide commentary or critique on the educational priorities established by the expert panel, several findings are worthy of further discussion. These include: the levels of prioritisation of speciality areas of mental health;

consideration of educational priorities that were listed as “essential” but also “mostly unmet”; and the current state of evidence for occupational therapy practice in mental health.

The first point for further discussion is the varying prioritisation of specialist areas of mental health practice. Both “Older Person’s Mental Health” and “Eating Disorders” were given generally low ratings of importance and, prior to the final round, were categorised as “to be removed”. Although occupational therapy practice in Older Person’s Mental Health has been identified as a key area for expansion given the ageing population (Ceramidas, de Zita, Eklund, & Kirsh, 2009), this practice seems to be given lesser value by many practicing occupational therapists. One respondent highlighted this issue in a comment in the final round of project: “Why does this always drop to the bottom? It is a growing area and should be taught equally as youth and adolescent psychiatry.” A similar situation was present for the practice area of Eating Disorders. While there are a growing number of occupational therapists practicing in this area, and an emerging understanding of the importance of occupational therapy interventions from other health professionals, current occupational therapy specific literature is scarce. This apparent “de-prioritisation” of these areas of mental health practice could be related to several factors. Firstly, because there are fewer occupational therapists employed in these areas, participants could have considered these areas to be of lesser importance. Secondly, these may be considered to be “specialty” areas of practice that are not suitable for newly graduated therapists who have not had other mental health experience. Finally, given that only a limited number of the expert panel worked in these areas of practice (e.g., only five of the thirty-seven person expert panel worked in older person’s mental health), there may also be a more limited recognition of their importance. These factors raise an important question: given the potentially expanding role of

occupational therapy in more specialised areas of mental health, should these be incorporated into curricula or should individuals seek further knowledge and training after graduation?

Finally, it is important to consider those priorities that were categorised as “essential” but that were rated as “mostly unmet” by respondents in Phase One. These were “mental health fieldwork experiences”; “risk assessment and management”; “professional self-care / resilience” and “sensory approaches”. These are considered essential but largely not attained by graduates, so they may be the topics most urgently in need of curriculum review.

Positive mental health fieldwork experiences have long been recognised as important in supporting graduates’ choice to work in mental health (e.g., Cusick, Demattia, & Doyle, 1993). In the 1993 *Minimum standards for the education of occupational therapists* (World Federation of Occupational Therapists, 1993), fieldwork experience in “psychosocial” settings was a mandatory requirement for all students. Although this specific requirement was not included in the 2002 update of the minimum standards (Hocking & Ness, 2002), most programs in Australia and New Zealand have retained the principle that fieldwork experiences in mental health or psychosocial areas of practice are important for all students (personal communication, ANZOTMHA network, 3 December 2013). However, despite this principle, many programs struggle to secure sufficient numbers of placements in mental health settings (Lloyd et al., 2002; Rodger et al., 2009) which can lead to a vicious cycle: low student placement numbers leads to lower numbers of graduates selecting to work in mental health which further diminishes the pool of occupational therapists in mental health available to supervise students of the future. Although a variety of innovative models to enhance capacity for student education have been described in the literature (e.g., Rodger et al., 2009), these have not been broadly adopted and difficulties in sourcing sufficient numbers of high

quality mental health fieldwork experiences persist. Given the importance placed on mental health fieldwork experiences by both academics and current clinicians, there would appear to be a good foundation for collaborative solution-finding involving universities, mental health services and clinicians.

Risk assessment and management is one of the core drivers of modern mental health practice, yet is an area in which occupational therapists feel under-prepared (Hayes, Bull, Hargreaves, & Shakespeare, 2008). This challenging aspect of practice has the potential to overwhelm new clinicians and may make mental health practice (especially in community settings) less attractive to new graduate occupational therapists. In addition to needing strong skills in risk assessment and management, mental health clinicians of the future also need a solid understanding of the potential harm that may be caused by overly conservative or risk-averse practices (Flewett, 2010) and the importance of “dignity of risk” in the process of recovery from mental illness. With our focus on day-to-day life, independence and self-management, occupational therapists are well placed to be leaders in this area. However, results from this study suggest that education provided around this area in entry-level programs should be enhanced. Training programs aimed at clinicians already working in mental health services (e.g., Flewett, 2010; Pisani, Cross, Watts, & Conner, 2012), provide a structure that may be applicable to professional preparation programs. A brief (3-hour) training program exploring risk assessment and management strategies for individuals presented in specially-designed case studies was shown to be effective in increasing clinicians’ knowledge of and confidence in risk assessment and management (Pisani et al., 2012) and may be a useful addition to professional preparation curricula.

“Professional self-care / resilience” was also identified as an “essential priority” that was “mostly unmet”. A substantial body of research has highlighted that occupational therapists working in mental health may be at increased risk of burnout (Lloyd & King, 2004; Scanlan, Meredith, & Poulsen, 2013). The high “emotional work load” of mental health practice (Scanlan & Still, 2013) as well as lack of understanding of the occupational therapy role and contribution (Hayes et al., 2008; Lloyd et al., 2002) have been presented as potential factors related to this increased risk of burnout. Although much has been written on this topic, much less has been written about strategies that might promote resilience against burnout in mental health practice. It is therefore probably unsurprising that “Professional self-care / resilience” was identified as an educational priority that is currently “mostly unmet”. Although some research has identified leadership and job design strategies that can be implemented in workplaces to support resilience against burnout, perhaps the most useful findings in this area have emerged from research conducted by Ashby, Ryan, Gray, and James (2012) and their development of The PRIOrity (Professional Resilience, Identity, Occupation) model. This model is likely to support individual occupational therapists to develop a better awareness of the strategies that can be useful in developing and maintaining professional resilience in mental health practice, and may be used in education programs to support this identified need.

The final priority area that was identified as “essential” but currently “mostly unmet” was “sensory approaches.” Over the last 5 to 10 years, sensory approaches have emerged as a novel and powerful tool to support more “trauma-informed” and “recovery supporting” services. Sensory approaches are also suggested to be a useful tool in supporting reductions in the use of the coercive practices such as seclusion and physical and pharmacological restraint. Occupational therapists, most notably Tina Champagne, have led the development

and implementation of these approaches to care (e.g., Champagne & Stromberg, 2004; Novak, Scanlan, McCaul, MacDonald, & Clarke, 2012; Sutton, Wilson, Van Kessel, & Vanderpyl, 2013), but this is an area of practice still in its infancy. This is clearly an area that is valued by occupational therapists (and mental health services more broadly), and to maximise its potential contribution, greater focus in educational programs may be warranted.

The final issue for consideration is the current state of evidence to support occupational therapy practice in mental health. Although the amount of research is increasing, there are many aspects of practice that continue to have limited or no evidence to support their use. This raises a critical issue for the profession: do we continue to educate students about practices that do not have a solid evidence base or do we focus purely on those interventions that are evidence-based? It could also be argued that to increase the evidence to support occupational therapy in mental health, every clinician should have skills in research. It is therefore interesting to reflect on the fact that “research” was generally given low ratings of importance and was eventually listed as an “optional priority”.

Conclusion and future directions

This study has supported the development of a list of education priorities for occupational therapy students to prepare them for mental health practice, from the perspective of occupational therapists working in mental health in Australia and New Zealand. These priorities were categorised into “essential priorities” that should be included in every occupational therapy program, “important priorities” that should be included in most programs and “optional priorities” that could be included in some programs (e.g., as part of elective units).

This list of priorities can serve as one source of information to inform curriculum review in occupational therapy programs across Australia and New Zealand. To provide further support for this curriculum review, the next stages of this project will include: (i) seeking input from other key stakeholders (e.g., mental health consumer academics) about the appropriateness of the priorities; (ii) mapping of how the priorities are currently included (or not included) in occupational therapy curricula in Australia and New Zealand; and (iii) the integration of these various sources of information with curriculum planning and educational theory literature to develop a suite of “best practice” approaches to supporting students’ understanding of specific topics and an overall framework for the review of mental health curricula.

Now is a time rich with opportunity and we invite the profession at every level (students, clinicians, managers and academics) and other stakeholders to review, consider and debate the results of this study. We encourage individuals or groups with differing opinions to present these or to critique the list of priorities developed from this project: either directly to the author team or in the professional literature. With rigorous debate, we hope to set the strongest possible foundation for reinvigorating occupational therapy curricula and supporting the development of a new generation of occupational therapists who can not only thrive in the current mental health service system environment, but also help to transform it.

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Figure 1. Outline of the overall research process.

IDENTIFYING EDUCATIONAL PRIORITIES

Please list below what you consider to be the main **educational priorities** for occupational therapy students to prepare them for contemporary mental health practice (both now and into the future). At this stage, we are not requesting you to rank these priorities, but simply to identify the range of educational priorities that exist from your perspective:

Be sure to identify **both** educational needs that you feel are currently met and those you think are partially met or not met. There are sections for both occupational therapy specific skills and generalist / generic mental health skills. List each priority and then indicate whether you feel each priority is currently “met,” “partially met” or “unmet” in occupational therapy graduates.

Occupational therapy specific educational priorities

1.	_____	☐ Met
	_____	☐ Partially met
		☐ Unmet
2.	_____	☐ Met
	_____	☐ Partially met
		☐ Unmet

Figure 2. Extract from Phase One survey

Table 1. Demographics of participants in each phase and round.

	Phase One (N = 85) n (%)	Invited to Phase Two		Phase Two		
		Accepted (N = 37) n (%)	Not accepted (N = 7) n (%)	Round One (N = 35) n (%)	Round Two (N = 29) n (%)	Round Three (N = 28) n (%)
<i>Gender</i>						
Female	78 (91.8)			33 (94.3)	28 (96.6)	28 (100)
Male	7 (8.2)			2 (5.7)	1 (3.4)	0 (0)
<i>Country / state of practice</i>						
New Zealand	8 (9.4)	5 (13.5)	1 (14.3)	5 (14.3)	4 (13.8)	2 (7.1)
New South Wales	25 (29.4)	8 (21.6)	2 (28.6)	8 (22.9)	7 (24.1)	6 (21.4)
Queensland	17 (20)	7 (18.9)	1 (14.3)	7 (20)	6 (20.7)	6 (21.4)
South Australia	3 (3.5)	2 (5.4)	0 (0)	2 (5.7)	2 (6.9)	2 (7.1)
Victoria	20 (23.5)	8 (21.6)	2 (28.6)	7 (20)	5 (17.2)	8 (28.6)
Western Australia	12 (14.1)	7 (18.9)	1 (14.3)	6 (17.1)	5 (17.2)	4 (14.3)
<i>Experience in mental health</i>						
Less than 1 year	6 (7.1)	2 (5.4)	0 (0)	1 (2.9)	0 (0)	0 (0)
1 - 2 years	15 (17.9)	3 (8.1)	2 (28.6)	3 (8.6)	2 (6.9)	3 (10.7)
2 - 5 years	14 (16.7)	6 (16.2)	4 (57.1)	7 (20)	8 (27.6)	8 (28.6)
5 - 10 years	19 (22.6)	11 (29.7)	0 (0)	9 (25.7)	7 (24.1)	6 (21.4)
10 - 15 years	8 (9.5)	6 (16.2)	0 (0)	6 (17.1)	6 (20.7)	5 (17.9)
Over 15 years	22 (26.2)	9 (24.3)	1 (14.3)	9 (25.7)	6 (20.7)	6 (21.4)
Not Applicable	1					
<i>Practice area</i>						
Acute inpatient	14 (16.5)			5 (14.3)	4 (13.8)	6 (21.4)
Inpatient rehabilitation	7 (8.2)			1 (2.9)	2 (6.9)	2 (7.1)
Community acute	6 (7.1)			2 (5.7)	2 (6.9)	1 (3.6)
Community general	15 (17.6)			7 (20)	6 (20.7)	4 (14.3)
Community rehabilitation	9 (10.6)			4 (11.4)	5 (17.2)	2 (7.1)
Other	32 (37.6)			16 (45.7)	10 (34.5)	13 (46.4)
Not applicable	2 (2.4)			0 (0)	0 (0)	0 (0)
<i>Age group of client population</i>						
< 18 years	7 (8.2)			2 (5.7)	1 (3.4)	1 (3.6)
15-25 years	5 (5.9)			3 (8.6)	4 (13.8)	4 (14.3)
18-65 years	51 (60)			22 (62.9)	17 (58.6)	13 (46.4)

>65 years	6 (7.1)			4 (11.4)	5 (17.2)	5 (17.9)
Other (e.g., “all ages”)	11 (12.9)			4 (11.4)	2 (6.9)	5 (17.9)
Not applicable	5 (5.9)			0 (0)	0 (0)	0 (0)
<i>Sector</i>						
Non-government	4 (4.7)	5 (13.5)	0 (0)	3 (8.6)	6 (20.7)	3 (10.7)
Public health service	68 (80.0)	24 (64.9)	7 (100)	24 (68.6)	20 (69)	21 (75)
Private health service	5 (5.9)	2 (5.4)	0 (0)	1 (2.9)	0 (0)	0 (0)
Other	8 (9.4)	6 (16.2)	0 (0)	7 (20)	3 (10.3)	4 (14.3)
<i>Work location</i>						
Metropolitan	63 (74.1)			25 (71.4)	23 (79.3)	22 (78.6)
Regional	16 (18.8)			8 (22.9)	4 (13.8)	5 (17.9)
Rural / Remote	5 (5.9)			2 (5.7)	2 (6.9)	1 (3.6)
Not applicable	1 (1.2)			0 (0)	0 (0)	0 (0)
<i>Management of other staff</i>						
Manages others		12 (32.4)	0 (0)	16 (45.7)	14 (48.3)	13 (46.4)
Does not manage others		25 (67.6)	7 (100)	19 (54.3)	15 (51.7)	15 (53.6)
<i>Number of staff managed</i>						
Up to 5 others		6 (16.2)	0 (0)	5 (14.3)	9 (31)	8 (28.6)
5 - 19 others		2 (5.4)	0 (0)	7 (20.0)	2 (6.9)	2 (7.1)
20 or more others		4 (10.8)	0 (0)	4 (11.4)	3 (10.3)	3 (10.7)
Not applicable		25 (67.7)	7 (100)	19 (54.3)	15 (51.7)	15 (53.6)

Note: Where cells are blank, this information was not collected in that stage of the study.

Table 2. Final rankings and categorisation of educational themes

Final Rank	Educational theme	Number of times mentioned in Phase One	Met / Partially met / Unmet (Phase One) [†]
<i>ESSENTIAL PRIORITIES</i>			
1	Clinical reasoning / assessment formulation: combining occupational and psychiatric information to inform goal setting and intervention planning	7	Partially met
2	Client-centred practice and consumer engagement	15	Mostly met
3	Therapeutic use of self / therapeutic relationship / boundaries	29	Partially met
4	Functional implications of mental illness	21	Partially met
5	Therapeutic use of occupation	9	Partially met
6	Mental health fieldwork experiences	2	Mostly unmet
7	Collaborative goal setting	6	Partially met
8	Common occupational therapy interventions in community and inpatient settings	15	Partially met
9	Occupational therapy assessments in Mental Health	29	Partially met
10	Importance of occupation for positive mental health	4	Partially met
11	Observational assessment / Task and activity analysis	8	Mostly met
12	Engaging challenging consumers: Low motivation / lack of engagement	7	Partially met
13	Consumer self-management of illness (e.g., relapse prevention, early warning signs, management of hallucinations)	6	Partially met
14	Intervention planning	3	Partially met
15	Occupational therapy assessments: Functional assessment / assessment of basic and instrumental activities of daily living	12	Mostly met
16	Risk assessment and management	47	Mostly unmet
17	Occupational therapy roles: Maintaining occupational focus (including in generic positions)	10	Partially met
18	Basic communication skills: communicating with consumers and families	17	Partially met
19	Professional self-care / resilience	13	Mostly unmet
20	Knowledge of high prevalence disorders (e.g., anxiety, depression)	1	Mostly met
21	Strengths focus	3	Partially met
22	Reflective practice	2	Mostly met
23	Recovery, hope-inspiring practice and recovery orientation of services	33	Partially met
24	Knowledge of low prevalence disorders (e.g., schizophrenia / bipolar disorder)	1	Mostly met
25	Interviewing skills	3	Mostly met

Final Rank	Educational theme	Number of times mentioned in Phase One	Met / Partially met / Unmet (Phase One) [†]
26	Lifespan development approach / considering consumers' developmental needs / bio-psycho-social-developmental approach	8	Partially met
27	Engaging challenging consumers: disruptive / abusive / inappropriate behaviour	5	Partially met
28	Mental State Examination	50	Partially met
29	Sensory approaches [‡]	22	Mostly unmet
IMPORTANT PRIORITIES			
30	Occupational therapy role: explaining occupational therapy role to others (multidisciplinary team / clients / other service providers)	8	Partially met
31	Non-pharmacological interventions	5	Partially met
32	Evidence-Based Practice	6	Partially met
33	Occupational therapy Assessments: Comprehensive occupational assessment	9	Mostly met
34	Interventions to support independence in basic and instrumental activities of daily living	5	Partially met
35	Psychiatric terminology	5	Partially met
36	Grading and adaptation	3	Partially met
37	Evaluation of occupational therapy practice	2	Partially met
38	Intervention strategies for anxiety and depression	3	Mostly met
39	Crisis intervention	10	Mostly unmet
40	Early intervention	1	Partially met
41	Communication for effective teamwork	15	Partially met
42	Skills training approaches	4	Mostly met
43	Environmental interventions to enhance functional performance	1	Partially met
44	Mindfulness	4	Mostly unmet
45	Occupational balance / occupational dysfunction	5	Partially met
46	De-escalation and containment strategies	4	Partially met
47	Physical health needs of mental health consumers / physical health interventions	10	Partially met
48	Motivational Interviewing	10	Mostly unmet
49	Engaging challenging consumers: Lack of awareness of illness	2	Mostly unmet
50	Social skills interventions	1	Partially met
51	Group work [§]	35	Partially met
52	Culturally sensitive practice (including for specific populations such as Indigenous and refugee populations) [§]	10	Partially met
53	Occupational therapy assessments: Cognitive Assessments [§]	12	Partially met

Final Rank	Educational theme	Number of times mentioned in Phase One	Met / Partially met / Unmet (Phase One) [†]
54	Complexity: substance abuse / dual diagnosis / drug and alcohol [§]	15	Mostly unmet
<i>OPTIONAL PRIORITIES</i>			
55	Occupational therapy models: general application of models to practice	17	Partially met
56	Ethics and ethical reasoning	4	Partially met
57	Family-inclusive practice / carer engagement	10	Mostly unmet
58	Work / vocational rehabilitation	7	Partially met
59	Trauma-informed care	5	Mostly unmet
60	Occupational therapy models: Model of Human Occupation	2	Mostly met
61	Brief interventions in acute settings	1	Mostly unmet
62	Emotion regulation	2	Mostly unmet
63	Generic mental health assessments	5	Partially met
64	Counselling skills	15	Partially met
65	Occupational therapy roles: Understanding occupational therapy roles in a variety of settings	25	Partially met
66	Positive mental health / building resilience	7	Partially met
67	Psychological theories: Cognitive-behavioural approaches / CBT	20	Partially met
68	Psychosocial assessment	1	Mostly unmet
69	Personality Disorders	3	Mostly unmet
70	Cognitive difficulties - remediation approaches	2	Mostly unmet
71	Mental Health Act	21	Mostly unmet
72	Grief and loss	1	Mostly unmet
73	Care coordination / case management	20	Partially met
74	Medications: Knowledge of medications and side effects	36	Mostly unmet
75	Knowledge of basic sociological / psychological concepts	2	Partially met
76	Relaxation skills training	3	Partially met
77	Stigma	5	Partially met
78	Complexity: co-morbidities	2	Mostly unmet
79	Mental health frames of reference	2	Partially met
80	Cognitive difficulties - compensatory approaches	1	Mostly unmet
81	Child and Adolescent Mental Health	7	Mostly unmet
82	Problem solving	1	Mostly unmet
83	Consumer psychoeducation	5	Partially met
84	Psychiatric Assessment	16	Mostly unmet
85	Medications: compliance / adherence, difficulties and strategies	3	Mostly unmet

Final Rank	Educational theme	Number of times mentioned in Phase One	Met / Partially met / Unmet (Phase One)[†]
86	Time management	3	Partially met
87	Advocacy for clients	1	Partially met
88	Needs assessment	1	Partially met
89	Empowerment	1	Partially met
90	Communication / collaboration with other service providers (e.g., NGO, primary care)	3	Partially met
91	Understanding roles of other mental health professionals in MDT	17	Partially met
92	Engaging challenging consumers: managing symptoms	1	Partially met
93	Solution-focussed therapy	2	Mostly unmet
94	Eating Disorders [‡]	1	Mostly unmet
95	Occupational Therapy Models: Canadian Model of Occupational Performance and Engagement [¶]	1	Partially met
96	Mental Health First Aid [¶]	2	Mostly unmet
97	Older Person's Mental Health [¶]	3	Partially met
98	Research [¶]	3	Partially met

Notes

[†]Calculated from responses from Phase One. Unmet = 0, Partially met = 1, Met = 2. Mean score < 0.67 =

Mostly unmet, from 0.67 to 1.33 = Partially met, > 1.33 = Mostly met.

[‡] Moved from "Important" to "Essential" in Round Three

[§] Moved from "Optional" to "Important" in Round Three

[¶] Moved from "To be deleted" to "Optional" in Round Three