Mental health education in occupational therapy professional preparation programs: Alignment between clinician priorities and coverage in university curricula

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ABSTRACT

Background/Aim: Occupational therapy programs must prepare graduates for work in mental health. However, this are of practice is complex and rapidly changing. This study explored the alignment between educational priorities identified by occupational therapists practising in mental health and level of coverage of these topics in occupational therapy programs in Australia and New Zealand.

Method: Surveys were distributed to heads of all occupational therapy programs across Australia and New Zealand. The survey included educational priorities identified by occupational therapists in mental health from a previous study. Respondents were requested to identify the level of coverage given to each of these priorities within their curriculum. These data were analysed to determine a ranking of educational topics in terms of level of coverage in university programs.

Results: Responses were received for 19 programs from 16 universities. Thirty-four topics were given "High level coverage" in university programs and these were compared against the 29 topics classified as "Essential priorities" by clinicians. Twenty topics were included in both the "Essential priorities" and "High level coverage" categories. Topics considered to be "Essential priorities" by clinicians which were not given "High level coverage" in university programs included: mental health fieldwork experiences; risk assessment and management; professional self-care / resilience; and sensory approaches.

Conclusion: While there appears to be overall good alignment between mental health curricula and priorities identified by practising occupational therapists, there are some discrepancies. These discrepancies are described and establish a strong foundation for further

discussion between clinicians, academics and university administration to support curriculum review and revision.

Keywords: Mental health; Curriculum design; Student education

INTRODUCTION

University education programs must graduate entry-level occupational therapy practitioners who are equipped to assume professional roles within the current practice climate and to help shape the development of the profession into the future. Graduates must be able to demonstrate proficiency in contemporary assessment and intervention processes in a diverse practice arena, as well as possess the knowledge, skills and reasoning to translate new evidence into practice. They must also be prepared to navigate an often challenging political landscape (Fortune, Ryan, & Adamson, 2013).

Mental health, in particular, is a diverse and rapidly changing area of practice. Since occupational therapy first emerged in the asylums of the early 20th Century (Fossey, 2012), there have been substantial changes in the way mental health care is provided, which have impacted on occupational therapy practice. These changes include a shift in focus from institutional to community-based care, re-orientation of services to be more consistent with a recovery approach, an increase in service provision by the non-government and private sectors, and an increased focus on promotion of mental well-being, prevention and early intervention, and the social and economic participation of people with mental illness (Scanlan, Pépin, et al., 2015). In addition, practitioners in this field are affected by factors impacting on the profession more broadly, such as an increasing need to provide services that are evidence-based and both clinically and cost-effective (McCluskey & Cusick, 2002; Morley & Smyth, 2013).

The content of occupational therapy education programs is shaped by information from a range of external sources in addition to the internal requirements of each university. Programs must demonstrate that they meet criteria laid down by accrediting bodies, including the

World Federation of Occupational Therapists (2016) and the Occupational Therapy Council (Australia & New Zealand) (2013). Additional guidance is also included in competency and practice standards documents (e.g., National Mental Health Strategy, 2013; Occupational Therapy Australia, 2010; Occupational Therapy Board of New Zealand, 2015). Curriculum content must also be developed through consultation with a range of stakeholders including consumers, carers and the occupational therapy practice community (Occupational Therapy Council (Australia & New Zealand), 2013). Such consultation generally occurs between each occupational therapy program and occupational therapists practicing in the local geographical area (Thomas & Judd, 2015). It is rare, however, to see this done at a more macroscopic, whole-of-profession, level.

The Australia and New Zealand Mental Health Occupational Therapy Academics (ANZOTMHA) network is made up of mental health academics from each university in Australia and New Zealand providing entry level occupational therapy education. Established in 2012, one of ANZOTMHA's priorities was to develop an understanding of the perspectives of a range of stakeholders across Australia and New Zealand regarding educational priorities for preparing occupational therapy graduates for mental health practice (Pépin et al., 2013). The first stage of that process involved an investigation of the views of occupational therapists working in mental health settings in Australia and New Zealand (Scanlan, Pépin, et al., 2015). Using a "policy Delphi" approach (Bissett, Cusick, & Adamson, 2001), the expert panel from this study identified a set of 29 "essential priorities" that they thought should be covered in every occupational therapy program, 24 "important priorities," 44 "optional priorities" and 51 topics that were "not priorities." In addition to identifying these educational priorities, participants in this study indicated the extent to which they felt each topic was sufficiently covered in university curricula on a three-point scale

("met," "partially met", or "unmet"). Of the 29 "Essential priorities," seven were rated as, on average, "mostly met," four as "mostly unmet," and the remaining 18 as "partially met" (Scanlan, Pépin, et al., 2015).

The study described in this paper has two aims: (1) to determine the degree of coverage of the educational priorities identified by Scanlan, Pépin, et al. (2015) in occupational therapy programs in Australia and New Zealand, and (2) to determine the extent that coverage of topics in university curricula align with how clinicians categorise both the importance of the educational priorities and perceptions of how well they were covered in existing curricula. It is expected that this knowledge will provide a foundation for further professional dialogue between mental health clinicians, academics and university administrators and will contribute to review and revision of occupational therapy curricula. While this study is focused on the alignment between curricula and clinician priorities, the study team acknowledge that this is only one aspect of curriculum review. Input from other key stakeholder groups, most especially consumers and carers, is also critical.

METHOD

This study was approved by the Human Research Ethics Committee of the lead author's university. It involved a cross-sectional survey of academics in occupational therapy programs across Australia and New Zealand in which they were asked to rate to what extent each of the educational priorities identified in the study by Scanlan, Pépin, et al. (2015) was covered in their curricula. The level of coverage across programs for each topic was then compared with the findings of Scanlan, Pépin, et al. (2015), specifically the clinicians' ratings of importance, and perceptions of how well the topics were covered.

Sampling

The survey was distributed via email to the program convenors of all occupational therapy programs offered in universities in Australia and New Zealand via the Australian and New Zealand Council of Occupational Therapy Educators (ANZCOTE). Program convenors were asked to identify a mental health academic, or other individual with knowledge of the curriculum, to complete the survey.

Data Collection

The survey listed all 149 educational topics identified in the study by Scanlan, Pépin, et al. (2015). Respondents were asked to identify the extent to which each topic was covered in their program(s) by selecting one of the 10 codes listed in Table 1.

< Insert Table 1 about here >

Data Analysis

Determining degree of coverage of educational priorities in university curricula

For each program, each educational topic was allocated a score according to the highest level of coverage from "Not covered" to "In depth coverage in mental health occupational therapy unit." Definitions for each score are included in Table 1. These data were then analysed using the many-faceted Rasch analysis program Facets (Version 3.71.4: Linacre, 2014). Many-faceted Rasch analysis is a statistical approach that converts ordinal-level data (in this case "level of coverage") into interval level data and allows for the simultaneous consideration of numerous different aspects of the data being analysed (in this case: educational topic, level of coverage and the multiple observations of each combination from the various programs) (Linacre, 2014). Outputs from the analysis allow for the exploration of measurement

characteristics (e.g., rating scale functioning) and the fit of the data to the expectations of the Rasch model. Analyses also produce "measure scores" for items under analysis (in this case: educational topics).

Results from initial analyses indicated that scoring codes could be collapsed (collapsed scoring codes are indicated in the final column of Table 1). With the collapsed scoring in place, analyses were re-run and the resultant "measure scores" for each topic were used to rank topics according to overall "level of coverage" in university curricula. "Measure scores" are interval-level measures reported in "logits" (log-odds units) (Bond & Fox, 2007). Based on this ranking, topics were classified into four "level of coverage" categories: "High"; "Moderate / high"; "Moderate / low"; and "Low / no." These four categories were selected to mirror the number of categories used in the clinician categorisation from Scanlan, Pépin, et al. (2015). Attempts were also made to include similar numbers of topics in each equivalent category (from this study and the Scanlan, Pépin, et al., 2015 study), whilst maintaining logical "cut points" according to the spread of "measure scores" from the analysis. "Measure scores" for each educational topic derived from the analysis represent an "overall" picture of the combined university curricula.

Determining alignment of degree of coverage with clinicians ratings of educational priorities

For this part of the analysis topics included in both the "Essential priorities" category from Scanlan, Pépin, et al. (2015) and the "High coverage" category from the survey of academics were tabulated. Topics with lower levels of priority were not considered in this study to enable detailed consideration of those topics considered most important by clinicians and educators. These tabulations allowed for identification of topics that were aligned (i.e., topics

included in both “Essential priorities” by clinicians and “High coverage” by academics) and where discrepancies existed (i.e., topics included in only one of these categories).

RESULTS

Responses were received from 16 of the 21 universities offering occupational therapy programs in Australia and New Zealand at the time of the study. This represented a response rate of 76%. Three universities reported on both undergraduate and graduate entry master programs, so a total of 19 programs were included in the final dataset.

Coverage of educational priorities in university curricula

“Measure scores” for educational topics ranged from 2.66 to -2.05 logits. Thirty-four topics were categorised as “High coverage” (logit range from 2.66 to 1.00), 23 as “Moderate / high coverage” (logit range 0.87 to 0.61); 37 as “Moderate / low coverage” (logit range 0.56 to 0.10); and 55 as “Low / no coverage” (logit range 0.06 to -2.05). A full overview of the educational topics and their measure scores can be found in the associated technical report (Scanlan et al., 2016).

Alignment of degree of coverage with clinicians ratings of educational priorities

Table 2 presents the 29 topics ranked by the expert panel of clinicians in the study by Scanlan, Pépin, et al. (2015) as “Essential priorities”, along with corresponding rankings in terms of coverage in university curricula determined by the present study. This table also includes clinicians’ perceptions of how well each topic area was met in terms of students’ / new graduates’ knowledge of the area. Nine of the 29 topics rated as “Essential priorities” by clinicians did not receive “High coverage” in university curricula. Of note, two of these topics (“Observational assessment / Task and activity analysis” and “Risk assessment and

management"), although not included in the "High coverage" category, were ranked just outside of this category.

< Insert Table 2 about here >

Table 3 presents the 34 topics included in the "High coverage" in university curricula category along with corresponding rankings in terms of clinicians' priorities. Of these 34 topics, 14 were not ranked as "Essential priorities" by clinicians.

< Insert Table 3 about here >

For ease of reference, Table 4 includes a summary of discrepancies between clinicians' priorities and level of coverage in university curricula.

< insert Table 4 about here >

DISCUSSION

This study was conceived to explore the alignment between perceived priorities for occupational therapy education held by occupational therapists currently practising in mental health, how effectively they believe these are taught and what was covered in occupational therapy curricula in the Australian and New Zealand context. Results from this study are useful for several reasons. Firstly, for occupational therapists practising in mental health to gain a broader understanding of what students and new graduates should be expected to know. Secondly, for academics involved in the design and delivery of mental health content

in occupational therapy programs to review content to determine if some aspects should be added, removed or changed. Discrepancies identified between clinicians' priorities and level of coverage in university curricula create a starting point for consideration and discussion around what is necessary to include in university curricula to effectively prepare students for mental health practice – both now and into the future.

Of the 29 topics classified as "Essential priorities" by clinicians, 20 received a "High coverage" in university curricula. This suggests that university curricula are, to a large extent, giving in-depth coverage to those topics perceived as being of highest priority by clinicians. However, there are several discrepancies that warrant further exploration. These are discussed below.

Topics given higher priority by clinicians than in university curricula

Nine topics were classified by clinicians as "Essential priorities" but were not, on average, given a "High coverage" in university programs (see Table 4). Scanlan, Pépin, et al. (2015) found that four of these topics: "mental health fieldwork experiences"; "risk assessment and management"; "professional self-care/resilience"; and "sensory approaches" were also rated as "mostly unmet" in terms of clinicians' perceptions of how well students and new graduates were prepared to apply these knowledge and skills to the mental health practice context.

Mental health fieldwork

Securing enough mental health practice education opportunities has long been challenging, culminating in removal of the mental health placement requirement from the Minimum Standards for the Education of Occupational Therapists (World Federation of Occupational Therapists, 2016). Explanations for mental health placement shortages include: generic

service contexts diminishing therapists' belief in their setting as a valuable learning experience (Thomas et al., 2007), staff retention difficulties (Hayes, Bull, Hargreaves, & Shakespeare, 2008), and demanding caseloads (Lloyd, King, & Bassett, 2002). The results of the present study highlight the ongoing perception that mental health fieldwork is an area of need, and indicates that it requires the concerted and collaborative attention of all parties.

Clinicians' perception of mental health fieldwork being 'unmet' is interesting. The rapidly changing practice and political landscape in mental health services implies that students should be exposed to a variety of roles that occupational therapists may undertake in diverse mental health environments. Far from being "less important" than "traditional" placements, student exposure to emerging roles for occupational therapy, especially under the guidance of a practising occupational therapist, is critical to supporting the maintenance and enhancement of the occupational therapy role in mental health.

Risk assessment and management

Risk assessment and management is a specific focus within mental health services, of relevance for all professions (National Mental Health Strategy, 2013). Some universities covered this topic in substantial depth, while others did not cover it at all. As a generic skill, it may be viewed by some university programs as outside the purvey of occupational therapy. It is also a field in which local, or service-level, protocols are common, limiting the extent of detail that can be provided within university curricula. Understanding that clinicians value students' understanding of risk assessment and management is helpful to inform future university curriculum discussions.

Professional self-care / resilience

Professional self-care in mental health has been highlighted in recent literature, particularly in relation to investigations of burnout (Scanlan, Meredith, & Poulsen, 2013; Yang, Meredith, & Khan, 2015), but was identified as inconsistently covered within occupational therapy curriculum in the current study. Implications of failure of self-care or lack of resilience include increased turnover intention, lower levels of job satisfaction, and ultimately, compromised service delivery and client care (Scanlan et al., 2013).

Ashby and colleagues (Ashby, Gray, Ryan, & James, 2015; Ashby, Ryan, Gray, & James, 2013) have noted that maintaining an occupational focus in practice is related to better professional resilience for occupational therapists in mental health. This suggests that supporting students to develop strategies to maintain this occupational focus in their practice, along with other strategies to support professional resilience may be areas for further exploration in curricula.

Sensory approaches

Use of sensory approaches is a relatively new practice area in mental health, driven initially by a desire to reduce use of seclusion and restraint internationally (Champagne & Stromberg, 2004). Inclusion of new topics in university curricula typically requires attention to several criteria, including professional relevance, adequate evidence, allocation of space in a crowded curricula, and the availability of a skilled professional to develop and present the content. The evidence in support of sensory approaches in mental health has been rapidly accumulating, although some of it remains equivocal (Scanlan & Novak, 2015). Evidence from the present study that clinicians desire students to have knowledge in this field lends support to inclusion of this content in curricula.

Other topics

In addition to the topics identified above, five other topics were categorised by clinicians as "Essential priorities" but were not given "High coverage" in university programs. These topics were related to engaging challenging consumers and occupational therapy assessments.

Two topics related to engaging challenging consumers: working with consumers with "low motivation / lack of engagement" and "disruptive / abusive / inappropriate behaviour". Interestingly, in practice, there is somewhat of an overlap between these topics and use of sensory approaches, which have largely been viewed as supporting self-regulation (Scanlan & Novak, 2015). While it is likely that many strategies related to engaging consumers with these challenges will be learnt from role models in real-world settings, it is important to consider whether education about these strategies could be more embedded into on-campus curricula. These topics may also be embedded in general teaching around developing positive therapeutic relationships rather than covered as a specific topic, and so were not identified as being specifically mental health related. Indeed, some of the authors have engaged in curriculum discussions in which concerns were expressed that presenting information about "challenging clients" only in mental health course work might perpetuate negative attitudes and stigma towards individuals with mental illness. Given that challenging behaviour is potentially relevant to all fields of practice, some have indicated that they prefer to provide this information in more generic units.

Although the broad category of "Occupational therapy assessments in mental health" was prioritised by clinicians and given a high level of coverage in university curricula, discrepancies existed in terms of specific assessment types. Clinicians prioritised "Observational assessment / Task and activity analysis" whereas university coverage

favoured specific assessments, typically assessments associated with the Model of Human Occupation. This highlights a common tension in occupational therapy in mental health practice. While there is a push for the use of standardised assessments, it is often argued by clinicians that non-standardised observational assessments are more practical for use in real-world clinical settings. The foundation of observational skills is an important educational outcome for students, requiring learning in both the university and the field. However, while observational assessments are valuable in practice, in this era of evidence-based practice there could be risks for the profession in not vigorously pursuing the development and use of standardised assessments to gather outcomes and inform practice. This may be an area for ongoing discussion between the field and academics in light of the potential for occupational therapy assessments to be perceived as less relevant or evidence informed in comparison to assessments by other disciplines.

Topics given higher priority in university curricula than by clinicians

Several topics were prioritised by university programs (i.e. included in the "High coverage" category in terms of university curricula) but were not categorised as "Essential priorities" by clinicians (see Table 4). These will be discussed in more detail in the sections below.

Evidence based practice and research

While evidence based practice was given in-depth coverage in university curricula it was rated as important, rather than essential, in the preparation of occupational therapists for mental health practice by clinicians (Scanlan, Pépin, et al., 2015). The lower rating of this topic by clinicians is reflective of the findings of an earlier systematic review (Upton, Stephens, Williams, & Scurlock-Evans, 2014) and surveys of Australian and New Zealand occupational therapists (Graham, Robertson, & Anderson, 2013; Hitch & Lhuede, 2015). A

number of barriers to implementation of evidence based practice by occupational therapists have been identified including lack of: research-related skills, time, and relevant and accessible evidence (Graham et al., 2013; Upton et al., 2014). It is the last two of these, perhaps, that best explain the perception of clinicians that these skills are not essential for practice. Notably, there was a widely held perception among the respondents in the survey by Graham et al. (2013) that evidence based practice was separate to clinical reasoning. Given the prioritisation of maintaining an occupational focus by clinicians this may reflect the tension between being evidence based and occupation-centred given the limited evidence base for occupation-focused interventions (Gustafsson, Molineux, & Bennett, 2014). While evidence-based practice and research in occupational therapy in mental health are complex and challenging, the repeated calls for "more research" and the critique that occupational therapy in mental health lacks rigour, supporting evidence, and best practice guidelines, demonstrate the critical importance of these areas. While research in occupational therapy in mental health has increased dramatically in recent years (Hitch, Pépin, & Stagnitti, 2015), there is still need for this research to be appraised, synthesised and translated into best practice guidelines.

Occupational therapy specific knowledge and skills

For ease of discussion, a number of topics related to occupational therapy-specific knowledge and skills in mental health have been combined. These topics include: Occupational therapy models, Interventions to support independence in basic and instrumental activities of daily living; Grading and adaptation; and Occupational therapy role – explaining occupational therapy role to others.

Occupational therapy education supports students to develop occupational therapy-specific knowledge and skills. In mental health practice however occupational therapists are often employed in generic roles, such as case managers, where these skills and theoretical frameworks may be perceived as less relevant, or where therapists have little time or opportunity to use specific occupational therapy assessments and intervention (Hayes et al., 2008). Further, a number of experienced practitioners are likely to have been trained before the 1990's at a time when the occupational therapy profession and theory base was less well-developed. Thus, they are likely to have sought a range of alternative clinical and theoretical frameworks upon which to build their practice. In moving the profession forward, there is a need for graduating occupational therapists to have a clear professional identity and awareness of occupational therapy-specific theoretical models and frameworks to inform clinical reasoning and service delivery (Ashby et al., 2013). Consequently, there appears a strong rationale for maintaining a focus on occupation-specific knowledge and skills in curricula, in order to support professional identity and occupation-focused practice of occupational therapists working in generic roles (Ashby et al., 2015).

Group work

Group work has traditionally been an important method of service delivery for occupational therapists in mental health. While group work is still relatively common in inpatient settings (Scanlan, Argent, Ayling, Mouawad, & Woodward, 2015), anecdotal evidence suggests that the frequency of this activity may be declining in some community settings. If the use of group work is declining, this may suggest a reduced need for coverage in current curriculm. However, the risk associated with diluting this topic in curricula is that the use of group work may further decline in practice, with graduates potentially lacking understanding of the value of group work in practice. In light of this result, it is interesting to note that one recent study

of clinicians' perceptions of research priorities (Hitch & Lhuede, 2015) identified "consumer experiences of group work" as a research priority. Further exploration is needed with regard to the current use of group-based approaches by occupational therapists in Australia and New Zealand.

Intervention strategies for anxiety and depression

Interventions for anxiety and depression were not rated as an "Essential priority" by clinicians in the Scanlan, Pépin, et al. (2015) study, and this should be considered in the context that most respondents were employed in public mental health services. These services tend to provide support to individuals with low prevalence disorders such as schizophrenia and bipolar affective disorder. The higher prevalence disorders of anxiety and depression are arguably more likely to be seen in primary health care where there are currently few occupational therapists practising. However, national mental health reform strategies in Australia over recent years have focussed on increasing access to allied health services for individuals with high prevalence disorders (National Mental Health Commission, 2015). Therefore, it may be useful to retain a strong focus on intervention strategies for anxiety and depression in occupational therapy curricula to best position new graduates to deliver occupationally focused interventions within the changing landscape of mental health services.

Culturally sensitive practice (including for specific populations such as Indigenous and refugee populations)

The capacity to practice safely with people from a range of cultures is a fundamental requirement of accreditation for all occupational therapy training programs (National Mental Health Strategy, 2013; Occupational Therapy Council (Australia & New Zealand), 2013) and is also a requirement in practice. Scanlan, Pépin, et al. (2015) found that this was not an

"Essential priority" for clinicians, and warrants further discussion within the profession and mental health services more broadly. This is especially true in light of feedback from some populations of the critical importance of attending to culture for mental health and wellbeing. For example, Aboriginal and Torres Strait Islander social and emotional wellbeing cannot be addressed without a central focus on culture (Dudgeon, Milroy, & Walker, 2014). The profession may need to become more critically reflexive about the dominance of white, Western views in theories and practice (Gerlach, 2015) and occupational therapy programs may facilitate this reflexivity.

Personality Disorders

One potential explanation for this topic being considered less of a priority for clinicians involved in the original study (Scanlan, Pépin, et al., 2015), is the historic tension in mental health services around whether or not services should be provided to individuals with a primary diagnosis of personality disorder (Crawford, 2008; Moran, 1999). Alternatively, it might reflect more current thinking and recognition by clinicians that, in the context of trauma-informed approaches to practice, the concept of "personality disorders" may have limited clinical usefulness (Kezelman, 2011). In this context, it may be relevant for occupational therapy programs to review how this topic is covered in programs to ensure that students are adequately equipped to work in an occupational way with individuals with personality disorder diagnoses and trauma histories who may benefit from mental health interventions.

Study Considerations

While this study is the first to consider the alignment between clinician priorities and academic programs in Australia and New Zealand, several considerations must be

acknowledged. Firstly, it should be remembered that the university coverage portrayed in this paper reflects a general combined result, and that it does not indicate topic coverage within any specific university. It is possible that individual universities may cover topics at an in-depth level while others do not. Secondly, as participation was voluntary, not all university programs are represented in this study. Thirdly, findings are compared with data from clinicians in one study collected in Australia and New Zealand at one time point. These views may not be representative of the wider population of occupational therapists who work in mental health.

A final, and important consideration is that of consumer participation in mental health research, education and practice. Consumer participation is a key strategy in mental health reform both nationally and internationally. Participation occurs in many ways, from being an equal partner in one's own care, to participating at organisational and system wide levels. Direct involvement of consumers in service delivery through peer worker roles is also targeted for growth (National Mental Health Commission, 2015). Co-production, in which workers, consumers, families and carers work together to design, deliver and evaluate services is emerging as the way of the future for mental health services (National Mental Health Commission, 2015). Working alongside consumers as full partners requires a new skill set which is not yet well-defined. As consumer participation was not identified as a priority by clinicians, this topic was not included in this research. However, given the current context, it is essential that the topic of consumer participation and co-production is considered and enhanced in all mental health curricula.

Conclusion

This study has taken an Australia and New Zealand-wide approach to exploring mental health curricula in occupational therapy programs and considering how these align with clinician-identified priorities from an earlier study. Results from this study set the foundation for exploration and review of current curricula, and further discussion and debate in the profession. While clinician priorities are an important source to inform curriculum design, other sources, most especially the views of consumers and carers and theories of learning and teaching, are also important and warrant consideration. While the process of curriculum review and revitalisation is complex, this study provides a valuable foundation for this process.

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Table 1. Scores and definitions for level of coverage in university programs

Category	Definition	Score 1[†]	Score 2[‡]
In depth coverage in mental health occupational therapy unit	In depth coverage in an occupational therapy specific unit that is focused on mental health / specific case (in PBL-type programs) with a mental health focus	8	4
In depth coverage in general occupational therapy unit	In depth coverage in a foundation / capstone unit or covered in another specific occupational therapy unit.	7	3
In depth coverage in "health sciences" type unit	In depth coverage in another health sciences unit (e.g., psychology) required to be taken by all students.	6	3
Brief coverage in mental health occupational therapy unit	Brief coverage in an occupational therapy specific unit that is focused on mental health / specific case (in PBL-type programs) with a mental health focus	5	3
Brief coverage in general occupational therapy unit	Brief coverage in a foundation / capstone unit or covered in another specific occupational therapy unit.	4	2
Brief coverage in "health sciences" type unit	Brief coverage in another health sciences unit (e.g., psychology) required to be taken by all students.	3	1
In depth coverage in elective	In depth coverage in a unit not required for all students, but that is taken regularly by a reasonable proportion of the cohort (e.g., > 5-10% of each cohort). Could be an occupational therapy specific elective or general elective.	2	1
Brief coverage in elective	Brief coverage in a unit not required for all students, but that is taken regularly by a reasonable proportion of the cohort (e.g., > 5-10% of each cohort). Could be an occupational therapy specific elective or general elective.	1	1
Not covered	The topic is not specifically covered in any area of the program	0	0
Not known	Unsure whether the topic is covered in the program	n/a[§]	n/a[§]

Notes:
"In-depth" coverage = specific content delivered about this aspect (e.g., a specific lecture on the topic or similar) and specific coverage in assessments.
"Brief" coverage = discussion of the aspect, but not detailed exploration of the area and it is not specifically covered in assessments
[†] Scores used in the initial Facets analysis (0-8)
[‡] Scores used in the final Facets analysis (0-4)
[§] In the analyses, these responses were treated as missing data

Table 2. Topics included in the "Essential priorities" category by clinicians, with coparison to level of coverage in university programs

Clinician rank[†]	Educational topic	University rank[‡]	Alignment[§]	How well met[¶]
1	Clinical reasoning / assessment formulation- combining occupational and psychiatric information to inform goal setting and intervention planning	1	Yes	Partially met
2	Client-centred practice and consumer engagement	15	Yes	Mostly met
3	Therapeutic use of self / therapeutic relationship / boundaries	16	Yes	Partially met
4	Functional implications of mental illness	9	Yes	Partially met
5	Therapeutic use of occupation	18	Yes	Partially met
6	Mental health fieldwork experiences	54	No	Mostly unmet
7	Collaborative goal setting	20	Yes	Partially met
8	Common occupational therapy interventions in community and inpatient settings	21	Yes	Partially met
9	Occupational therapy assessments in mental health	4	Yes	Partially met
10	Importance of occupation for positive mental health	25	Yes	Partially met
11	Observational assessment / Task and activity analysis	35	No	Mostly met
12	Engaging challenging consumers – Low motivation / lack of engagement	47	No	Partially met
13	Consumer self-management of illness (e.g., relapse prevention early warning signs management of hallucinations)	48	No	Partially met
14	Intervention planning	7	Yes	Partially met
15	Occupational therapy assessments – Functional assessment / assessment of basic and instrumental activities of daily living	26	Yes	Mostly met
16	Risk assessment and management	36	No	Mostly unmet
17	Occupational therapy roles – Maintaining occupational focus (including in generic positions)	80	No	Partially met
18	Basic communication skills – communicating with consumers and families	32	Yes	Partially met
19	Professional self-care / resilience	70	No	Mostly unmet
20	Knowledge of high prevalence disorders (e.g., anxiety depression)	5	Yes	Mostly met

21	Strengths focus	27	Yes	Partially met
22	Reflective practice	6	Yes	Mostly met
23	Recovery hope-inspiring practice and recovery orientation of services	2	Yes	Partially met
24	Knowledge of low prevalence disorders (e.g. schizophrenia / bipolar disorder)	3	Yes	Mostly met
25	Interviewing skills	28	Yes	Mostly met
26	Lifespan development approach / considering consumers' developmental needs / bio-psycho-social-developmental approach	29	Yes	Partially met
27	Engaging challenging consumers- disruptive / abusive / inappropriate behaviour	68	No	Partially met
28	Mental State Examination	10	Yes	Partially met
29	Sensory approaches	58	No	Mostly unmet

Notes:
† These rankings are based on clinicians' ratings of importance for each topic (Scanlan, Pépin, et al., 2015)
‡ These rankings are based on reports from academics about level of coverage of each topic in university curricula (results from the present study)
§ "Alignment" refers to situations where a topic is included in both the "Essential priorities" category from clinicians and the "High coverage" category from university programs.
¶ Clinician perception of how well met the topic area was in terms of students' / new graduates ability to apply this knowledge in a mental health practice setting

Table 3. Topics included in the "High coverage" in university programs category, with comparison to clinician rankings

University rank[†]	Educational topic	Clinician rank[‡]	Alignment[§]
1	Clinical reasoning / assessment formulation – combining occupational and psychiatric information to inform goal setting and intervention planning	1	Yes
2	Recovery hope-inspiring practice and recovery orientation of services	23	Yes
3	Knowledge of low prevalence disorders (e.g. schizophrenia / bipolar disorder)	24	Yes
4	Occupational therapy assessments in mental health	9	Yes
5	Knowledge of high prevalence disorders (e.g. anxiety depression)	20	Yes
6	Reflective practice	22	Yes
7	Intervention planning	14	Yes
8	Occupational therapy assessments – comprehensive occupational assessment	33	No
9	Functional implications of mental illness	4	Yes
10	Mental State Examination	28	Yes
11	Occupational therapy models – general application of models to practice	55	No
12	Evidence-Based Practice	32	No
13	Interventions to support independence in basic and instrumental activities of daily living	34	No
14	Group work	51	No
15	Client-centred practice and consumer engagement	2	Yes
16	Therapeutic use of self / therapeutic relationship / boundaries	3	Yes
17	Occupational therapy models – Model of Human Occupation	60	No
18	Therapeutic use of occupation	5	Yes
19	Occupational therapy assessments – Model of Human Occupation assessments	102	No
20	Collaborative goal setting	7	Yes
21	Common occupational therapy interventions in community and inpatient settings	8	Yes
22	Intervention strategies for anxiety and depression	38	No
23	Culturally sensitive practice (including for specific populations such as Indigenous and refugee populations)	52	No
24	Occupational therapy role – explaining occupational therapy role to others (multidisciplinary team / clients / other service providers)	30	No

25	Importance of occupation for positive mental health	10	Yes
26	Occupational therapy assessments – Functional assessment / assessment of basic and instrumental activities of daily living	15	Yes
27	Strengths focus	21	Yes
28	Interviewing skills	25	Yes
29	Lifespan development approach / considering consumers' developmental needs / bio-psycho-social-developmental approach	26	Yes
30	Personality Disorders	69	No
31	Research	98	No
32	Basic communication skills – communicating with consumers and families	18	Yes
33	Grading and adaptation	36	No
34	Occupational therapy models – Canadian Model of Occupational Performance and Engagement	95	No

Notes:

† These rankings are based on reports from academics about level of coverage of each topic in university curricula (results from the present study)

‡ These rankings are based on clinicians' ratings of importance for each topic (Scanlan, Pépin, et al., 2015)

§ "Alignment" refers to situations where a topic is included in both the "High coverage" category from university programs and the "Essential priorities" category from clinicians.

Table 4. List of topics which had discrepancies between clinician categorisation and level of coverage in university programs

Topics categorised as "Essential priorities" by clinicians but not in the "High coverage" in university programs category	**Topics included in the "High coverage" in university programs category but not categorised as "Essential priorities" by clinicians**
1. Mental health fieldwork experiences 2. Observational assessment / Task and activity analysis 3. Engaging challenging consumers – Low motivation / lack of engagement 4. Consumer self-management of illness (e.g., relapse prevention, early warning signs, management of hallucinations) 5. Risk assessment and management 6. Occupational therapy roles – Maintaining occupational focus (including in generic positions) 7. Professional self-care / resilience 8. Engaging challenging consumers – disruptive / abusive / inappropriate behaviour 9. Sensory approaches	1. Occupational therapy assessments – Comprehensive occupational assessment 2. Occupational therapy models – general application of models to practice 3. Evidence-Based Practice 4. Interventions to support independence in basic and instrumental activities of daily living 5. Group work 6. Occupational therapy models – Model of Human Occupation 7. Occupational therapy assessments – Model of Human Occupation assessments 8. Intervention strategies for anxiety and depression 9. Culturally sensitive practice (including for specific populations such as Indigenous and refugee populations) 10. Occupational therapy role – explaining occupational therapy role to others (multidisciplinary team / clients / other service providers) 11. Personality Disorders 12. Research 13. Grading and adaptation 14. Occupational therapy models – Canadian Model of Occupational Performance and Engagement