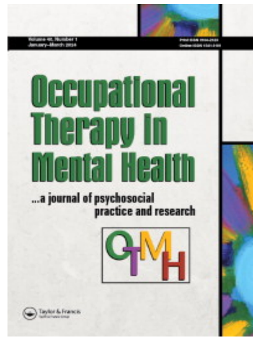

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Preparedness of Occupational Therapy Academics to Support Students Experiencing Psychosis: A Qualitative Study

Rebecca Matson, Chris Edge, Hannah Roberts, and Claire Saunders

School of Health Sciences, University of Liverpool, Liverpool, UK

ABSTRACT
Students experiencing psychosis face increased difficulties within the higher education environment with support from academic staff being identified as one of the most significant factors in reducing attrition rates. Focus groups and interviews were used to consider the experiences of eight occupational therapy academics. Thematic analysis identified themes relating to the how of supporting a student experiencing psychosis; the challenges of supporting a student with psychosis; and mechanisms of support. Despite a small sample size, this study highlighted important considerations relating to the need for additional support and resources for academics to equip them to effectively provide student support.

KEYWORDS
Psychosis; higher education; mental health; student support

Introduction

Experience of psychosis has been found to have a significant connection with academic achievement, with substantially lower numbers of individuals who have experienced psychosis progressing onto higher education than both students without a mental health condition, and those with other conditions such as anxiety and depression (Dickson et al., 2020; McEwan & Downie, 2019). Psychosis describes the experience of hallucinations, delusions, or thought disorders (Gaebel & Zielasek, 2015). Onset of psychosis has been identified as most commonly occurring between the ages of 16 to 30, with an average age of onset thought to be around 24 (NIMH, 2022). Although at the average age of onset a high number of individuals may have already completed higher education, this has particular implications given the range of onset, spanning across the potential age of transition into a higher education environment (Dickson et al., 2020). The age of

CONTACT Rebecca Matson rebecca.matson@liverpool.ac.uk School of Health Sciences, University of Liverpool, Liverpool, UK.

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transition into higher education has been found to connect with the likelihood of a student disclosing their mental health difficulty with mature students, in the UK that is those over the age of 21, being more likely to disclose. However, attainment rates are comparable for mature and younger students and correlate more strongly with whether or not a disclosure is made rather than the age of the student (OfS, 2023).

Increasing levels of mental health difficulties, in general, are being reported among higher education students, including a higher number of students arriving at university with a pre-disclosed mental health need (Thompson et al., 2022). A Student Academic Experience Survey completed in 2022 found that 34% of students considering leaving university attributed this to their mental health with a number of students highlighting the importance of support provided by academic staff alongside that provided by mental health specialists (HEPI, 2022). However, literature to date has suggested a poor level of preparedness for supporting students with mental health difficulties among academic staff as a whole (Gulliver et al., 2017; Margrove et al., 2014; Spear et al., 2021). The prevalence of mental health difficulties is thought to be even higher in healthcare students, due to factors such as increased pressure relating to balancing the combination of academic and clinical placement demands (Hughes & Byrom, 2019; Ramluggun et al., 2022).

Widening participation, that is increasing access to education for underrepresented groups, has been identified as a vital priority in healthcare education both in relation to expanding and diversifying the workforce (Jordan, 2022). Much of the previous focus relating to widening participation has been on socioeconomic factors and strategies to reduce the financial burden (Rainford, 2021), but there is increasing acknowledgment of the need to consider additional factors, specifically the high attrition levels of students with mental health needs (HEPI, 2022). Availability of support from academic tutors is a potentially important factor in reducing attrition. While not a mandatory requirement it has become common practice in the UK for students in higher education to be allocated a staff member as an academic advisor or personal tutor (McGill et al., 2020). The exact nature or remit of this role, as well as the term used, can vary between universities but tends to involve a mixture of academic support, focusing on progression through the course, and pastoral support, focusing on student wellbeing. The overall aim of the academic advisor role is to aid in the transition into the higher education environment and signpost toward additional sources of information and assistance (Yale, 2019).

While psychosis may be experienced by students within any course, the demands each course may entail vary significantly as well as the expected level of support from an academic tutor therefore a decision was made to

focus on one specific course for this initial study. This study will narrow the focus from previous studies considering the experience of academics teaching on healthcare courses (Hughes & Byrom, 2019; Ramluggun et al., 2022) to consider the specific experience of occupational therapy academic staff. Occupational therapy as a profession is focused on identifying barriers to participation and supporting individuals to identify strategies to overcome these (WFOT, 2012) therefore; occupational therapy academic staff are likely to have a unique perspective on this issue.

The primary aim of this study is to gain an understanding of the preparedness of occupational therapy higher education academic staff for supporting students experiencing psychosis with the following objectives:

- To consider how these staff would support a student experiencing psychosis
- To gain insight into the challenges associated with effectively providing this support
- To evaluate mechanisms already in place to enable staff to provide the required support

Methods

This study used a mixture of online focus groups and online individual interviews to gain insight into the preparedness of academic staff for supporting students experiencing psychosis. This was broadened from the initial choice of focus groups alone due to challenges in coordinating the availability of academics to attend a shared session and to support incorporation of a breadth of experiences. Such an adaptation to a study has been made previously by Baillie et al. (2016) in a study with ward-based staff where factors such as shift patterns created added complexities in participants being able to attend a focus group. The precedent of making this adaptation has also been discussed as reasonable in Barbour and Barbour (2018) where it is necessary to support the gathering of sufficient rich data.

Focus groups were chosen to provide a more natural dynamic for discussion and comparison of experience that would have potential to enrich the data. All three researchers involved in conducting the focus groups were experienced at facilitating group discussions and well- prepared to manage the dynamics within a focus group. Each focus group was co-facilitated by two of the researchers due to the added potential challenge of facilitating the groups within a virtual forum (Gaiser, 2008). Individual interviews were conducted by one researcher. A discussion guide was used to provide a structure for the focus groups while allowing for additional prompts or questions by the facilitators in order to pursue topics of relevance further

as they arise. The same questions were used in order to support consideration of the same issues within both approaches and facilitate triangulation. Initial questions gathered demographic information (length of time working in academia and clinical experience) and views on the role of an academic advisor in providing support to students with mental health difficulties. Subsequent questions focused on any experience participants may have of working with students experiencing psychosis, and the barriers and facilitators in this process (considering both personal preparedness and external supports).

Two focus groups and three individual interviews were conducted, totaling eight participants overall from seven different universities. Individual Interviews lasted between 40 and 43 minutes and both focus groups were approximately 80 minutes. Academic staff were recruited from universities across the United Kingdom through an online poster using twitter and through an email to the professional leads for occupational therapy at forty universities. The poster asked participants to contact the researchers following which they were emailed the participant information sheet and a link to an online consent form. On completion of the consent form participants were contacted to identify availability for a focus group in the first instance and where a participant's availability did not match that of others, a one-to-one interview was offered as an alternative. A further seven potential participants responded to the initial invite but did not go on to complete the consent form. Participant demographics are described in Table 1.

Participants were required to meet the following criteria: to be employed on a substantive contract in a higher education setting within the UK; to be an academic staff member on an occupational therapy program; and completing the role of academic advisor/personal tutor as part of their role. As the study considered preparedness rather than experience of supporting students with psychosis participants were not required to have any specific experience of doing so. A numerical identifier was allocated to each of the participants to ensure anonymity. Information that may make the participants identifiable was removed at the transcription stage to ensure confidentiality. All recordings were transcribed by a university transcriber.

Table 1. Demographic characteristics of participants.

Participant	University	Years in academia	Mental health clinical experience	Experience of supporting a student with psychosis
1	A	16 years	No	Yes
2	B	6 months	Yes	No
3	C	20 months	No	Yes
4	D	10 years	No	Yes
5	E	20 years	Yes	Yes
6	F	2.5 years	No	Yes
7	F	3.5 years	Yes	No
8	G	1.5 years	Yes	Yes

Ethical considerations

Approval for the study was granted by the University of Liverpool ILCAMS-REC study number 11560.

Written consent was obtained from all participants electronically and revisited and confirmed verbally at the beginning of the focus group or interview. Participants were advised of their right to withdraw from the study at any point, however, that should they decide to do so after the focus group had commenced it would not be possible to remove their data from the transcript due to the nature of focus group data. The importance of confidentiality being maintained by all group members was advised at the beginning of each focus group and that participants should not repeat any of the focus group discussion outside of this forum or identify any of the group members. All participants were provided with a debriefing form within 24 hours and advised that they were able to request an individual debriefing.

Data analysis

Data analysis was completed by the researchers following the six phases of thematic analysis identified by Braun and Clarke (2006) of familiarization with the data; generating initial codes; searching for themes; reviewing themes; defining themes and producing the report. The initial stages of the analysis process were supported by the use of NVivo to identify provisional codes within the transcripts. Analysis of the first transcript was completed by the whole research team to support triangulation in the analysis process and initial identification of codes. Each of the remaining transcripts were analyzed by one member of the research team, but with peer debriefing taking place during analysis to help mitigate the impact of individual researcher bias and support the confirmation of identified codes. During this process, the thematic analysis was compared to that of the initial transcript and codes but did not preclude the emergence of new codes. Following analysis of all of the transcripts, the codes were clustered by all three researchers according to their fit in relation to the identified study objectives. The study objectives were used as the over-arching themes and sub-themes within each of these then collectively developed by the researchers based upon connections between the codes. To support the trustworthiness of the analysis each sub-theme was checked against the coding and participant words, with quotations identified for verification of their validity.

Findings

The overall themes and sub-themes within these are identified in Table 2 below.

Table 2. Themes and sub-themes.

Theme	Sub-themes
1. The how of supporting a student with psychosis	1.1 Still a clinician 1.2 Mental health experience 1.3. A relational approach
2. The challenges of supporting a student with psychosis	2.1 Understanding the scope of your role 2.2 Balancing responsibilities 2.3 University support and challenging practice 2.4 Student engagement
3. Mechanisms of support	3.1 Structures of support for advisors 3.2 Role distinction 3.3 Identification of students needing support 3.4 Placement support

The how of supporting a student with psychosis

This theme relates to the factors that influence how an academic would support a student with experience of psychosis and the impact of this on their approach in practice.

Still a clinician

Participants discussed the challenge of managing the dual identity of being both an academic and a health professional; both of which impacted on their approach to student support. Their identity as an occupational therapist actively informed their response as an academic advisor in comparison to academics for non-healthcare courses as described by participant 6:

> if we were lecturing in geography for example, you know, we wouldn't have these skills, so we'd, you know, we wouldn't be able to help these students and, but yeah, but we're not lecturing in geography.

Participant 8 described viewing this as therapeutic use of self in their teaching. How they responded to students was seen as a form of role modeling to aid the development of the students' own professional identity through active learning:

> how do these young people learn to be people who can develop, like relationships … we learn that not just through getting content in a classroom, but we learn that through an experience.

There was however a sense of conflict between a need to model qualities inherent to the profession to the students, but while working within the boundaries of the role of academic advisor as outlined within the university environment.

Mental health experience

The preparedness of participants to work with a student experiencing psychosis varied in relation to their previous clinical background, and whether this included any mental health experience. Participant 4 who had worked within mental health stated that for this reason "we're, potentially

more equipped than, *some* of the academic advisors" identifying this added aspect they could bring to working with students with issues such as psychosis. However, the benefits of clinical experience in mental health had its limits as described by participant 7:

> I mean I'm quite confident about what my understanding of psychosis is and how it impacts but, there's always the challenge of how do we manage that within higher education, within the classroom, within placements?

Having experience of working in mental health settings provided a certain amount of awareness and understanding, but academics with that experience could also find themselves outside their comfort zone due to having to respond to these difficulties within a different role and a different environment with specific challenges and barriers.

A relational approach

A number of participants described the importance of developing a positive relationship with their advisees to enable them to have open discussions about factors such as the impact of their mental health on their studies. However, there were inherent challenges within that due to a perceived power dynamic in the academic-student relationship that could lead to students avoiding disclosure. Participant 1 stated:

> there's no getting away from the fact that when you come as a student there is that, isn't there, somebody's there, they're the person who's going to be assessing you, they hold, you know, that power balance.

Another important relational factor was for academics to develop relationships with connected services and agencies to ensure the most appropriate support was in place for students. Participant 2 described how the need to initiate contact with other services could be unexpected for some academics:

> they're going, 'I've gotta do what?! I've got to talk to a mental health practitioner?!' I'm like, well yeah, we need to get them involved.

Liaison with other agencies and the ability to effectively refer onwards to support services was perceived as key in both supporting a student with psychosis but also in maintaining the professional boundaries within the academic advisor role.

The challenges of supporting a student with psychosis

Participants reflected on the challenges to supporting a student with experience of psychosis in view of the role of an academic and the student response to the support that was available.

Understanding the scope of your role

There was generally perceived to be a lack of clarity within the scope of the role of an academic advisor, as well as variations across universities in relation to expectations. For academics with an occupational therapy background, boundaries could more easily become blurred, due to the shift from working in a clinical context to an academic context and working with students rather than patients. Participant 5 suggested this made understanding and working within the scope of the academic advisor role more difficult stating:

> it can get a bit messy if that boundary isn't monitored somehow.

Participants described possessing the skills to identify mental health issues and concerns, and to support students with such issues, but that in doing so they could easily step outside the expected role of an academic advisor. Participant 7 described one such situation with an advisee:

> if she needs something she gets in touch and we have a tutorial and she's, I'm definitely offering her some, mental health support even though it's not, badged as that its, per., it's academic tutoring.

A number of participants reflected that their university's role expectations conflicted with a sense of their professional standards and obligations as an occupational therapist, thus triggering what could be called a "professional conscience". Reconciling the duties inherent in their registration with the academic advisor role became challenging when encountering a student with a mental health difficulty such as psychosis, knowing they had the expertise to support them but that doing so was beyond the remit of their university role.

Balancing responsibilities

Several participants discussed issues around the multiple expectations placed on academics and the challenge of meeting their role as an academic adviser within the context of these demands. Participant 2 discussed the "time factor and the capacity you have as a lecturer" as being one of the most significant barriers in supporting students with additional needs such as psychosis. Making the time to follow up with a student who had disclosed a specific difficulty or who appeared to be struggling could be missed in balancing other role responsibilities.

Participants described university expectations in relation to the time allocated to the academic advisor role as unrealistic and often insufficient to enable it to be fulfilled in relation to students with no additional needs, let alone those who required added support. Participant 5 stated:

> I think we get something like 15 minutes per student per semester, 45 minutes in total a year.

The time allocation was seen by most participants as unrealistic to enable them to provide sufficient support and guidance to their advisees in view of both academic and pastoral concerns.

University support and challenging practice

Participants described a lack of perceived support from their university to enable them to effectively meet the needs of students who have experienced psychosis. A number of participants described decisions around student support mechanisms, and the expectations upon them, being made at a much higher level. There was a lack of consultation with academic staff and limited scope for using their clinical experience to influence procedure. Participant 1 discussed the implications of this in relation to a particular student with psychosis who faced termination of studies:

> we felt that actually this sort of conversation had been sort of done away from us as a staff team with student wellbeing and the student, erm, and we weren't brought in to that so we sort of felt that perhaps we hadn't done, not that we hadn't done everything we could but that we hadn't influenced perhaps in the way that that would have been more positive.

This could lead to academic staff feeling disempowered in their role and frustrated at being unable to support students to the best of their skills and abilities.

Student engagement

All participants suggested a significant factor in their ability to support a student experiencing psychosis was the willingness of a student to actively engage in the support process. When working with learners in a higher education setting there was an increased sense of personal responsibility which could lead to academics feeling restricted in the support they could offer. Participant 4 stated:

> you can't actually make them, as well isn't it, because they're adults, capable of consent so it's, you know you're signposting with no guarantee that they're going to actually take you up on.

This could lead to added challenges when working with a student in a more acute phase of psychosis where insight is more likely to be reduced as described by Participant 5:

> he went, AWOL. Erm, and, eventually we managed to track him down again and he had been very unwell and obviously has no insight and therefore can't communicate with the University.

While a higher education student may be capable of consenting to support, impaired insight could lead to significant limitations in the support

that could be provided. Participant 2 described a situation where a student may be willing to access support but concerned as to the implications of seeking this. In seeking support, it could be perceived that the student was not coping, which had added implications when completing a healthcare course:

> it's difficult because the student didn't wanna be seen, that she could not manage and she could not cope and she wanted, she still wanted to engage.

Students were aware of the additional pressure to maintain their wellbeing and of the potential impact of this on continuation with their studies.

Mechanisms of support

This theme relates to the policies and procedures in place to support and guide the delivery of the academic advisor role and how this would shape the experience of supporting a student experiencing psychosis.

Structures of support for advisors

Participants discussed universities often identifying the role of the academic advisor as to direct students to support services, which while these services could be appropriate and helpful to the student, participants suggested a lack of guidance from those services for academic advisors to increase their own understanding of difficulties such as psychosis. Participant 8 stated:

> we've got a fab disability team and great mental health advisors and they'll come in and do, bits of training except the training is kinda like this is where we are, this is how we work, this is our process.

The lack of training about how to support a student experiencing psychosis within a higher education setting was discussed by several participants suggesting a knowledge gap for academics that limited the support they could provide. Participant 3 stated:

> there isn't a, a manual in the office for us academics to use with, for students with psychosis, so in general I feel quite unsupported.

In clinical practice, participants would have access to supervision but this was not available to academics completing the role of academic advisor. Participant 1 stated:

> we kind of expect it in clinical practice don't we, as Occupational Therapists, and then you, you come into academia and you're supposed to just crack on with it aren't you really.

As a result, academics could feel quite isolated when dealing with difficult issues in the absence of a support mechanism they had come to expect

in their previous role. Peer support from colleagues helped meet this need to an extent and was noted to be particularly important for those who had not worked in a mental health setting in practice. Participant 6 reflected on the benefits of this during a situation where a student became acutely unwell with psychosis:

"I come from a physical background, so I don't have, much experience of, of psychosis, erm, (pause) but, I felt quite supported because we all dealt with it as a team." Accessing peer support from colleagues provided a sense of shared decision making and responsibility that was valued by participants.

Role distinction

Participants discussed that their role in relation to teaching responsibilities tended to be clear, but that their role as an academic advisor was less distinct. They discussed that while there may be a role outline available there could be several variances in role expectations in practice, often shaped by the specific name given to the role. Participant 1 suggested the use of the word personal added an extra aspect to the role:

> we're also PATs, personal academic tutors, so if it was a student that was my PAT, then I would feel that my role was, it was less distinct.

Being allocated as a student's academic advisor could create increased expectation of individual support and guidance beyond academic study. Participant 6 described how the name given to the role could be used to shape expectations and boundaries:

> I think we've, we've moved away from being called personal tutors I think to try and help with that boundary.

Amongst all participants, there was an evident need for greater clarity within the role and role expectations. This led to varying approaches both within a department and across the wider university impacting the level of support a student may expect.

Identification of students needing support

Participants reflected on the added challenges of identifying students in need of support who perhaps may not have disclosed their mental health difficulty. A few participants described experiences of students displaying symptoms of psychosis that were apparent both to them and at times to other students. Participant 5 described one such situation:

> the warning signs were there that the anxiety levels were so high that she couldn't function, and she then became concerned that things were deteriorating.

The impact of delayed identification of difficulties was thought to result in more limited responses and opportunities to provide the necessary support. Participant 8 described how this led to more of a reactive than proactive approach:

> it's very reactive, we're all going 'Yeah how could we, how would we react if' … I w., wished I had the space to do differently.

This ability to take a more proactive approach was limited by the time available for reflection and forward planning.

Support during practice placements

Participants reflected on the added challenges that could arise when a student was on a practice placement as part of their training and may not have disclosed their difficulties to their practice educator for that placement or become more unwell during the placement. Participant 3 stated:

> it's very much luck of the draw whether they do want to confide in you or not, erm, whether they have any conditions.

While it was very much seen as the student's choice as to whether they disclosed their condition, not doing so could lead to added challenges. Participant 4 described navigating the challenge of having a knowledge of this that they could not disclose on a student's behalf without their consent:

> I always felt a bit gee., guilty knowing, that I'm kind of sending this person, but there's that whole confidentiality isn't it, and you're not, you're not doing it to kind of, marginalize them, or, you know, to, to segregate them, you, you're doing it in a supportive way.

While the student's choice to disclose was respected there could also be a feeling of guilt on the part of the academic in being unable to share this information with the person who would be supporting them day to day on their placement.

Discussion

This study sought to gain insight into the preparedness of occupational therapy academics to support students experiencing psychosis. The themes emerging from this study related to the impact of previous clinical experience and professional identity when transitioning to an academic role, as well as the influence of university processes and procedures in relation to student support. Academics highlighted a range of factors such as an unclear remit to their role as academic advisor and the blurred boundary

imposed by the need for pastoral support for students experiencing additional difficulties such as psychosis.

The need for additional support for students experiencing psychosis has been highlighted within the literature with McEwan and Downie (2019) identifying that students with psychosis have been found to be less successful within higher education than students with other mental health conditions such as depression or anxiety. Yet there is an apparent lack of resources to prepare academics to support students experiencing psychosis. Participants referred to the mental health training available to them focusing on how to direct students to other services and lacking specificity as to how to support students experiencing potentially more complex issues such as psychosis. This area of insufficient training has previously been highlighted as an issue for academic staff as a whole with Spear et al. (2021) who in their study involving academics from 27 universities across the UK found that while mental health issues in higher education students are increasing, academics as a whole feel ill-prepared to support them due to both a lack of training and unclear support structures. Participants in this study described peer support and guidance from their colleagues as providing some form of buffer within the academic environment but noted the lack of supervision that would be received within clinical practice and that was seen as a requirement of their professional registration.

While university descriptions of an academic advisor or personal tutor role tended to advocate for directing students to other services, placing the need for pastoral support as being met by other staff either within or external to the university, this was not always felt to be feasible or appropriate when an academic advisor met with a student experiencing a crisis or deterioration in their mental health. The expectations set out by universities could feel in conflict with professional body requirements and stated duties as a health professional, leading to a blurring of boundaries and a need for similar professional support to that which would be expected in practice. This echoes the findings of previous studies considering the transition made from clinician to academic for occupational therapy academics, but also health professionals as a whole who often felt they should be doing more to support students (Cabatan et al., 2019; Marais, 2023; Murray et al., 2014; Ramluggun et al., 2022).

A number of the areas highlighted within this study, while limited to the experience of occupational therapy academics supporting students with psychosis, had potential wider implications for supporting students with mental health issues as a whole, as well as across different courses within the university. The relevance of such considerations for academics has perhaps been highlighted in the existing literature but is yet to be fully explored (Spear et al., 2021). There is also a need to explore the experience

of occupational therapy academics in providing support to students with a broader range of mental health difficulties to consider these implications further. As identified previously by Ramluggun et al. (2022), another important consideration for further research is the support structures available to academics completing an academic or personal advisor role. While providing pastoral support to students drew on skills and expertise from clinical practice, academics lacked access to supporting mechanisms they were accustomed to in practice such as supervision. The impact of supporting increasing numbers of students with mental health needs on academic staff has received much less attention within the literature than the challenges posed to the students themselves, and greater consideration of staff wellbeing is much needed (Hughes et al., 2018; Margrove et al., 2014; Ramluggun et al., 2022). This is particularly significant in view of the increasing prevalence of mental health difficulties within the higher education population.

Limitations

While this study has begun to develop the evidence base in relation to academics supporting students experiencing psychosis it is important to acknowledge the limitations. The applicability of these findings is limited by a relatively small sample size, while forty universities were contacted the participants only represented seven of these, therefore could not be seen as representative of the experience of occupational therapy academics as a whole. However, the participants represented seven different universities and therefore capture some variability in experience.

It is also necessary to acknowledge the impact of recruitment bias and that participants who agreed to take part may have been more inclined to do so due to having related experience. Although not an inclusion criterion, all of those who took part had either worked in a mental health setting prior to moving to academia or had experience of supporting a student with psychosis since doing so, which is likely to have altered their level of confidence and preparedness. While this will have added a richness to the discussion it may have been of value to also have those without such experience as part of the discussions. The initial intention of this study was to use focus groups alone as a method of data collection however it was necessary to vary this due to difficulty in coinciding the schedules of different potential participants. This was acknowledged as leading to differing levels of depth in discussion between the different formats however, to minimize this variation wherever possible the same interview schedule was used for both methods.

Implications for practice

This study has highlighted the current challenges faced by occupational therapy academics in the UK in supporting students experiencing psychosis and suggests a need for increased clarity in their role as academic advisor as well as clearer support structures to enable them to successfully complete this role. While this study focused solely on occupational therapy academics a number of the findings may have relevance to academics as a whole and might have implications for improving practice within higher education. Occupational therapy academics, with their understanding of the impact of health on occupational participation and the importance of role identity, may be particularly well placed to provide guidance on how to improve such structures within higher education.

Author contributions statement

RM & CE were involved in the conception and design of the study. Data collection and analysis were completed by RM, CE & HR. drafting of the paper was completed by RM, CE, HR & CS.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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ORCID

Rebecca Matson http://orcid.org/0000-0003-0790-366X
Chris Edge http://orcid.org/0000-0001-9419-2987
Hannah Roberts http://orcid.org/0009-0001-0595-575X
Claire Saunders http://orcid.org/0009-0003-6314-4431

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