An Investigation into an Occupation-Focused Self-Management Programme for College Students experiencing Mental Health Difficulties.

A Thesis submitted to the Trinity College Dublin, the University of Dublin for the degree of Doctor of Philosophy

Kieran Lewis

Discipline of Occupational Therapy, School of Medicine

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Declaration

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Summary

In response to ever increasing numbers of students in higher education experiencing mental health difficulties, an occupation-focused self-management programme, called the Unilink Self-Management Programme (USMP) was introduced into the Disability Service of an Irish third-level Higher Education Institute in 2012. The USMP is underpinned by the Person Environment Occupation Model (Law et al., 1996) and Recovery Model (Deegan 1988; Anthony 1993) and is delivered by Occupational Therapists in the college context. It is designed to enable students experiencing mental health difficulties to engage in their student roles, and to develop personal and practical self-management skills to maintain their health and well-being.

Research was undertaken to explore this novel intervention, with the research aim: ***'To understand the experiences, reflections and personal outcomes of student and staff participants using the Unilink Self-Management Programme (USMP) in a real-world HE context'***.

Two research objectives were established to address this aim: a) To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme b) To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme.

To address research objective one, an exploratory multiple case study approach was chosen. This involved the presentation of ten in-depth case studies of students who completed the USMP. A mixed methods approach was chosen, combining qualitative data from interviews with students over three phases (pre-programme, post-programme and twelve month follow-up), with quantitative data from the SF-36v2 Quality of Life measure (Ware et al, 2007) and the Brief Symptom Inventory (Derogatis, 1993). This was further integrated with progression data from an audit of case notes. To address research objective two, a process evaluation was used to frame the experiences and reflections of students and occupational therapists using the Medical Research Council (MRC) guidance on process evaluations of complex interventions (Moore et al., 2015). This combined data from interviews with students who completed the USMP and at least two phases of the research, with data from interviews with occupational therapists who delivered the

programme, and with descriptive data on the use of the programme from an audit of the clinical notes.

Thirty student participants and six occupational therapy participants took part in the research which was carried out over a four-year period 2013-2017. Ten students completed all three phases of the research, with a further ten students completing two phases. The majority of the students who completed the USMP graduated (86%). This compared favourably with national progression data and literature on the experiences of students with mental health conditions. Students highlighted an increased understanding of their mental health, recovery and occupation over the course of three interviews. They described how their mental health impacted upon their student lives, but also how they developed an increased ability to recognise this and felt able to respond. 45% of students (n=20) who completed the programme showed increased quality of life at phase two of the research, with this rising to 80% at twelve month follow-up (n=10). 35% of students (n=20) showed reduced psychological symptomatology on the Brief Symptom Inventory, with this rising to 70% at twelve month follow-up (n=10).

Both students and occupational therapists positively received the USMP. The individualisation of the programme in terms of number of meetings and duration of the programme was valued by students and occupational therapists, as was the one-to-one meeting format and personalisation of the content to each student. The collaborative relationship with the occupational therapist and focus upon occupation were considered to be core elements of the USMP in terms of promoting change. In particular, both students and occupational therapists highlighted the sharing of opinions around the concepts of mental health, recovery and occupation as an important foundation for a collaborative relationship and as a positive experience for them.

Presentations

- Kieran Lewis, Clodagh Nolan, Elizabeth McKay , The Development of an Occupation-Focused Self-Management Programme for Students in Higher Education, 1st COTEC-ENOTHE Congress, National University of Ireland Galway, 15-19 June, 2016 Conference Paper, 2016

- Kieran Lewis, Achieving meaningful integration and participation in community life: The value of a context-specific recovery-orientated mental-health service within higher education, ENTER Mental Health & Irish Institute of Mental Health Nursing 2015 European Conference 'Transforming Mental Health Services: Current Trends across Europe'. School of Nursing, Trinity College Dublin, the University of Dublin, 4-5 June, 2015, Conference Paper.

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Chapter One: Introduction

1.1 Introduction

This thesis presents an exploratory case study of the *Unilink* S*elf-Management Programme (USMP)* (Lewis, 2012), a complex Occupational Therapy intervention for college students with mental health difficulties, as delivered within an Irish Higher Education Institution (HEI) over the period 2013-2017. This chapter begins with a presentation of key terms and definitions as a guide for the reader, followed by a section that outlines the need for interventions for college students experiencing mental health conditions, with particular reference to the Irish Higher Education (HE) context. Subsequently, an overview of the development of the *USMP* intervention is provided. The research rationale and aim of the study are then presented, followed by a brief description of the study design, and concluding with an outline of this thesis.

1.2 Definition of Terms

Before proceeding with an introduction to this research study it is useful to clarify the technical terminology that will be used throughout.

1.2.1 Occupational Therapy

Occupational therapy (OT) is a client-centred health profession concerned with promoting health and well-being through occupation. The Person Environment Occupation model (Law, Cooper and Strong et al., 1996) is a guiding philosophy for the development of the *USMP*. Hence, the definition of occupation here is drawn from the work of these authors. It refers to occupation as '*groups of self-directed, functional tasks and activities in which a person engages over the lifespan'* (p.16). Occupational Therapists aim to enable people to do the everyday activities that they want and need to do when faced with illness, injury, and disability or challenging life events (Association of Occupational Therapists of Ireland, 2020).

1.2.2 Higher Education Institutions

HE in Ireland is predominantly provided by Universities, Institutes of Technology and Colleges of Education, which are collectively known as Higher Education Institutions (HEI). The majority of students enter HE having completed the Leaving Certificate at the end of second-level education (Department of Education and Skills, 2020).

1.2.3 Self-Management

In this research study, the following widely cited definition of self-management is taken from the summary report of the *1st Annual Crossing the Quality Chasm Summit: A Focus on Communities* which was organised by the Institute of Medicine (2004). It states that:

'Self-management is defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions' (p.57)

1.2.4 Self-Management Support

A differentiation is often made in the literature between the concept of self-management and that of self-management support or self-management interventions. In line with their earlier definition of self-management above, which informs this research study, the Institute of Medicine (2003) proposed that self-management support involves:

'the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal-setting, and problem-solving support.' (p.52)

1.2.5 Mental Health

Various terms have been used to reflect the range of mental health issues that might be encountered, from the psychological distress experienced by many people, to serious mental disorders and illnesses that affect a smaller population. Mental health is best thought of as a continuum that includes

positive emotional wellbeing, which changes throughout our lives (Fox, Byrne and Surdey, 2020). The World Health Organisation (2007) described mental health as "*a state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"* (WHO, 2001a, p.1). This view represents a change from the perception of mental health as being characterised by disorder. In this study the following terms are used in line with the recently published *National Student Mental Health and Suicide Prevention Framework* (Fox, Byrne and Surdey, 2020):

- *Mental health conditions* are those which are clinically diagnosable – they may be more or less severe, and their treatment pathways may vary.
- *Mental health difficulty* and *mental health issue* are broad terms that describe mental distress that may or may not be temporary and/or be related to a diagnosable mental health condition.
- *Wellbeing* is a broader and more subjective term relating to quality of life. (Office of Students UK, 2019).

All student participants in this study were registered with the HEI's Disability Service, which requires a student to provide documentary evidence outlining a diagnosis of a mental health difficulty from a consultant psychiatrist or specialist registrar. As such, the term '*mental health condition'* will be used in this study when referring to these students.

1.3 Background

This section provides a comprehensive overview of mental health in HE in an Irish context, beginning with a commentary on the prevalence of mental health difficulties in HE internationally, a profile of mental health in HE in Ireland, and an outline of national mental health policies in Ireland. It continues with an examination of support structures provided to students with mental health conditions in HEIs in Ireland, and importantly, introduces the Occupational Therapy approach which informs this thesis.

1.3.1 The Mental Health of Students in Higher Education

The mental health of students in higher education has gained increasing focus over the past two decades, with studies showing a significant increase in student need which is far exceeding the resources available through student supports (Auerbach et al., 2018; Bartlett, 2014; Castillo & Schwartz, 2013; Centre for Collegiate Mental Health, 2016; Eisenberg, Hunt & Speer, 2013; Fox, Byrne and Surdey, 2020; Thorley, 2017). International prevalence studies show that approximately one in three students in higher education will experience a mental health difficulty at some stage in their college journey (Auerbach et al., 2018; Bruffaerts, Mortier, Kiekens et al., 2018; Ibrahim, Kelly, Adams, & Glazebrook, 2013; Jenkins, Ducker, Gooding et al., 2020; Pedrelli, Nyer, Young et al., 2015). The student role often includes personal and academic stressors that can have a negative impact on mental health such as adjustment to new environments, interpersonal relationships, management of academic tasks, financial problems, curtailing of existing supports, and greatly increased personal autonomy (Bulo & Sanchez, 2014; Cvetkovski et al., 2012; Cleary, Walter & Jackson, 2011; Deatherage, Servaty-Seib, Aksoz, 2014; Hamaideh 2011; Ibrahim et al., 2013; Tupler et al., 2015). Students in HE are also considered to be a high-risk population due to their age, as the onset of most mental health problems occurs before twenty-four years of age (De Girolamo, McGorry, & Sartorius, 2019; Jones, 2013; Kessler et al., 2007; Mowbray et al., 2005; Reavley and Jorm, 2010). Experiencing a mental health difficulty can lead to significant role impairment, which negatively impacts upon academic attainment and progression, as well as leading to reduced levels of quality of life, and increased levels of reported psychological symptoms and suicidality (Alonso et al., 2018; Arria, Caldeira, & Vincent, 2013; Auerbach et al., 2018; Bruffaerts et al., 2018; Dooley et al., 2019; Eisenberg et al., 2009; Horgan et al., 2018; Jenkins et al.,2020; Kessler et al., 1998; Mojtabai et al., 2015; Mortier et al., 2018; Storrie et al., 2010).

1.3.2 The Mental Health Profile of Students in Higher Education in Ireland

Ireland has one of the highest rates of diagnosed mental health conditions in Europe, with 18.5% of the population recorded as having diagnoses such as anxiety, bipolar, schizophrenia, depression, or substance misuse (OECD, 2018), and also the highest rate of inpatient psychiatric admissions amongst 20 – 24 year olds (Health Research Board, 2019). As noted previously, approximately 75% of all serious mental health conditions first emerge by the age of twenty-four (Jones, 2013; Kessler et al., 2007; Mowbray et al., 2005; Reavley and Jorm, 2010). As most Irish school leavers entering higher education fall within this age bracket, this suggests that a significant number of individuals with mental health difficulties are enrolled in HEIs.

The overall student population in HE increasingly reports difficulty in managing mental health (Dooley and Fitzgerald, 2012; Dooley, O'Connor, Fitzgerald et al., 2019; Fox, Byrne and Surdey, 2020; Price, Smith & Kavalidou, 2019). The *MyWorld 1 (MW1) Survey* (Dooley and Fitzgerald, 2012) and *MyWorld 2 (MW2) Survey* (Dooley, O'Connor, Fitzgerald et al., 2019), have shown increasing trends in respondents falling into the severe or very severe categories for depression (23% MW2 from 14% MW1) and anxiety (28% MW2 from 15% MW1). Suicidality has been highlighted as a particular issue in the Irish context (Dooley and Fitzgerald, 2012; Dooley, O'Connor, Fitzgerald et al., 2019; Horgan, Kelly, Goodwin, et al., 2018) with the *MyWorld 2 Survey* reporting that 68% of respondents have thought about taking their own life without any intent, 38% reporting deliberate self-harm without wanting to take their own life, and 12% of respondents reporting that they had deliberately hurt themselves, whilst also wanting to take their own life. The most frequently reported stressors identified by students in higher education were college (68%), the future (42%), finance (41%), exams (39%), relationships (25%), family (24%), friends (18%) or issues related to work (15%) (Dooley, O'Connor, Fitzgerald et al., 2019). Students highlighted issues within the student role such as sleep, attendance at college/work and

increased substance use as being related to mental health (Dooley et al., 2019).

1.3.3 Mental Health Policy Context in Ireland

Mental healthcare policy in Ireland has seen a shift over the past fifteen years, reflecting international trends in moving from a focus on impairment and deficit, to placing an emphasis on quality of life and empowering individuals in their recovery journey (McGrath, 2015). This is reflected in policy documents such as *A Vision for Change* (Department of Health, 2006), *Healthy Ireland* (Department of Health, 2013), and the recently published mental health strategy *Sharing the Vision* (Department of Health, 2020). When launched in 2006, *A Vision for Change* recommended a radical change in mental health towards a system of supports based in the community and with a recovery orientation at all levels. However, successive reports on the implementation of this policy show a picture of understaffing in community mental health teams and underdeveloped structures (Mental Health Commission, 2009; Mental Health Reform, 2015).

The *Healthy Ireland 2013-2025* (2013) framework aims to increase the proportion of people who are healthy at all stages of life and to reduce health inequalities and has been used to shape the development of healthy campus policies amongst HEIs in Ireland. It places an emphasis on empowering individuals and all sectors of society to contribute to the promotion of health and wellbeing. *Sharing the Vision* was launched in June 2020 with a focus on promotion, prevention, early intervention, and service access at a community level, underpinned by a recovery orientation strategy over the period 2020-2030 (Department of Health, 2020). However, despite these policy developments, accessing mental health services has become an increasingly pressing issue within Irish society, with the Inspector of Mental Health Services noting *'serious staff shortages throughout the mental health sector'* (Mental Health Commission, 2017, p. 50,). This has been exacerbated by a decrease in the mental health budget from 13% of the overall health budget in 1984 to 6.1% in 2017 (Seanad Public Consultation Committee, 2017), which

compares unfavourably with other European countries and internationally (OECD, 2014).

In this context, supporting students experiencing mental health difficulties has become an increasing concern within HE for administrators, academic staff, and student support services. Higher Education presents a unique opportunity in an individual's life to identify, prevent and treat emerging mental health difficulties (Hunt and Eisenberg, 2010; Royal College of Psychiatrists, 2011), and HEIs have an important role to play in supporting those students who experience varying levels of mental health difficulty. HEIs have traditionally provided counselling and health services for the student population, and there has been an increase in the uptake of these services (Castillo and Schwartz, 2013; Eisenberg, Hunt and Speer, 2013; Bartlett, 2014; Centre for Collegiate Mental Health, 2016). Mirroring international trends, there has been a surge in demand for college-based mental health services over the past ten years in Ireland (AHEAD, 2018; Fox, Byrne and Surdey, 2020; Psychological Counsellors in Third Level Colleges in Ireland, 2021). Consequently, the HE sector in Ireland is currently reviewing how services are provided in response to the growing number of students with complex mental health needs (Fox, Byrne and Surdey, 2020). Many HEIs are now adopting wide-ranging mental health strategies encompassing areas such as college regulation and policy, student services, health promotion initiatives, awareness campaigns, training of staff across college, student-led activity such as peer support, on-line mental health resources, and curriculum design (Fox, Byrne and Surdey, 2020).

1.3.4 Supporting Students with a Diagnosed Mental Health Condition in Higher Education in Ireland

Legislation in Ireland provides for equal access to and participation in HE and protection against discrimination, as outlined in the Equality Act (2004), the Equal Status Acts (2000 - 2018) and the Disability Act (2005). HE providers are legally obliged to accommodate the needs of those with disabilities, including those experiencing mental health conditions (Fox, Byrne and Surdey, 2020).

To meet these obligations, HEIs have established Disability Services to coordinate the provision of reasonable accommodation. Since the establishment of these services, the number of students with disabilities in HE has increased annually (AHEAD, 2015a). The Fund for Students with Disabilities (FSD) was launched in 1994 by the Higher Education Authority and is supported by the Irish Government and European Union. It was established to assist HEIs in providing supports to enable students with disabilities to fully participate in, and successfully complete their chosen course of study (HEA, 2020). The overall goal of access policy is that the student population in Irish HEIs should reflect the diversity of Ireland's population at large. With this aim, the Disability Access Route to Education (DARE) was established in 2009 by HEIs which had previously provided independently administered supplementary admission routes to school leavers with disabilities (Reilly, 2017).

DARE is an alternative admissions scheme for students whose disabilities have had an impact on their second-level education. The entry requirements for courses in HE in Ireland are based upon a points system related to results in examinations at the conclusion of second-level education. The DARE scheme offers a points reduction on course entry for applicants who meet the established criteria for having a disability. The number of eligible DARE applications has grown from 940 in 2010 to 3,542 in 2017 (DARE, 2018). Of these, the number of eligible DARE applications in the Mental Health category has grown from 78 in 2010 to 635 in 2017 (DARE, 2018). *The National Plan for Equity of Access to Higher Education, 2015-2021* (Higher Education Authority, 2015) outlines targets for increasing the participation of students with disabilities, including mental health conditions. At the time of publication of this plan, new entrants to HE with disabilities accounted for 6% of the general student population with a target established to increase this to 8% by 2019. In the academic year 2018/19, 8.3% of new entrants to undergraduate courses were students with disabilities.

The number of students disclosing a diagnosed mental health condition to their educational institution through Disability Services in Ireland has

increased fivefold in the period 2009-2018 (AHEAD, 2019), which is reflected in disability data internationally (Advance HE, 2018; KPMG, 2015; Thorley, 2017). When compared to the overall number of students with disabilities, the proportion of students disclosing a mental health condition has increased nationally from 8.9% (n=645) in 2010/11 to 16.1% (n=2,442) in 2018/19. In the HEI where this research study was conducted, this trend has been even more pronounced. The number of students disclosing a mental health condition represented 15% (n=123) of the overall number of students with disabilities in 2010-11, rising to 24.3% (n=396) by 2018-19, and has increased further to 471 students in 2019/20, representing 27% of all students disclosing a disability within the research context (Disability Service, 2020).

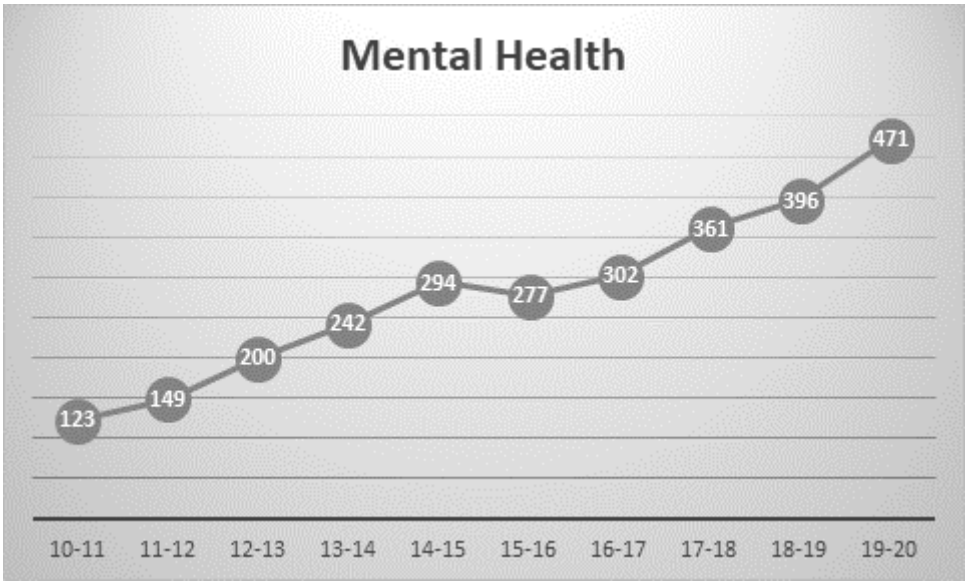

Figure 1. 1: Number of Students disclosing a Mental Health Condition within the research context 2010/11-2019/20

For students with a disclosed mental health condition, reasonable accommodations in Irish HEIs include course-based accommodations, principally in the form of examination accommodations. However, many Disability Services also provide individualised supports for students with disabilities funded through the FSD (Murphy, 2017). In the HE context in Ireland, this has included the development of Occupational Therapy Services

embedded within some Disability Services, with the aim of providing students with practical support in the management of their student role. It has been increasingly recognised that academic reasonable accommodations do not always meet the complex needs of students whose student role can be seriously impacted by a mental health condition (Murphy, McKernan, and Heelan, 2016). Individualised approaches such as those provided by Occupational Therapy Services nationally, are needed to provide practical support in managing academic demands (Murphy, McKernan, and Heelan, 2016).

1.3.5 Occupational Therapy Approaches within Higher Education

Historically, Occupational Therapy as a profession has largely been on the periphery of college-based student services. Occupational Therapists may support students off-site within external health service structures, often working independently from college-based student services or the HEI overall. Many Occupational Therapists are working in HEIs internationally in roles of Disability Officers, Mental Health Advisors or Specialist Mental Health Mentors. There are very few examples of on-campus Occupational Therapy services in HEIs internationally, but a number have been established in the United States and in Ireland over the past two decades, either within Occupational Therapy faculties or embedded in student services (Keptner, 2017; Keptner and McCarthy, 2020; Nolan, 2011).

In 2004, an Occupational Therapy Service was established in the research site for this study, as a collaborative approach between the Discipline of Occupational Therapy and the Disability Service. In line with Karen Unger's on-site model of supported education (1990), it is located on campus, allowing for service provision that is flexible, responsive, and available to individuals as needed. Twenty-two (22) students availed of the service in its first year, and this has grown to over 250 students in the academic year 2018-2019. The majority of students who avail of the Occupational Therapy Service have mental health difficulties, but it is increasingly accessed by students on the Autistic Spectrum, those with Attention Deficit Hyperactivity Disorder,

Developmental Coordination Disorder, Significant Ongoing Illnesses, and Physical or Sensory Disabilities. These students are referred to the Occupational Therapy Service by Disability Officers based upon a needs assessment. Over the past 16 years, the Occupational Therapy approach has been developed and refined in line with the Person Environment Occupational (PEO) model (Law et al., 1996), and Recovery model as described by Deegan (1988) and Anthony (1993). Specific assessments and interventions have been developed (Nolan, 2011, 2014) and the *Unilink Self-Management Programme* (Lewis, 2012) is one such intervention.

1.3.6 Self-Management Interventions with Individuals experiencing Mental Health Conditions

'The recovery approach in mental health services emphasises the expectation of recovery from mental ill-health and promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual's personal journey towards recovery'

(Mental Health Commission, 2005a, p.4).

With the increasing move towards the development of recovery-orientated approaches within Irish mental health services (Department of Health, 2005; Department of Health, 2020; McGrath, 2015), there has been a focus upon the use of self-management approaches with individuals experiencing mental health conditions, with programmes such as the Wellness Recovery Action Plan (Copeland, 1997) now commonly used. Davidson (2005) maintains that self-management can be a practical way to translate the ideas of recovery into practical tools of everyday living, and views self-management as an aspect of recovery that generates skills for everyday living.

The evidence-base underpinning the use of mental health self-management approaches has expanded greatly over the past ten years (Canacott et al., 2019; Dalum et al., 2018; Lean et al., 2019; Petros & Solomon, 2015). Self-management approaches seek to empower individuals to better manage the functional effects of various difficulties, carry out desired roles, and manage the emotional impact of these difficulties with the support of a healthcare

professional. They give the individual the opportunity to reconnect with their lives within the context of living with a mental health difficulty, and further involve putting the person in direct control of managing themselves and their well-being (Crepaz-Keay, 2010). For students in HE, the ability to self-manage in the student role, and the challenges that this can entail, has significant implications for both well-being and academic success (Canadian Association of College and University Student Services and Canadian Mental Health Association, 2013; Eisenberg, Lipson and Posselt, 2016). Self-management approaches are particularly relevant for college students as the student role demands increasing levels of self-advocacy, self-determination, and indeed self-management. Students are considered to be adults within the context of HE and often move into more independent living away from their family and other support structures. The *Unilink Self-Management Programme (USMP)* was developed to enable students with mental health conditions to develop personal skills and to fully participate in their student roles in college.

1.4 The Unilink Self-Management Programme

The original inspiration for the *USMP* was drawn from a discussion between the researcher and the clinical supervisor in 2009, which centred around the skills and strategies that students had developed prior to coming to college, and the challenges they were experiencing in trying to apply these personal strategies and skills in their new student role in college. This led to the development of a pocket-sized tool based upon the Wellness Recovery Action Plan (WRAP) (Copeland, 1997). Permission was obtained from the developers of WRAP in the Copeland Centre for the use of this resource within Occupational Therapy meetings, and for students to carry with them, and refer to, during their college lives. The format of the card (Appendix 16) was closely based upon WRAP, but without the crisis planning section, as the tool focuses on daily self-management of the student role rather than crisis planning explicitly. Following feedback from students and Occupational Therapists at the end of the academic year 2009/10, the tool was developed as a workbook-based programme for use during meetings between occupational therapists and students.

Over the period 2010-2012, three editions of the *USMP* were produced based on updated literature reviews and on-going feedback from students and occupational therapists using the programme. In addition to the researcher's own experience of working as an occupational therapist with students experiencing mental health conditions, input from an expert group of occupational therapists and disability officers contributed to the development and refinement of these versions of the *USMP*. Version One of the workbook was used with five students during the academic year 2010/2011; Version Two was used with ten students in the academic year 2011/2012; while Version Three, which was used in this research study, was developed for use during the 2012/2013 academic year. Amendments to the programme that were introduced over this period included organising content within the Person Environment Occupation model (Law et al, 1996), re-formatting of the workbook from four to six sections (Figure 1.2), the inclusion of subsections on Recovery, Occupation, and Mental Health in the introductory section, and the addition of goal-setting and routine formation worksheets.

Section One:	Introduction: Discussion of the key concepts of recovery, occupation, mental health, and the Person Environment Occupation model (Law et al., 1996).
Section Two:	Identifying the things that I need to do to engage in my student role and to look after my mental health.
Section Three:	Identifying the things that may contribute to my <u>not</u> engaging in my student role.
Section Four:	The signs that I am <u>not</u> engaging in my student role and possibly becoming unwell
Section Five:	Personal and practical strategies for engaging and re-engaging in my student role.
Section Six:	Review: Overview of the strategies and concepts covered in the programme.

Figure 1. 2: Overview of the Unilink Self-Management Programme (Lewis, 2012)

Critical features, specific components, and parameters for delivery of the *USMP* were established, based upon the Recovery approach and Person Environment Occupation Model (Law et al., 1996), together with findings from a literature review. These elements are described in detail in Chapter Three of the thesis.

1.5 The Unilink Self-Management Programme as a Complex Intervention

Complex interventions have been described as containing several interacting components, which may act independently or interdependently, but which all contribute to the functioning of the intervention (Craig et. al., 2008). While noting that interventions are rarely truly simple, Craig et al. (2006; 2008) propose that there are several dimensions of complexity: i) the number of interacting intervention components; ii) the number and difficulty of behaviours required by both those delivering the intervention and those who receive it; iii) the number of groups or organisational levels targeted by the intervention; iv) the number and variability of outcomes and v) the degree of flexibility or tailoring of the intervention permitted (Craig et al., 2008).

The Royal College of Occupational Therapists (Pentland et al., 2018) identify core elements of Occupational Therapy practice which support the claim that Occupational Therapy is a complex intervention, such as: i) the degree to which the Occupational Therapy intervention is tailored to the individual's needs, issues, strengths and contexts; ii) the on-going adaption of the intervention in response to the individual in their context; iii) the number of interacting factors when considering the dynamic interaction between the person, their occupation and their environment; and iv) the wide array of possible outcomes of the Occupational Therapy intervention and the variability of how these outcomes are measured (Pentland et al., 2018).

As an individualised, occupation-focused, and context-based intervention, the *USMP* reflects many of the core elements of Occupational Therapy practice as a complex intervention outlined above. The individually tailored format and intervention content and the focus upon the individual in their college

context, demonstrate that the *USMP* can be viewed as a complex intervention.

1.6 Rationale for this Research Study

This study has been undertaken with the overall research aim of *'To understand the experiences, reflections and personal outcomes of student and staff participants using the Unilink Self-Management Programme (USMP) in a real-world HE context'*. The lack of evidence-based occupation-focused approaches designed specifically for students in HE in Ireland, as well as a dearth of research into the use of self-management approaches with this population, highlights the need for this research. Complex interventions for mental health are often costly and can have unanticipated results, and so should be evaluated by the best methods available. The pressure to identify effective interventions can lead to premature commencement of large evaluation studies (Hallingberg et al., 2018). Craig et al. (2008), claim that 'too strong an emphasis on the main evaluation to the neglect of adequate development and piloting or consideration of the practical issues of implementation will result in weaker interventions' (p.4). This study has been conducted to explore participants' experiences of using this individualised self-management programme as an intervention to enable college students with mental health difficulties to engage in their student roles.

To address the research aim, a mixed methods approach was chosen, combining data from student and occupational therapist participants, who engaged in the USMP. An exploratory case study design (Yin, 2018) was used to provide an in-depth understanding of personal outcomes from ten case studies of student engagement in the USMP. To further examine the experiences and reflections of student and occupational therapist participants in using the USMP, a process evaluation was carried out based upon the guidance as outlined by the **Medical Research Council** (Moore et al., 2015).

The mixed-methods research design included qualitative data from interviews with students at three points (pre-programme, immediately post programme, and at twelve-month follow-up). It also included quantitative data from self-

report measures of mental health status (Brief Symptom Inventory, Derogatis, 1993) and Quality of Life (Ware et al., 2007), as well as demographic information and progression data from an audit of clinical notes. Interviews were also carried out with Occupational Therapists following delivery of the *USMP*.

1.7 Thesis Outline

This thesis is presented in seven chapters, of which this is the first. Chapter Two presents a detailed discussion of the literature pertaining to the mental health of students in HE, mental health self-management interventions and Occupational Therapy self-management interventions. Chapter Three describes Version Three of the *Unilink Self-Management Programme* upon which this study is based. The research design and methods used to address the research questions identified are presented in Chapter Four. Subsequently, Chapters Five and Six present a rich picture of the experiences, reflections, and personal outcomes of the students and occupational therapists who used the programme. Chapter Seven discusses these findings in relation to the literature, as well as implications for Occupational Therapy, self-management approaches and college-based student support services. It further proposes recommendations for future programme development.

Chapter Two: Literature Review

2.1 Introduction

This chapter presents the literature which informs the exploratory case study examining the *Unilink* S*elf-Management Programme (USMP)* (Lewis, 2012), a complex Occupational Therapy (OT) intervention for college students with mental health difficulties. The following section outlines the procedure for identifying and collating the pertinent literature which is examined in this chapter.

2.2 Identification of literature

A comprehensive search of the literature relating to self-management of mental health difficulties for students in higher education (HE) included international databases and electronic journal archives from health, medicine, and OT e.g. CINAHL, ERIC, PROQUEST, PsychINFO, and also encompassed international, EU, national and sectoral literature, government and institutional guidelines, commissioned research via State agencies, and independent research studies. Reference lists of retrieved journal articles and book chapters were also investigated. Inclusion and exclusion criteria (Table 2.1) were established from which search keywords were extrapolated and used singly or in phrases, principally: 'Occupational Therapy', 'mental health', 'self-management approaches', 'self-management interventions', 'occupation-focused self-management approaches', 'higher education', 'college', 'university', 'students', 'occupation-focused interventions' and 'occupation-focused approaches'. No time-based parameters were applied.

Table 2. 1: Inclusion and Exclusion Criteria

Inclusion Criteria
• Sources published in English • Sources related to students in Higher Education including relevant research studies, legislation, policy documents and reports. • Research studies related to mental health self-management interventions with young adults and adults. • Research studies related to mental health occupational therapy interventions with young adults and adults.
Exclusion Criteria
• Studies related to students in primary or secondary education • Research studies which focus upon non-mental health self-management interventions

2.2.1 Selection of literature

Suitable articles were retrieved in full, reviewed, annotated, and collated. A descriptive review was conducted and the material organized into the principal themes of the literature review which are: i) the student role in higher education, ii) the experience of having a mental health difficulty in college, iii) the prevalence of mental health difficulties among students in higher education, iv) mental health interventions for college students, and v) mental health self-management and OT approaches. To conclude this chapter, research objectives and research questions are presented based upon the literature reviewed.

2.3 The Student Role in Higher Education in Ireland

The student population in HE is becoming increasingly diverse both within Ireland and internationally, as is the student role. Course structures vary widely in terms of contact hours, mode of delivery, number of students, academic demands, and the inclusion of internship / placement. This section will examine the literature pertinent to each of these factors.

2.3.1 The Irish Higher Education Context

HE in Ireland is provided by universities, technological universities, institutes of technology, colleges of education, and other higher education institutions (HEIs). There are twenty-three publicly funded HEIs in Ireland, with a further seven institutions in receipt of partial funding, together with a number of smaller private colleges (HEA, 2020). Students pay an annual contribution charge which may be covered through a means tested grant system. However, since 1996, tuition fees in most HEIs have been subsidised through public funding (Higher Education Authority [HEA], 2021). The student population ranges from 1,000 to 33,000 students per institution, based in both urban and rural locations, with the majority of full-time undergraduate (UG) students (89%) entering HE directly from secondary education. Ireland has a highly educated population by international standards, with 41% having an HE qualification (IDA, 2019). In younger groups, Ireland compares favourably with other countries, with 54% of 25-34-year-olds in Ireland having attained a tertiary education compared to 45% across Organisation for Economic Co-operation and Development (OECD) countries (OECD, 2018). This reflects increasing levels of participation over time in Ireland as only 30% of 60-64-year olds attended higher education. Significant growth in enrolments has been observed over the past five years, with the number of students in UG and postgraduate (PG) courses increasing by 11% (Erskine & Harmon, 2021).

2.3.2 The Student Population in Higher Education

Annual student surveys and reports present a rich picture of the student population in HE, analysing health and wellbeing, income and expenditure, socio-economic background, travel to college, and accommodation (CSO, 2020; Erskine & Harmon, 2021; HEA, 2020). Recent statistics from the HEA (2020) established that in the academic year 2019-20, there were 235,697 students enrolled in twenty-three publicly funded HEIs which included 189,930 UG students and 45,767 PG students; of these, 189,904 were enrolled in full-time courses and 45,793 in part-time courses. With regards to gender, there are more students who identify as female (n=126,573) than

male (n=108,953) or as other (n=171), with this breakdown consistent at UG and PG levels (HEA, 2020).

Ireland participates in the Eurostudent project, which collates data across thirty countries on the social and living conditions of students in HE, with the Eurostudent VII report in 2019 providing data on almost 20,000 students in HE in Ireland. The majority reported living with parents / guardians / other family (40%), with a partner or spouse (14%), with children (8%), or alone (7%) (Erskine & Harmon, 2021). Of those who indicated that they do not live with a parent or guardian, 39% of UGs and 23% of PGs reported living in student accommodation. Overall, full-time UGs are likely to live with their parents or in student accommodation, whereas part-time students are more likely to live with partners in private accommodation. There is no significant relationship between gender, type of HEI attended, disability, and the type of accommodation they are living in (Erskine & Harmon, 2021). The survey indicates that 11% of the total student population in HE have children, being disproportionately weighted to PG students, of whom 27% are parents (Erskine & Harmon, 2021). Approximately 25% of all students surveyed in Eurostudent VII indicated that they have a disability, with mental health being the most common (Erskine & Harmon, 2021).

The HEA administers an annual Equal Access Survey to gather data on the social, economic, and ethnic background of students entering HE for the first time (HEA, 2018). In 2017/18, 14.4% of respondents reported that they had a disability. In terms of ethnicity 84.9% of respondents identified as Irish, with 7.5% identifying as any other white background, 2.4% being African or any other black background, and 3.2% being of an Asian background. In 2017/18, mature students made up 8% of new full-time entrants, and 83% of part-time new entrants (HEA, 2018). This compares to Eurostudent VII which reports that mature students represented 11% of full-time UG students, and 68% of part-time UG students, and 15% of the overall undergraduate student population (Erskine & Harmon, 2021).

Within the HEI selected for this research study, 13,087 students were registered on UG programmes in the academic year 2017/18 (Senior Lecturer's Report, 2018) of which 1,539 were International (Non-EU) students, and 24.2% of the UG cohort entered via alternative admission routes based upon disability, socio-economic criteria or being a mature student. At PG level, there were 3,215 full time and 1,613 part-time students (HEA, 2018). 58% of UG students were female with 42% being male, and at PG level, 60% of students are female with 40% being male.

2.3.3 The Student Role in Higher Education

Going to college is typically viewed as an exciting life event, full of opportunities for new experiences and learning and HE is a time of many transitions, opportunities, and challenges for students (Fox, Byrne and Surdey, 2020). The college years are central to the development of identity and to successful transition to adulthood as well as to overall wellbeing (Astin, 2004; Fox, Byrne & Surdey, 2020; Schwartz, 2016; S; Sussman and Arnett, 2014). The student role demands increasing levels of self-awareness, self-advocacy, and self-management. From the perspective of the HEI, students are considered to be adults and perhaps move into more independent living away from their family and other support structures. The ability of students to manage themselves in the student role, and the challenges that this can entail, have significant implications for both well-being and academic success (Canadian Association of College and University Student Services and Canadian Mental Health Association, 2013; Eisenberg, Lipson and Posselt, 2016). However, many students who are at this developmental stage in life have not yet established a stable life structure and third level education can bring stressors such as living away from family and friends for the first time, coming from a structured to a self-directed learning setting, taking on additional work commitments to support themselves, relationships, financial pressure, responsibility for personal health, course selection, academic demands, and career choices (Auerbach et al., 2018; Bulo and Sanchez, 2014; Cleary, Walter, & Jackson, 2011; Deatherage, Servaty-Seib, Aksoz, 2014; Holdaway et al., 2018; McLafferty et al., 2017). This may contribute to reduced social support

and increased stress, which are known contributors to mental health difficulty (Liu, Stevens, Wong et al., 2018; Slavich & Auerbach, 2018).

The positive relationship between higher levels of educational attainment and health outcomes in the general population is well-established (Cutler, & Lleras-Muney, 2010; Feinstein et al., 2006; Goldman & Smith, 2011; Spittel, Riley & Kaplan, 2015). Education has been shown to have more significant effects on health outcomes than income (Cutler, & Lleras-Muney, 2010; Feinstein et al., 2006). Additionally, higher educational attainment is linked to employment in Ireland; individuals aged 25-64 years old with a third level qualification are more than twice as likely to be employed than those with no formal education/primary education (Central Statistics Office, 2019). A strong body of research has established links between engagement in the student role and positive outcomes such as academic progression (Kuh et al., 2008), practical competence and skills transferability (Kuh, 1993; 1995), and student satisfaction (Kuh and Vesper 1997; Kuh et al., 2005; Kuh et al., 2007). The extent to which students are engaging in activities in HE has been shown to be linked with high-quality learning outcomes (Krause and Coates, 2008; Kuh, 2001). Given the importance of academic achievement and engagement in the student role, there has been increasing focus internationally upon how students engage in student life and how they perceive the institution fosters engagement and achievement.

In the Irish context, the Irish Survey of Student Engagement (ISSE) is carried out nationally every two years by the HEA in collaboration with HEIs and the Union of Students in Ireland. The survey firstly explores the time and effort that students put into academic learning and other educationally beneficial activities, and secondly, how HEIs encourage students to participate in meaningful activities that are linked to learning. The ISSE 2020 report collated responses from 44,707 students in 26 HEIs across Ireland, including first year UG, final year UG and taught PG students, representing a response rate of 31%. Findings highlighted that four out of five students rated their experience in college as good or excellent and that their experience contributed to their knowledge, skills, and personal development (HEA., 2020). However, only

approximately half of the students surveyed rated their institution as a supportive environment.

Irish students in HE express similar concerns to those noted in the international literature (Dooley et al., 2019; Erskine & Harmon, 2021), with academic demands, finances, concern about the future, relationships with friends or family, balancing work and studies, and issues related to work being reported as primary stressors within student life. In the Eurostudent VII survey (Erskine & Harmon, 2021), 74% of students reported experiencing at least one difficulty in their student role, with issues related to meeting the academic standards required in their programme of study most frequently reported. This is consistent with the MyWorld 2 survey (Dooley et al., 2019), where 68% of Irish students reported college as a stressor. In the Eurostudent VII survey, 29% of students reported experiencing serious financial problems, with accommodation being the largest single expenditure for students, accounting for almost 47% of their income (Erskine & Harmon, 2021). Similarly, the MyWorld 2 Survey (Dooley et al., 2019), found that 37% of young adults reported high levels of stress connected to their current financial situation. Family was a major source of financial support for students, with 53% of students receiving financial support from their family or a partner, while 35% of students (43% of UG students; 20% of PG) received financial support through SUSI (Student Universal Support Ireland) a public grant agency (Erskine & Harmon, 2021).

College can often be the first time where students are trying to balance multiple life demands; academically, socially, and professionally, both within and outside of college. Students are still forming their self-identity (Arnett, 2014), and exploring new experiences while also taking on increased responsibilities. Eurostudent VII reported the average weekly time spent in study related activities for full-time students in Ireland as 37 hours, broken down into 20 hours spent in taught studies and 17 hours spent on personal study time (Erskine & Harmon, 2021). This greatly varied across courses, with students in Arts courses engaging in less hours of taught studies and personal studies, and students in Health and Welfare courses engaging in significantly

more hours in both (Erskine & Harmon, 2021). Paid employment is an important aspect for students, with 54% of Irish students working to some level during term-time (Erskine & Harmon, 2021). Approximately one third of full-time students and nine out of ten part-time students were in paid employment throughout term-time or occasionally, with the majority (69%) working outside of term-time (Erskine & Harmon, 2021). College is a time when students can struggle to balance multiple life roles and the demands associated with these.

A study examining work-life balance as a predictor of anxiety and depression amongst college students found a negative correlation between work-life balance and perceived stress, anxiety, and depression (Sprung & Rogers, 2020). The study sample was recruited from one institution and was composed mostly of female students in the later years of their courses. However, the findings are consistent with other studies demonstrating a link between anxiety and depression amongst adults in the workplace (Haar et al., 2014), and the negative impact of tension between work and academics on the psychological wellbeing of college students (Laughman, Boyd & Rusbasan, 2016; Park & Sprung, 2013). Further research has shown that the amount of time spent in employment whilst attending HE impacts negatively on time spent in personal study and academic achievement (Erskine & Harmon, 2021; Keute, 2017; Pike et al., 2008; Tessema et al., 2014). Issues related to work were identified as a significant stressor for 15% of students in Ireland (Dooley et al., 2019), and 18% of students in the Eurostudent VII reported issues with college engagement due to the demands of paid work.

Eurostudent VII also examined the experiences of students with disabilities (defined as a health problem that has lasted or is likely to last for at least six months) (Erskine & Harmon, 2021), with 25% of students indicating a disability. Of these, 6% reported that their disability severely limited their ability to engage in everyday activities and 56% reported a moderate limitation. Furthermore, 8% stated that their disability severely limited their ability to engage in study, with 59% reporting that it moderately limited this ability. More students with a disability reported experiencing at least one

difficulty in their student role compared to students without a disability. The most pronounced differences were difficulties due to personal reasons, finances, and health issues / impairments (Erskine & Harmon, 2021). The report further examined their satisfaction with support services provided by the HEIs and high levels of dissatisfaction were reported by students with disabilities.

2.3.4 Student Progression and Retention in Higher Education

HEIs have long focused upon supporting students to increase levels of retention and graduation (Eisenberg, Lipson, and Posselt, 2016). Ireland has relatively high retention rates when compared internationally (HEA, 2019; OECD, 2016), although different data collection methods are used to reflect student journeys through college, the retention and progression statistics, and overall course completion rates. International research has shown that withdrawal is most likely to occur in the first year of study (Blaney and Mulkeen, 2008; Yorke and Longden, 2008). Hence, many HEIs focus on the retention and progression of new entrants to UG study.

Within the HEI selected for this research study, progression and retention data for new UG entrants is tracked annually in the Senior Lecturer's Report (Mitchell, 2020). In this analysis, retention is defined as students who progressed, or repeated year one, or transferred to another course within the institution. Progression from 1st year to 2nd year excluded students who repeated years and transferred course. The institution's strategic plan (2014-2019) set out a target of improving the retention rate from first to second year from the 84% in the academic year 2011 / 2012 to 90% in 2019. These retention and progression rates are outlined in table 2.2 below.

Table 2. 2: Retention and Progression rate from first to second year within the research context for the academic years 2012/13 to 2018/19

Academic Year	Retention Rate	Progression Rate
2012/13	91.5%	N/A
2013/14	95%	93.4%
2014/15	95%	94%
2015/16	95%	94%
2016/17	96%	91%
2017/18	96%	88%
2018/19	96%	91.5%

The most recent report for the academic year 2018-19 included retention data across all years of courses, which showed a trend of decreasing withdrawals at UG level throughout the years from first year to final year (Mitchell, 2020).

Internationally, students with disabilities are viewed as one of the groups most vulnerable to withdrawal (Jones, 2008; Newman et al., 2010; Wessel et al., 2009). A report on the completion rate of Irish students who entered HE in 2007/2008 (HEA, 2019), gave a completion rate of 76% for all students in HE, with this rising to 83% for Universities, and a completion rate of 85% within the HEI context for this study. While there is often more than one reason that accounts for non-completion (Georg, 2009), factors most cited in the literature include course choice, academic difficulties, social difficulties, personal problems, academic attainment prior to college, and financial pressures (HEA, 2019; Redmond et al., 2011; van Stolk et al., 2007). Data from the Disability Service (DS), where this research was carried out indicates that the percentage of students registered with the DS who completed their course over a nine-year period from 2005 to 2013, ranged from 78% to 86% with an average at 82.5% (Reilly, 2019). Three disability groups showed considerably lower rates of completion: students with Autism at 76%; those

who are Deaf or hearing impaired at 74%; and students with a mental health condition at 72% (Reilly, 2019).

2.4 The Mental Health of Students in Higher Education

The mental health of students in HE is increasingly recognised as an important public health issue within Ireland and internationally. In the report 'In it Together – Taking Action on Student Mental Health' (2017), a coalition of student groups, colleges, and universities in Ontario, Canada, maintained that: *'post-secondary students must be recognized as a distinct population cohort, separate from children and youth and adults, with unique mental health service and support needs'* (p. 2). HEIs are struggling with rising numbers of students reporting mental health issues with the demand for student supports greatly exceeding resources available (Auerbach et al, 2018; CACUSS, 2013; Fox, Byrne & Surdey, 2020; Hill et al., 2020; Pereira, 2019; Thorley, 2017). This is reflected in the international literature based upon whole student populations or specific cohorts of students (e.g. year of course, course of study), reports based upon self-report measures or surveys, or through data on students who formally disclose a mental health condition to their institution with a clinical diagnosis from a medical practitioner. However, there is lack of clarity in the differentiation between mental health and ill-health (Barkham et al., 2019).

Fox, Byrne & Surdey (2020) suggest that mental health is best viewed along a continuum that includes positive emotional wellbeing which is not static and fluctuates throughout our lives. This is consistent with the most recent mental health policy in Ireland, which proposes that mental health is more than the presence or absence of a mental health condition (Department of Health, 2020). The World Health Organisation (WHO) defines mental health as a: '… *state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community*' (WHO 2001a, p.1). A recent scoping review by Fusar-Poli et al. (2020) is consistent with the WHO definition, proposing that good mental health involves the skills and resilience to cope with the stressors of life, which allows individuals to function productively. They identify

fourteen core domains that define good mental health as follows: (i) mental health literacy, (ii) attitude towards mental disorders,(iii) self-perceptions and values,(iv) cognitive skills, (v) academic/occupational performance, (vi) emotions, (vii) behaviours,(viii) self-management strategies, (ix) social skills, (x) family and significant relationships (xi) physical health, (xii) sexual health, (xiii) meaning of life, (xiv) and quality of life. A differentiation is made in terminology used within this research study, with mental health condition referring to those with a diagnosed DSM-V disorder, and mental health difficulty referring to a broad range of mental health issues which may include those with a diagnosed mental health condition.

2.4.1 Prevalence of Mental Health Difficulties in the Student Population in Higher Education

There has been a significant increase over the past five years in the number of studies and reports providing prevalence estimates of mental health difficulty in the student population. However, there is a large variance in the design and quality of these sources, terminology used, and varying response rates, which calls into question whether they are representative of the overall student population (Barkham et al., 2019). The World Mental Health International College Student Initiative [WMH-ICS] is one of the first systematic attempts to conduct epidemiological research with college students (Cuijpers et al., 2019), based upon a sample of 13,984 students from Australia, Belgium, Germany, Mexico, Northern Ireland, South Africa, Spain and the United States of America, with a weighted mean response rate of 45.5%. Findings from the WMH-ICS between 2013 and 2020 have contributed significantly to understanding mental health difficulty in the student population, and table 2.3 (Appendix 17) provides an overview of these international prevalence studies and systematic reviews.

Clearly, there are a wide variety of prevalence estimates, which can be attributed to differences in definitions of mental health difficulty or mental health issues, choice of self-report screening tools, clinical diagnosis, study designs, study populations, and the focus of studies. Despite this variability, it

is estimated that approximately one in three college students will experience a mental health difficulty (Auerbach et al., 2018; Bruffaerts et al., 2018; Ibrahim, Kelly, Adams & Glazebrook, 2013; Jenkins et al., 2020; Pedrelli, Nyer, Young et al., 2015). Several studies compared the prevalence of mental health difficulty between students in HE and participants who were not students, some finding little or no difference (Auerbach et al., 2018; Blanco et al., 2008). Others reported varied findings of increased prevalence amongst college students compared to age matched peers (Cvetkovski, Reavley & Jorm, 2012; Dyrbye, Thomas & Shanafelt, 2006; Leahy et al., 2010; Stallman et al., 2010; Winzer et al., 2014), while other studies reported findings of higher levels of prevalence in participants who were not students (Kovess-Masfety et al., 2016). Furthermore, much of the literature focused on the prevalence of specific diagnoses such as depression (Ibrahim & Kelly, 2013), symptoms of anxiety or depression (Jenkins et al., 2020; Kovess-Masfety et al., 2016; Mahmoud, Staten, Hall, & Lennie, 2012), or other diagnoses (Eisenberg et al., 2011; Sulkowski, Mariaskin & Storch, 2011). Others focused on a set of specific diagnoses based upon findings from previous studies (Auerbach et al., 2018) or the specific measures used (Auerbach et al., 2016; Bruffaerts, Mortier, Kiekens G. et al., 2018), or on non-diagnostic areas such as stress, mental distress or suicidal ideation (Akram et al., 2020; Kovess-Masfety et al., 2016; Mahmoud et al.,2012).

In terms of estimates of individual diagnoses, data derived from large scale health surveys such as the American College Health Association-National College Health Assessment (ACHA-NCHA) survey or access / disability data, provide the broadest source of estimates. Anxiety and depression are the most prevalent diagnoses amongst college students (ACHA, Canadian Reference group, 2019; ACHA, US Reference group, 2019; Auerbach et al, 2018; Blanco et al., 2008; Advance HE, 2018; KPMG, 2015; Liu et al., 2018; Pedrelli et al., 2015), with a high incidence of suicidal thoughts and behaviours also noted (Akram et al.,2020; Kovess-Masfety et al., 2016; Mortier et al., 2016; Mortier et al., 2018).

Suicide is the second leading cause of death worldwide for individuals aged 15–29 years (WHO, 2016). The link between mental illness and increased risk of suicidal thoughts and behaviours has been well-established (Franklin et al., 2017; O' Connor and Nock, 2014), although suicidal ideation may occur in the absence of a mental health condition (Chiles and Strosahl, 2005). The high prevalence of suicidal ideation and the risk of suicide amongst the student population in HE has been examined in numerous studies (Akram et al., 2020; Dooley et al., 2019; Lageborn et al., 2017; Mortier et al., 2017; Mortier et al., 2018; O'Neill et al., 2018). A meta-analysis by Mortier et al., (2017) representing a total of 634,662 students in HE, reported lifetime and 12-month estimates for suicidal ideation, plans, and attempts. Lifetime estimates for suicidal ideation were 22.3%, plans 6.1%, and attempts 3.2%; 12-month estimates were 10.6%, 3% and 1.6% respectively, and pooled estimates were generally higher for females, as compared with males (Mortiers et al., 2017). A further cross-sectional examination of first year UG students across 19 HEIs in eight countries by Mortier et al. (2018) reported higher lifetime prevalence estimates of suicidal ideation, plans, and attempts of 32.7%, 17.5%, and 4.3%, respectively, using a modified version of the Columbia Suicidal Severity Rating Scale (Posner et al., 2011). It also noted higher 12-month prevalence of 17.2%, 8.8%, and 1.0%, respectively. A Swedish study investigating the risk of suicide based upon national registers showed a two-fold increase in risk during HE attendance compared to post-graduation (Lageborn et al., 2017). A cross-sectional study by Akram et al. (2020), examined the prevalence of suicidal ideation among students from six universities in the UK (population n=1273) and assessed the association with psychiatric risk factors, indicating that 37.3% students were classified as high-risk for suicidal behaviour using the Suicidal Behaviours Questionnaire-Revised (SBQ-R; Osman et al., 2001). Moreover, 42.2% of students contemplated suicide at least once within the previous twelve months. Logistic regression analysis showed that suicidal ideation was significantly associated with symptoms of depression, mania, psychosis, and stress.

The transition to college can be difficult for many students, especially if they have a previously diagnosed mental health condition (Conley et al., 2014), and is a period when students are most likely to withdraw from college (Blaney and Mulkeen, 2008). As a result, there is a strong focus in the literature upon students in their first-year of college (Auerbach et al., 2018; Bruffaerts R, Mortier P, Kiekens G. et al., 2018; Mortier et al., 2018). Findings from these studies are in line with the overall prevalence estimates outlined above, but are also of particular interest given that the onset of most mental health conditions among these college students was prior to college entry, with high rates of persistence throughout the student journey (Auerbach et al., 2016.; Bewick, 2010; Cvetkovski, Jorm, & Mackinnon, 2019; Zivin et al., 2009). There are fewer studies available for postgraduate students (Eleftheriades et al., 2020; Levecque et al., 2017), who are found to be at greater risk of anxiety and depression than the general population (Barreira, Basilico, & Bolotnyy, 2018; Evans, Bira, & Gastelum, 2018; Levecque et al., 2017). A brief review by Tsai and Muindi (2016) which included seven studies on PG mental health, found reported prevalence rates for emotional problems, including depression, within a range of 43% to 44.7%. Within this cohort, PhD students were found to express higher rates of depression and anxiety than other PG students (Evans, Bira, & Gastelum, 2018; Levecque et al., 2017; Panger G, Tryon J, Smith A, 2014). However, data from the ACHA-NCHA (2018), indicates that graduate students report lower levels of prevalence for clinically diagnosed depression and anxiety than undergraduate students. A study by Wyatt and Oswalt (2013) reported lower levels of feelings and behaviours related to poor mental health and negative impacts on academic performance in PG students compared to UG students .

It has been suggested that medical students and other health professional programmes have higher rates of mental health distress. A systematic review of studies published between January 1980 and May 2005 reporting on depression, anxiety, and burnout amongst U.S. and Canadian medical students, reported a high prevalence of depression and anxiety with high levels of overall psychological distress (Dyrbye et al., 2006). A recent cross-

sectional study amongst medical students and other health related courses in Saudi Arabia, showed an overall prevalence rate of 47% depression (Alfaris et al., 2016). More recent global studies, however, have not supported these findings; for example, a meta-analysis by Puthran et al. (2016) found a global prevalence of 28% of medical students who could be classified as clinically depressed. Additionally, findings suggest little or no difference in prevalence between medical students and non-medical students from other faculties (Puthran et al., 2016). In their systematic review and meta-analysis, Rotenstein et al. (2016) report a prevalence of depression and anxiety amongst medical students of 27.2% with the overall prevalence of suicidal ideation as 11.1%. A lower prevalence of depression in medical students compared to non-medical students was reported by Ibrahim, Kelly, Adams, & Glazebrook (2013).

Female students, minority groups, and students with financial problems constitute groups with higher risks of mental health difficulty (Cvetkovski, Reavley & Jorm, 2012; Eisenberg et al., 2007; Eisenberg, Hunt & Speer, 2013; Ibrahim, Kelly and Glazebrook, 2013; Said, Kypri & Bowman, 2012). Female students are more likely to screen positively for depression and anxiety whereas male students are at higher risk of suicide (Hunt and Eisenberg, 2010). Additionally, a high prevalence of mental health difficulty is found in those who identify as bisexual or homosexual (Eisenberg et al., 2007; Higgins et al., 2016; Liu et al., 2018).

2.4.1.1. Prevalence studies of Mental Health Difficulty in Ireland

As outlined in Table 2.4 below, there are few high-quality research studies exploring the prevalence rates of mental health amongst students in HE in Ireland. Students from Ulster University in Northern Ireland were included in the World Mental Health International College Student Project [WMH-ICS] (McLafferty et al., 2017; O'Neill et al., 2018;), and although it must be noted that the HE system in Northern Ireland is separate to that of the Republic of Ireland, the data still provides a useful comparison. Findings show higher lifetime and 12-month prevalence rates for mental health issues and suicidal ideation than international studies, with an overall prevalence rate of 53.2%

and 56.6% respectively (McLafferty et al., 2017). Overall prevalence rates in the WMH-ICS study are higher than those reported for the Northern Ireland student cohort (39.1% against 36.9%) as they included ADHD and Suicidality in the 'Any Disorder' category (Auerbach et al., 2018).

A cross-sectional study of 220 first year undergraduate students in one HEI, found that 59% experienced depressive symptoms that may require treatment and 28.5% of students experienced suicidal ideation (Horgan et al., 2018), although the response rate of 10% and a largely female sample were limitations within this study. A cross-sectional study of 3rd Year undergraduate students of Business and Economics and 5th year Medicine students (n=317) indicates 13.9% students with depression and 5.9% with suicidal ideation (Curran et al., 2009). Data from two large scale surveys examining the mental health of adolescents and young adults in Ireland (Dooley & Fitzgerald, 2012; Dooley et al., 2019), and from a recent survey conducted by the Union of Students of Ireland (Price & Smith, 2019), perhaps provide the broadest prevalence estimates of mental health difficulty in Ireland. Using the Depression Anxiety Stress Scales (DASS-21) (Henry & Crawford, 2005), the MyWorld 1 Survey of 8000 students reported 14% of students as being in the severe or very severe range for depression and anxiety (Dooley & Fitzgerald, 2012), and 7% of respondents reported that they had made an attempt to take their own life. The subsequent MyWorld2 Survey (Dooley et al., 2019), reported higher rates on the DASS-21, with 23% of students in the severe or very severe range for depression and 28% for anxiety, with 63% having ever thought about suicide, 35% having thought about it within the previous year, and 14% in the previous six months (Dooley, O'Connor, Fitzgerald et al., 2019). Furthermore, 10% of students reported a suicide attempt at some point in their lives, with 2.3% in the past year, and 1% within the past three months. In line with the findings of Mortiers et al. (2017), more female students reported a suicide attempt (11%), than male students (8%). These studies focused upon young adults from between 17-25 years of age, and so would have excluded many PG students. The USI National Report on Student Mental Health in Third Level Education (Price,

Smith & Kavalidou, 2019) included findings from 3,340 UG and PG students from HEIs in Ireland and Northern Ireland, with a very low response rate of 0.89% of the total number of students in these HEIs. Findings indicate that 32.2% of students received a formal mental health diagnosis at some point in their lives, with depression and anxiety by far the most prevalent. The DASS-21 was also used and reported much higher levels of anxiety and depression than the MyWorld surveys, with 49.3% of students in the severe or very severe range for anxiety and 43.1% for depression. In comparing these findings to other studies, the low response rate and self-report of a mental health diagnosis rather than the use of a clinical assessment tool, are significant limitations.

It is difficult to establish a reliable estimate for students with mental health difficulties in HE in the Republic of Ireland due to the low number of studies, low response rates, small sample sizes, and variability of measures used. Table 2.4 presents an overview of studies with prevalence estimates of mental health difficulty in Ireland.

Table 2. 4: Prevalence studies of Mental Health Issues in Ireland

Author and Year	Focus	Type of Study	Student Population	Prevalence / Findings
O'Neill et al. (2018)	To examine mental health disorders and childhood adversities as predictors of self-harm and suicidal behaviours	WMH-ICS surveys using questions adapted from the WMH Composite International Diagnostic Interview (CIDI)	First year undergraduates registered at Ulster University in Northern Ireland in the year 2015–2016 (N = 739)	Thirty-one percent endorsed suicidal ideation with almost 1 in 5 students having made a plan for suicide in the 12 months prior to the survey
McLafferty et al. (2017)	To provide baseline prevalence rates of mental issues, health ADHD and suicidal behaviour among first year undergraduate students in a University in Northern Ireland,	WMH-ICS surveys using questions adapted from the WMH Composite International Diagnostic Interview (CIDI)	First year undergraduates registered at Ulster University in Northern Ireland in the year 2015–2016 (N = 739)	Lifetime Prevalence rates were found for major depressive episode (24.2%) and generalised anxiety disorder (22.6%). Overall prevalence rate for experiencing any lifetime disorders was 53.2% 12-month prevalence rates were found for major depressive episode (27.7%) and generalised anxiety disorder (26%). Overall prevalence rate for 12 -month was 56.6%
MyWorld2 Survey (Dooley et al., 2019)	The study aims to gain new insight into, and increase our understanding of, young people's mental health and wellbeing from a risk and protective perspective.	Paper / Web-based Self-report survey with four sections: 1. Demographic characteristics 2. Personal wellbeing and lifestyle factors 3. Negative domains 4. Positive domains. Standardised measures used to assess negative and positive domains of mental health.	Young adults from 18-25, the majority of whom were in higher education (n=8,168 students)	20% of respondents were classified as in the moderate range for depression & 10% in the severe range and a further 13% on the very severe range on the Depression Anxiety Stress Scales (DASS-21) (Henry, Crawford (2005) 21% of respondents were categorised moderate range for anxiety, 9% on the severe range and 19% on the very severe range on the Depression Anxiety Stress Scales (DASS-21) (Henry, Crawford (2005)

				38% reporting deliberate self-harm without wanting to take their own life, with 12% of respondents reporting that they had deliberately hurt themselves, wanting to take their own life; and 10% reported that they had made an attempt to take their own life.
Price, Smith & Kavalidou, (2019)	To provide an overview of students' mental health in third level education in Ireland.	Self-report Web-based survey which survey included two validated scales: The Depression, Anxiety and Stress Scale (DASS-21) and the General Help Seeking Questionnaire (GHSQ).	Sent to 374,000 students in HEIs in Ireland and Northern Ireland. 0.89% response rate (n=3340)	Students reported extremely severe levels of anxiety (38.4%), depression (29.9%) and stress (17.3%) 32.2% report a formal diagnosis of a mental health difficulty at some point in their lives
Horgan et al. (2018)	To examine the prevalence of depressive symptoms and suicidal ideation among first year undergraduate university students in Ireland	Cross-sectional Centre for Epidemiology Studies Depression Scale (CES-D) (Radloff, 1977) and the Suicidal Behaviours Questionnaire-Revised (SBQ-R) (Osman et al., 2001).	1st year full-time students (n=220) at an Irish HEI	59% experienced depressive symptoms that may require treatment. 28.5% of students experienced suicidal ideation.
My World Survey (Dooley & Fitzgerald, 2012)	First national study of youth mental health in Ireland from age 12-25 years.	Self-report survey - MWS-SL contained a number of scales previously shown to have reliability and validity, organised into positive and negative aspects of psychological functioning	Young adults from 18-25, the majority of whom were in higher education (n=8000)	14% of respondents were classified as in the moderate range for depression 6% in the severe range and a further 8% on the very severe range on the Depression Anxiety Stress Scales (DASS-21) (Henry, Crawford (2005)

				15% of respondents were categorised moderate range for anxiety, 5% on the severe range and 9% on the very severe range on the Depression Anxiety Stress Scales (DASS-21) (Henry, Crawford (2005) 21% reporting deliberate self-harm without wanting to take their own life and 7% reported that they had made an attempt to take their own life.
Curran, Gawley, Gill & Crumlish (2009)	To determine the prevalence and correlates of depression, alcohol abuse and suicidal ideation among medical and business students in two Irish Universities	Beck Depression Inventory (BDI) and alcohol abuse with the CAGE Alcohol Abuse Screening Tool	3rd Year UG Business and Economics and 5th year medical students (n=317 students)	13.9% students depressed 5.9% Suicidal ideation 24.6% alcohol abuse

It is clear from both international and national research that there is a wide disparity in prevalence estimates of mental health difficulty due largely to the variability of study designs, measures used, and diagnoses included. The overall prevalence estimate of approximately one in three students is widely accepted, with no significant differences by course, or year of course (Auerbach et al., 2018). Several studies find no significant difference for prevalence rates between college students and non-college students within the 18-24 years age range (Auerbach et al., 2018; Blanco, 2008). The high rate of reported mental health difficulty prior to college entry and persistence into college, is particularly noteworthy in terms of focusing supports on the transition to college (Auerbach et al., 2016). The need for high quality studies of prevalence of mental health difficulty within Ireland is clearly demonstrated. However, the trend of increasing numbers of students reporting high levels of mental distress and diagnosed mental health conditions is suggested by the limited studies conducted in Ireland. These trends are supported by data from Disability Services nationally (AHEAD, 2018) and Counselling Service utilisation statistics (Psychological Counsellors in Higher Education Ireland, 2021).

2.4.2 Experience of Students in Higher Education with a Mental Health Condition

Much of the literature on student mental health has focused upon the prevalence of various mental health conditions as outlined in the previous section, and the impact on student participation in the student role, academic attainment and progression, quality of life, and reported psychological symptoms and suicidality (Alonso et al., 2018; Arria, Caldeira, & Vincent, 2013; Auerbach et al., 2018; Bruffaerts et al., 2018; Dooley et al., 2019; Eisenberg et al., 2009; Horgan et al., 2018; Jenkins et al.,2020; Kessler et al., 1998; Mojtabai et al., 2015; Mortier et al., 2018; Storrie et al., 2010; Wilks et al., 2020). However, there has been criticism of this focus upon challenges being situated within individuals alone (Tomlinson, 2013), and that a greater

understanding of the personal, social and contextual influences on these experiences is required to meet the needs of these students (Ennals, Fossey and Howie, 2015; Hartrey, Denieffe & Wells, 2017; Pedrelli et al., 2015; Storrie, Ahern & Tuckett, 2010).

A meta-synthesis of the qualitative literature on the experiences of students in HE with a mental health condition (Ennals, Fossey and Howie (2015), synthesises the available qualitative research with the aim of generating insights applicable to policy and practice in postsecondary education. It included a review of sixteen studies from five countries (US, UK, Canada, Australia, and South Korea), with an overall total of n=231 participants, with study sample sizes varying from 3 to 54 students. The authors identified three interconnected processes that shape the student experience: i) knowing oneself and managing one's mental illness; ii) negotiating the social space; and iii) completing academic work required for successful postsecondary participation. Knowing oneself and one's mental health means believing in and testing one's capability through engagement in the student role and developing strategies to meet demands within the student role. While some students develop an understanding of their mental health and ability to manage it, others experience it for the first time during their studies. The second process concerns student efforts to connect to others and to belong, but as part of this experience of the social space, decisions around disclosure were important aspects. Student social spaces include support services and resources, both formal and informal, that contribute to student participation in the student role. The third process highlighted by Ennals, Fossey and Howie (2015) is the importance that students place upon engaging in the academic aspects of the student role, from which they derive a strong sense of meaning, while also recognising the pressures and strains that come with this role.

Two systematic reviews have examined the personal, social, and contextual influences upon students experiencing a mental health difficulty (Hartrey, Denieffe & Wells, 2017; Storrie, Ahern & Tuckett, 2010). Storrie, Ahern & Tuckett (2010) examined the emotional and mental health problems of

university students in eleven studies (n=18,600 participants), ten of which were cross sectional and one longitudinal. Nine of the studies were conducted with students, one with staff, and one involved a retrospective review of student records. The review included studies from three countries (US, UK and Australia), with the majority involving low sample sizes or being conducted in single institutions; student populations varied greatly from students with a formal diagnosis of a mental health condition, to self-report measures of stress or distress. Methodological quality of the studies was assessed using the Joanna Briggs Institute data extraction tools. Four identified trends of increasing prevalence of mental health issues among students in the context of less availability of supports, while six identified student issues such as poor grades, academic progression, social isolation, decreased emotional and behavioural skills, and withdrawal from college. Seven articles referred to barriers to seeking help, identifying perceived stigma and lack of understanding around having a mental health difficulty, and the ability of students to recognise a mental health difficulty and gain knowledge of supports and resources that could help.

A more recent systematic review by Hartrey, Denieffe & Wells (2017) focused upon barriers to, and enablers of, the participation of students with diagnosed mental health conditions in HE, from the perspectives of students and staff. Nineteen studies were included in the review across four countries (US, Canada, Australia, and the UK), with a range of sample populations (n=10 students, n=4 academic staff; n=1 Disability Service staff; n=4 students and staff). Methodological quality was appraised using the Mixed Methods Appraisal Tool (MMAT), with one appraised as very high quality, seven as high quality, twelve as moderate, and an additional three studies appraised as low or very low quality were excluded from the review. Two themes were identified in the findings in relation to barriers and supports: i) factors internal to the person such as symptoms of mental health illness, fear of disclosure, and knowledge of mental health, and ii) factors external to the person such as support services available, and knowledge, beliefs and attitudes of the college community. The review focused on students with a diagnosed mental health

condition, but there was a large variety in educational settings and service provision; for example, four of the studies were conducted with students pursuing supported education (SEd) programmes rather than a degree course.

Within these studies, overall themes emerge that focus upon the interaction between the person, their environment, and occupation, which involves an emerging understanding of: a) self and one's mental health, b) the influences within the college context that enable a student to participate, c) the ability to engage with social aspects of college involving connection to others including support services, and d) engagement in the student role. These factors are further explored in the following section.

2.4.2.1 Understanding Self and Mental Health

A consistent theme in the literature is that of an emerging understanding of self among students and their mental health throughout the student journey. Sussman and Arnett (2014) differentiate emerging adulthood from adolescence and adulthood, across five dimensions; i) identity exploration, ii) feeling-in-between, iii) entertaining possibilities, iv) self-focus, and v) instability. While these dimensions are applicable to all students, it has significant implications for those students with a pre-existing mental health condition, especially during a period when there is a high likelihood of disengaging from treatment (Auerbach et al., 2016; Auerbach et al., 2018). Students may be moving away from home for the first time and can experience disruption to personal and professional support networks, resulting in a potentially negative impact on student well-being (Conley et al., 2014; HEFCE, 2015; Stroud, Maniero, & Olsen, 2013). There is an increased expectation of personal autonomy and responsibility, and for students to develop the ability to manage themselves, their studies, and their mental and physical health. This development involves an increased understanding of self and personal mental health. However, several studies have shown that many students do not recognise some of these experiences as a mental health difficulty (Collins and Mowbray, 2005; Karwig, Chambers and Murphy, 2015) and so are often unable to connect mental health difficulty with academic problems, thereby not perceiving themselves as unwell (Quinn et al., 2009).

2.4.2.2 Social Environment of College

A second theme within the literature involves student negotiation of the social environment of college, involving connection to others including formal and informal supports, disclosure of personal information and personal knowledge, beliefs, and attitudes within the college community. Feeling a sense of belonging to something within their college life and connection to others has been shown to be a key element for the wellbeing of students (Dougherty, 1996; Ekelman Bazyk, & Bazyk, 2013; Laidlaw et al., 2015; Leach, 2014, Megivern, Pellerito, and Mowbray, 2003; Royal College of Psychiatrists, 2011). Students gain support from others, including family and friends, which has been shown to reduce feelings of depression (Wright et al., 2013) and loneliness (Bernardon et al., 2011). For students who have moved away from home to study, social support from peers may be more important than from family members (Bernardon et al., 2011). Tinto's (1975) theory of retention emphasises the importance of academic and social integration into institutional communities (Eisenberg, Lipson and Posselt, 2016). The Irish Survey of Student Engagement (HEA et al., 2019) showed more students reporting a high quality of interactions with other students (57.3%) than with academic staff (40.9%), support services (34.7%), or administrative staff (34.5%).

Students make decisions about what personal information to share with both peers, academic and administrative staff as well as support services. O'Shea and Meyer (2016) found that amongst students with invisible disabilities including a mental health condition, the decision to utilise supports was framed by their own understanding and acceptance of their disability. Getting access to supports and accommodations may require students to disclose a clinical diagnosis, and the importance of having appropriately trained staff within disability services on campus to support disclosure, has been identified as crucial (Collins & Mowbray, 2005; Murphy, 2017; Venville, Street, and Fossey, 2014). Developing student knowledge of self and available supports should they become unwell, is key (Hartrey, Denieffe, and Wells, 2017) as students often do not recognise the signs of being unwell or know how to

access help (Becker et al., 2002; Collins and Mowbray, 2005; Furnham et al., 2011; Hunt and Eisenberg, 2010; Merritt et al., 2007 Quinn et al., 2009; Reavley et al., 2012; Wei et al., 2013).

Stigma is often associated with disclosure of a mental health condition and has been identified as a critical barrier to seeking support (Murphy, 2017; Venville, Street, and Fossey 2014). However, a systematic review by Clement et al. (2015) which examined the relationship between stigma and mental health help-seeking, found that perceived stigma in others was only the fourth highest barrier to help-seeking, with disclosure concerns and confidentiality the highest ranked barriers to seeking help. Of note, only two studies in this review were conducted in a university setting, with the remainder conducted within the general or clinical populations. Exploring barriers and facilitators to mental health help-seeking in young people aged between 12 and 25 years, Gulliver, Griffiths & Christensen (2010) note perceived stigma and embarrassment, problems recognising symptoms, and a preference for self-reliance as the most significant barriers. Several other studies exploring help-seeking behaviours among student populations have identified key barriers as wanting to handle the problem independently, believing that treatment was not needed, not having time, or a preference for self-management (Czyz et al., 2013; Eisenberg, 2012). These findings are similar to a national population study in the US (Mojtabai et al., 2011) finding that the largest treatment barriers were wanting to handle the problem personally, followed by low perceived need for care.

Several studies have highlighted the role of academic staff as a key aspect of supporting the mental health of students (Gulliver et al., 2018; Laws & Fielder, 2012). Gulliver et al., (2018) investigated the experiences and training of 224 teaching staff at the Australian National University with respect to assisting students with mental health problems. They found that many staff (60.0%) felt under-equipped overall to deal with student mental health and almost half (49.6%) reported they did not have access to formal training. A second study of thirty-four academics by Laws & Fielder (2012), found that there was a lack of clarity on role boundaries, and that institutional slowness in

responding to the mental health needs of students combined with increasing demands of academic roles, led to avoidance of investment in student well-being.

2.4.2.3. Engaging in the Student Role

A third theme in the literature focuses upon how students engage in the student role, the meaning that they place upon this role, and the impact of their mental health on engagement. Being a student is a highly valued role for students (Ennals, Fossey and Howie, 2015) as it provides structure to life, social connection, academic achievement and preparation for the future (Ekelman, Baszk, & Bazyk, 2013; Knis-Matthews et al., 2007). It also involves dealing with academic pressures and how these interact with life stressors and management of mental health (Ennals, Fossey and Howie, 2015). In the Eurostudent VII report in Ireland, students with a mental health condition reported the greatest difficulty engaging in study, with 11% reporting that a mental health condition severely limited and 69% reporting that it moderately limited, their ability to study (Erskine & Harmon, 2021).

Many studies have focused upon the impact of a mental health condition on academic attainment and progression. Experiencing a mental health condition is associated with substantial impairment in academic performance (Auerbach et al., 2016; Bruffaerts et al., 2018; Eisenberg, Golberstein, and Hunt, 2009; Stallman, 2010), which in turn can lead to lower rates of progression and retention in college (Auerbach et al., 2016; Bartlett, 2014; Collins and Mowbray, 2005; Hunt, Eisenberg and Kilbourne, 2010; Kessler, 1995; Mojtabai et al., 2015; Reilly, 2019). Progression through a college course can also be interrupted by difficulties associated with mental health (Arria, Caldeira, and Vincent, 2013; Megivern, Pellerito & Mowbray, 2003), with students taking periods out of study, repeating years, and as a result taking longer to progress through their course. Auerbach et al. (2016) examined the association of a mental health condition with entry to and withdrawal from HE, using data from the WHO World Mental Health Surveys (WMHS). They compared college students in the age range 18 – 22 years (n = 1,572) with peers who were not attending college (n = 4,178), a cohort which

included students who had recently left college without graduating (n = 702). Findings indicate that the presence of a mental health condition prior to college matriculation was associated with both reduced levels of entry to HE and higher likelihood of withdrawal. Although this study used survey data from 21 countries, the number of college students in the WMHS were too small to support separate analyses in each country. A cross-sectional study by Lipson & Eisenberg (2017) with a student population of 3,556 (n=2490 UG and n=1066 PG students) from four US colleges explored the relationship between mental health and academic performance. Findings indicate that students screening positively for depression, anxiety or an eating disorder, were nearly twice as likely to be dissatisfied with their academic performance, while students with positive screens for all three conditions were nearly three times more likely to be dissatisfied. Findings of the study also showed that mental health was strongly correlated with self-efficacy, motivation, and perceptions of faculty expectations (Lipson & Eisenberg, 2017).

Two large cross-sectional studies have focused upon the associations between the mental health of students and role-impairment (Alonso et al., 2018; Wilks et al., 2020). Alonso et al. (2018) examined role-impairment among first year students with a mental health condition through the use of a web-based survey of all incoming first-year students. Role-impairment was assessed using the Sheehan Disability Scale (Leon et al., 1997), which included four role domains of i) home management/chores, ii) college-related and other work, iii) close personal relationships, and iv) social life. The identification of a mental health condition was established through the use of short validated self-report screening scales including the Composite International Diagnostic Interview Screening Scales (CIDI-SC) (Kessler et al., 2013; Kessler & Ustun, 2004) and the AUDIT screening scale (Saunders, et al., 1993). The study included 13,984 students across 19 universities in eight countries (Australia, Belgium, Germany, Mexico, Northern-Ireland, South-Africa, Spain, and the United States). They defined severe role-impairment within the study as having a 7 to 10 rating on the Sheehan Disability Scale, confirmed in previous studies (Kessler & Ustun, 2004; Wittchen, Nelson, & Lachner, 1998). Findings

show that 20.4% of students reported severe role-impairment (Alonso et al., 2018). However, the level of role-impairment rose to 42.9% of students with at least one mental health condition as opposed to 10% of students without a mental health condition. Students reporting three or more mental health conditions were five times more likely to report severe role-impairment, with major depression, generalised anxiety and panic disorder being most associated with severe role-impairment. Several limitations were noted in the study including the use of a convenience rather than a representative sample, and the use of self-report measures rather than diagnostic interviews. Although response rates varied across sites, the overall mean response rate of 45.5% across the eight institutions compares favourably with other large-scale student surveys.

Wilks et al. (2020) examined associations of physical and mental health scores from the Short-Form 12 [SF-12] Health Survey (Ware et al., 1996) with self-reported academic role functioning using the Sheehan Disability Scale. The study involved a self-report survey of 3,855 first-year students from five universities in the US, with a response rate of 18.7%. 10.5% of respondents reported severe health-related academic role-impairment and that lower scores on the SF-12 quality of life measure were significantly related to higher levels of role-impairment, suggesting that the mental component summary was more strongly associated with role-impairment (Wilks et al., 2020). The use of the composite scores on the SF-12 did not provide insights into the specific physical and mental conditions / disorders that were associated with role-impairment as described by Alonso et al. (2018). It does, however, provide useful data on the connection between health-related quality of life and role-impairment, offering a potential target of interventions for students who report low scores, particularly on mental health scores. Interestingly, findings showed that although the SF-12 physical component summary on the SF-12 score (55.1) was half a standard deviation above the benchmark US adult population mean, the mean mental component summary score (38.2) was more than a full standard deviation below the US adult population mean.

It is well-established that higher levels of educational attainment are associated with positive health outcomes in the general population (Cutler, & Lleras-Muney, 2010; Feinstein et al., 2006; Goldman & Smith, 2011; Spittel, Riley & Kaplan, 2015), but the relationship between educational attainment and recovery in mental health, is a complex one. A longitudinal study by O'Shea and Salzer (2019) involving 623 participants examined the relationship between educational attainment and recovery-orientated outcomes on the Recovery Assessment Scale (RAS) (Giffort et al., 1995) and the Quality of Life (QOL) Interview (Lehman, 1983). As opposed to the positive health outcomes noted above, individuals with higher levels of educational attainment reported lower scores on the RAS, and participants with post high school education had statistically significant lower recovery scores compared to those without a high school education (O'Shea & Salzer, 2019). No significant difference was found in overall QOL, but lower levels of QOL were found in the following specific domains in the QOL Interview - the amount of fun a person has, friendships, interactions with other people, time spent with other people, people seen socially, and feeling comfortable around people (O'Shea & Salzer, 2019).

2.5 Interventions for Students Experiencing Mental Health Conditions

2.5.1 Mental Health Interventions for College Students

The ever-increasing prevalence of mental health conditions amongst students in HE and the impact that this can have upon engagement in the student role, makes the development of effective approaches to enable the participation of these students, essential. Many colleges have adopted wide ranging strategies that encompass areas such as college regulation and policy, student services, health promotion initiatives, awareness campaigns, training of staff across college, student-led activity such as peer support, on-line mental health resources, and curriculum design (Murphy, 2017; Universities UK, 2017).

Brown (2018) proposes an adapted version of the WHO model of informal and formal help (WHO, 2009), for use as a model of university student mental

health support. It describes support across five levels: Level 1, self-care – or readiness for university; Level 2, informal university / personal support; Level 3, structured university support; Level 4, university support services; and Level 5, external specialist support. Using this model, most institutions focus support at Level 4 through campus-based services, either in person or online. Numerous interventions have been developed and delivered individually or in a group, as guided self-help or online format, all with differing aims, content, methods, and results.

A systematic review and meta-analysis of 51 randomized controlled trials examined 59 interventions for common mental health difficulties among university and college students (Huang, Nigatub & Smail-Crevier, 2018). Interventions were categorised into cognitive and behavioural related interventions, mindfulness-based interventions, attention / perception modifications, as well as an 'other interventions' category which included exercise, music, peer support, and personalized feedback. Findings demonstrate moderate effect sizes for interventions for depression and anxiety. Cognitive Behavioural Therapy (CBT) and mindfulness-based interventions were effective for both depression and generalized anxiety disorder (GAD), and attention/perception modification was effective for GAD. The 'other interventions' category showed the highest effect size for both depression and GAD among university and college students (Huang, Nigatub & Smail-Crevier, 2018). However, participants were almost all students with mild to moderate mental health difficulty rather than a clinical population with severe symptoms.

Academic accommodations are varied and can include extra time in examinations, extended deadlines, separate examination venues, recording of lectures, individual tuition and flexible deadlines or attendance. Several studies of students with a diagnosed mental health condition have shown that these are the most useful supports for managing symptoms (Dougherty et al., 1996; Megivern Foster, Pellerito, and Mowbray, 2003; Knis-Matthews et al., 2007; Quinn et al., 2009; Murphy, 2017). However, there is a need for reasonable accommodations to be tailored to the individual rather than

provided as a blanket approach, and for these to be provided in combination with academic and mental health approaches that give practical support in managing academic demands (Murphy, McKernan, and Heelan, 2016; Murphy, 2017). An example of this type of support in the literature are Supported Education (SEd) programmes, which aim to provide the services necessary to place and keep individuals in HE settings and to achieve their educational goals (Rogers et al., 2010). Various models of SEd which support students experiencing mental health difficulties to engage in college have been proposed over the past thirty years. Unger (1990), the forerunner for SEd in the United States, proposed three approaches: i) an on-site service, ii) a mobile support service, and iii) a self-contained classroom service. SEd has been adopted by the Substance Abuse and Mental Health Services Administration in the United States (SAMHSA) as a promising practice in helping individuals experiencing a mental health condition to access and complete HE. However, a systematic review of SEd by Rogers et al. (2010) found limited data on the effectiveness of SEd programmes, and two further reviews (Davids-Brumer, 2018; Ringeisen et al., 2017) have also highlighted that although the evidence-base is growing, many of the studies do not employ rigorous methodological approaches. These studies identify a need to develop clear SEd service delivery models and specification of key components. Two further systematic reviews (Arbesman & Logsdon, 2011; Noyes, Sokolow & Arbesman, 2018) of OT interventions in employment and education for individuals with a mental health condition include studies on SEd and are described in section 2.5.4 below.

Although these approaches are provided by many HEIs, the demand for support is increasingly outstripping the services available. As a result, HEIs are developing more online interventions and student wide health promotion and prevention interventions to support student mental health. Several systematic reviews and meta-analyses have shown positive findings for the use of Internet and app based mental health interventions with university students across a range of mental health conditions using primarily CBT based approaches (Davies, Morris & Glazebrook, 2014; Donker et al., 2013; Farrer et

al., 2013; Harrer et al., 2018). A systematic review and meta-analysis of mental health promotion and mental ill-health prevention interventions (n=11 CBT based; n=10 mind-body based; n=1 psychoeducational) for students in HE showed a small but significant effect (Winzer et al., 2018), including sustainability of mental ill-health preventative interventions, especially in reducing the symptoms of depression and symptoms of anxiety. Many universities also use student-to-student peer support programmes. However, a systematic review by John et al., (2018) found limited studies to support their use, and of the three identified, two showed no statistically significant improvement in wellbeing outcomes with peer support, while a third article reported that peer support was useful in connecting students with student services.

2.5.2 Recovery-orientated approaches in Mental Health Services

Recovery grew out of the consumer and survivor movement in the United States in the late 1980s and quickly grew in popularity amongst mental health professionals throughout the following decades. Deegan (1988) introduced the discourse around recovery, claiming that rather than individuals experiencing mental health difficulty being rehabilitated, they recovered a new and valued view of self. Davidson and Strauss (1992) suggest four priorities that underpin individual recovery: i) discovering the possibility of an active sense of self; ii) identifying strengths, weaknesses, and possibilities for change; iii) initiating action and integrating the results of those behaviours into one's construction of actual capabilities; and iv) using sense of self to provide refuge from illness and pernicious elements of personal social environments. Anthony (1993) set out a guiding vision for recovery, focusing upon the idea of personal recovery, describing it as '*… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness ...' (p.527).*

Recovery-orientated practice has become a central philosophy in Irish mental health services over the past fifteen years, reflecting international trends in

the area (Department of Health, 2006; Department of Health, 2020; McGrath, 2015). Recovery has become a core element of service design and approaches delivered within these services. However, there has been criticism that recovery has been co-opted by health care professionals from its roots in rights activism to bring about social change, and used with services rebranded as "recovery-orientated" without the fundamental change to mental health services which the movement was original based upon (Beresford, 2019).

As part of the incorporation of recovery into mental health service delivery, there has been a conflation of two ideas: clinical recovery - defined by the reduction of symptoms and a move towards what might be deemed normal functioning; and a person-focused definition (Davidson & Roe, 2007). Recent international research and policy, however, has reaffirmed the focus upon personal recovery (Jackson-Blott, Hare, Davies, & Morgan, 2019), moving away from a medical model focus on clinical or physical recovery. A systematic literature review by Leamy et al. (2011) proposed a conceptual framework of personal recovery to provide an empirical basis for future recovery-oriented research and practice. They describe recovery as a non-linear process comprising five elements: Connectedness, Hope, Identity, Meaning, and Empowerment.

This move towards personal recovery orientates its definition back to '*reclaiming of personal control and a positive sense of self*' (Mental Health Commission, 2008, p.7), and that it is best defined by those who have lived experience of disability and recovery (Stoffel, 2011). Recovery-orientated approaches should be aimed at helping people to be who they are, rather than moulding them into what we believe they should be (Browne, 2006). Although health care professionals can provide specialized education and knowledge, clients are experts on the lived experience of pursuing health in the context of a mental health condition (Petros & Solomon, 2015), and the existing experience, knowledge and skills of individuals should be valued, even though these may be a challenge to some professionals (Mental Health Commission, 2008).

A systematic review by Winsper et al. (2020) examined how recovery-oriented interventions support users in their personal recovery journey, focusing upon functional, social and existential recovery outcomes. From a review of 309 studies, they identified four types of recovery-orientated interventions: i) psychoeducational approaches delivered either individually or in a group, ii) peer-support and peer led programmes, iii) social inclusion (i.e. employment, housing etc), and iv) pro-recovery and mental health training for health professionals or members of the public. Findings from the review showed significant associations between psychoeducational, peer, and social inclusion interventions and aspects of functional, existential, and, to a lesser extent, social recovery. Findings further demonstrated that recovery outcomes were mutually beneficial (e.g. functional recovery contributed to existential and social recovery). Winsper et al. (2020) further identify four mechanisms by which recovery-orientated approaches enable individuals to reach their recovery goals: 1) providing information and skills; 2) promoting a working alliance; 3) role modelling recovery; and 4) increasing choice.

2.5.3 Self-Management Interventions

Self-Management interventions have become an increasingly common aspect of mental health service provision in Ireland, as part of the overall movement towards recovery-orientated practice. As recommended by *A Vision for Change* (DOH, 2006) and *Sharing the Vision* (DOH, 2020), there has been increasing utilisation of mental health self-management programmes within Ireland.

> *'The recovery approach in mental health services emphasises the expectation of recovery from mental ill-health and promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual's personal journey towards recovery'.*
>
> (Mental Health Commission, 2005a, p. 1)

Although self-management interventions have been suggested as a practical way to incorporate recovery-orientated principles into mental health services,

their use within mental health services is relatively new (Crepaz-Keay, 2010). The use of self-management approaches has been used in the area of chronic illness for decades, with first references noted in the work on Creer in the 1960s (from Lorig and Holman, 2001). Although there is no universally accepted definition of self-management, many definitions focus upon the personal strategies that individuals engage in to live well in the presence of mental or physical disabilities (Packer, 2013), and involve an on-going lifelong process, rather than a single health promoting behaviour (Packer et al., 2018). The widely cited definition proposed by the Institute of Medicine [IOM] (2004) places an emphasis upon strategies adopted by individuals to live well but also upon increasing self-efficacy in achieving this:

> *'Self-management is defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions' (p. 57)*

Corbin and Strauss (1988) identified three tasks involved in successfully managing chronic conditions: role, emotional, and medical management. Lorig and Holman (2003) further described five core self-management skills needed to manage these three tasks including i) problem-solving, ii) decision-making, iii) resource utilisation, iv) forming relationships with healthcare providers, and v) taking action. Schulman-Green et al. (2012) further identify three self-management processes focusing on illness needs, activating resources, and living with a chronic illness.

As chronic diseases are increasingly recognised as a key aspect of health service use and expenditure, as well as a major contributor to mortality and ill-health, self-management has become an ever more prevalent aspect of health service provision. Within Ireland, self-management is now seen as a key element of health policy, as outlined in the *Healthy Ireland in the Health Services National Implementation Plan* (2015) and the *Living Well with a Chronic Condition: Framework for Self-management Support* (2017). These frameworks have focused upon the use of self-management interventions

with specific chronic conditions such as chronic obstructive pulmonary disease, asthma, diabetes, and cardiovascular disease.

Although self-management is a term attached to many health promotion and patient education programmes (Lorig & Holman, 2003), a differentiation is often made in the literature between the overall concept of self-management and that of self-management support or self-management intervention (deSilva, 2011). Consistent with their definition of self-management, the IOM (2003) proposed that self-management support involves: *'the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems'* (p. 52). Self-management support has been described not only as the approaches that help patients choose healthy behaviours, but also involves a fundamental change from patient-professional relationship to a collaborative partnership (Bodenheimer, Wagner, & Grumbach, 2002). Self-management interventions have been developed and researched for a number of chronic conditions such as asthma, diabetes, and cardiovascular disease, with a strong body of literature supporting their effectiveness (Health Information Quality Authority of Ireland, 2014; Panagioti et al., 2014; Taylor et al., 2014). Self-management interventions aim to empower individuals in their recovery by providing the skills and confidence they need to take active steps in recognising and managing their own health problems (Crepaz-Keay, 2010; Lean et al., 2019). They seek to give the individual an opportunity to reconnect with their lives within the context of living with a physical or mental health condition, and further involve placing the person in direct control of managing themselves and their well-being (Crepaz-Keay, 2010).

Both condition-specific and generic self-management interventions are available (Lean et al., 2019). Generic self-management programmes are targeted at any individual with one or more chronic diseases but are not tailored to support management of a specific chronic disease (Newman et al., 2004; Nolte & Osborne, 2013). Some of the most common examples of generic self-management programmes for chronic conditions include the Flinders programme (Battersby et al., 2013) and the Stanford Chronic Disease

Self-Management programme (CDSMP) (Lorig, et al., 1993) and the Expert Patient Programme in the United Kingdom. Although there is a broad variety of opinion upon what self-management intervention entails, it commonly includes: a) provision of information and education on a condition and its treatment, b) working collaboratively in creating individualised plans, c) developing skills for self-monitoring symptoms, and d) strategies to support adherence to treatment, including medication, psychological techniques, lifestyle, and social support (Lean et al., 2019).

2.5.4 Mental Health Self-Management Interventions

Self-management interventions have been recommended for individuals with mental health difficulties in various policy documents and guidelines (DOH, 2006, 2020; NICE, 2014a, 2014b), but have not been routinely incorporated into mental health service provision within Ireland. Petros and Solomon (2015) propose that mental health self-management programmes must go beyond developing an array of strategies and must include a framework for personal exploration to construct or rediscover a stable sense of self. Through a collaborative process, the individual can learn effective self-management strategies through personal trial and error in the context of daily life, rather than learning to adopt prescriptive strategies as suggested by health care providers (Kralik et al., 2004). Cockle-Hearne and Faithful (2010) suggest that while a focus upon technical skills may be more appropriate and effective in supporting an individual's self-management of conditions such as diabetes and arthritis, in order to support individuals in the management of mental health difficulty such as depression, a less technically focused approach may be more suitable, with more emphasis on facilitating behavioural change.

Many reviews of mental health self-management interventions have focused on broad self-management approaches such as psychoeducation and self-help, or on specific mental health diagnoses such as schizophrenia, psychosis, or bipolar disorder (Lean et al., 2019). Other reviews have explored general health outcomes for individuals with serious mental health illness (Dineen-Griffin et al., 2019; Kelly et al., 2014; Siantz and Aranda, 2014). Mueser et al.

(2002) published a review of the research on illness management for individuals with a mental health condition which included 40 randomized controlled trials (RCTs) focused primarily on studies involving participants with schizophrenia and bipolar disorder and excluding major depression and other mental health conditions. The findings of this review identified four elements of mental health illness management interventions as being: i) providing psychoeducation about mental illness and its treatment, ii) behavioural tailoring to facilitate medication adherence, iii) developing a relapse prevention plan, and iv) teaching coping strategies for persistent symptoms.

Petros and Solomon (2015) examined Illness Self-Management programmes (ISM) for individuals experiencing a mental health condition, although criteria were not specified for the selection of programmes; rather, the authors explore what they describe as five of the most popular ISM programmes:

i) Pathways to Recovery (PTR),
ii) The Recovery Workbook (TRW),
iii) Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES),
iv) Wellness and Recovery Action Planning (WRAP),
v) Illness Management and Recovery (IMR).

The authors reviewed the published literature for each programme and identified four major contextual domains for programme evaluation (structure, value orientation toward recovery, methods of teaching, and educational content) that supplemented empirical evidence. Criteria devised by Dougherty et al. (2014) for classifying the effectiveness of interventions (high, moderate or low) was used to evaluate the evidence for these interventions. Using this system of review, Petros and Solomon (2015) classified Pathways to Recovery (Ridgeway et al., 2002), The Recovery Workbook (Spaniol, Kohler and Hutchinson, 1994) and BRIDGES (Diehl and Baxter, 2006) as having low empirical evidence, albeit with BRIDGES approaching a moderate level. WRAP (Copeland, 1997) was classified as having a moderate evidence-base, although this is growing, and the methodology is improving. Although Petros and Solomon (2015) reported

that the Illness Management and Recovery programme (Mueser et al., 2006) was the most widely researched programme of the five outlined, they also classified it as having a moderate level of evidence.

Lean et al. (2019) conducted a systematic review of RCTs of self-management interventions for adults with severe mental illness, with a separate meta-analysis of symptoms, relapse, recovery, functioning, and quality of life outcomes. The review included thirty-seven RCTs involving 5,790 participants, with a range of clinical diagnoses including schizophrenia spectrum disorders, bipolar disorder, major depression, or mixed populations of people with these diagnoses (including those with personality disorder). Inclusion criteria for this review used three of the four domains identified by Mueser et al., (2002), reflecting a shift towards incorporating personal recovery into mental health self-management interventions. *'Behavioural tailoring to facilitate medication adherence'* (Lean et al., 2019 p.260) was omitted, as this was viewed to be at odds with a recovery-focused approach. Instead, a fourth criteria was added: that interventions should include a recovery-focused element such as setting personal recovery goals and learning how to manage mental health effectively as suggested by Mueser et al. (2013). In the thirty-seven studies reviewed, interventions ranged from 1 to 52 weeks in duration, and were mostly delivered in groups by health-care professionals (n=25) or peers (n=5). The remaining interventions were delivered individually online (n=2), by health-care professionals (n=2), or by a peer (n=1), or through a combination of group and individual sessions delivered by a health-care professional. The findings of this meta-analysis indicated reduced symptoms and length of admission and improved functioning and quality of life, both at the end of treatment and at follow-up (Lean et al., 2019). The review further reported recovery outcomes such as hope and empowerment at follow-up, and self-rated recovery and self-efficacy both following intervention and at one year follow-up.

A systematic review of studies on one of the most common mental health self-management interventions, WRAP (Canacott, Moghadda & Tickle, 2019), identified five studies across six papers which included two RCTs (Cook et al.,

2012; O'Keefe et al., 2016), and included 844 participants in total. Findings showed small but significant self-perceived recovery outcomes. However, improvements were not sustained over time, and were not significant in terms of reducing clinical symptomatology (Canacott, Moghadda & Tickle, 2019).

Various authors have proposed domains for reviewing self-management programmes. Barlow et al. (2001), in their review of self-management approaches for chronic conditions, identified domains for review programmes which included target population, delivery location, self-management tutors (delivered by), mode (of delivery), format and content. They further included sections on outcome measures and effectiveness. Petros and Solomon (2015) proposed domains of structure, value orientation toward recovery, methods of teaching, and educational content to supplement empirical evidence. In their review, Lean et al. (2019) categorised findings by format (group/individual), facilitator, sessions, duration (weeks), session length (hours), dose (hours), as well as a description of the programme. Seven mental health self-management programmes were selected in line with the work of Mueser et al. (2002; 2013) and Lean et al., (2019) that were recovery-orientated, provided psychoeducation about mental illness and its treatment, and included a focus upon a relapse prevention plan and teaching coping strategies. Table 2.5 (Appendix 18) provides a summary of the seven-programmes (Wellness Recovery Action Plan, Illness Management and Recovery Programme, The Recovery Workbook, Pathways to Recovery, Building Recovery of Individual Dreams and Goals through Education and Support, Medication and Symptom Management Education Program, Recovery is up to you), including systematic reviews and RCT studies where available, but with one single-group pre- and post-test design included for Pathways to Recovery, as no RCTs have been conducted on this intervention. As the focus of this current study was students currently attending college and who were experiencing a broad range of mental health conditions, both in-patient programmes and condition-specific approaches were not included in the review.

As outlined in Table 2.5 (Appendix 18), mental health self-management interventions have been delivered in a variety of formats such as self-help workbooks as well as individual or group formats, facilitated by healthcare professionals and by trained lay leaders, generally with lived experience of a physical or mental health condition.

Four of the interventions offered flexibility between individual or group delivery (WRAP, PTR, IMR, TRW), with the remaining three designed to be delivered in a group format. It has been proposed that group-based self-management interventions are purported to offer benefits in terms of the value of the group process for participants, and reduced costs. One-to-one interventions provide the opportunity to individually tailor interventions and are easier to integrate into clinical practice (Newman et al., 2004). In the delivery of self-management interventions, two of the programmes are facilitated by mental health professionals (IMR, Medication and Symptom Management Education program), with two delivered by peers with lived experience (BRIDGES, Recovery up to You), one by specifically trained facilitators who could be mental health professionals or peers (WRAP), with the remaining two (PTR, TRW) completed either as a self-help workbook within a group, or with the support of a mental health professional.

The use of lay leaders has been proposed as easier to implement with their increased availability, but also as a more effective model than delivered by healthcare professionals (Lorig and Holman, 2003). An RCT by Johnson et al. (2018) evaluated the use of a recovery workbook delivered by peer support workers through individual one-to-one sessions over a four month period, in addition to care as normal. These participants were compared to a control group where the recovery workbook was completed by the individual independently with no meetings. Findings showed benefits in terms of reduced hospital readmission but no significant results in self-rated recovery, self-management skills, symptom severity, loneliness, or social network engagement, at either 4 months or 18 months. However, there has been limited evidence comparing the effectiveness of lay-led and professional self-management interventions (Griffiths et al., 2007). It has been suggested that

health-care professionals with their knowledge and skills can act as powerful models and are more able to address factual issues related to an illness, but that peer leaders can act as role models and are less costly than using health professionals (Coleman et al., 2012; Newman et al., 2004).

A systematic review by Kelly et al. (2014) examining the evidence for self-management approaches targeting general health outcomes for individuals with serious mental health outcomes, found that the evidence supported the use of mental health peers or professional staff to implement health care interventions. All of the programmes outlined a set modular format or a manualised approach, with different levels of emphasis placed upon personal recovery goals such as employment, relapse prevention, symptom management, the development of wellness strategies, crisis planning, and how the individual developed and used social supports.

Choosing the best-fit conceptual model for a service is central to informing its methods of assessment, intervention, and clinical reasoning (Wong and Fisher, 2015). Models of practice serve to inform clinical reasoning and guide intervention and provide the profession with solutions (Turpin and Iwama, 2011). Four of the seven programmes identified Recovery as the core underlying philosophy. IMR (Mueser et al., 2006) references the Transtheoretical Model (Prochaska and DiClemente, 1984) and the Stress-Vulnerability Model (Liberman et al., 1986) as theoretical underpinnings. Intervention methods include Motivational Interviewing (Corrigan, McCracken and Holmes, 2001; Miller and Rollnick, 2002) which is used throughout the programme together with psychoeducation and aspects of Cognitive Behavioural Therapy, social and coping skills development, relapse prevention and peer support (Mueser, 2006). The Transtheoretical Model (Prochaska and DiClemente, 1984) posits that individuals are motivated to take on new behaviours but that interventions must be adapted to the various stages of change that they are experiencing. The Stress-Vulnerability Model (Liberman et al., 1986) states that mental health difficulty is not only an interaction between biological vulnerability and sources of stress in the environment, but also that individual coping skills are involved. PTR (Ridgeway et al., 2002) is

based upon the Strengths Model (Rapp and Goscha, 2006), focusing on identifying and using personal strengths and environmental resources towards the achievement of personal life goals (Fukui et al., 2010). WRAP (Copeland, 1997) was developed by a group of people experiencing mental health difficulty, and clearly articulates Recovery as its guiding philosophy. Peer modelling and support amongst group members and peer facilitators are key instructional techniques within WRAP (Cook et al., 2009). TRW (Spaniol, Koehler, and Hutchinson, 1994) involves practices such as skills training, psychoeducation, and recovery-focused approaches, but does not outline a theoretical framework. TRW uses reflection and self-exploration rather than providing specific self-management strategies, with the focus upon the individual's expertise and knowledge (Spaniol, Koehler, and Hutchinson, 1994). Within the group formats that are now available, peer modelling and sharing of personal stories and ideas of self-management, are key strategies.

2.5.5 Mental Health Occupational Therapy Interventions

2.5.5.1 Occupational Therapy Interventions for Individuals with Mental Health Conditions

A 2005 Cochrane Review of OT interventions highlighted a lack of evidence for practice within the area of mental health (Steultjens et al., 2005). However, the evidence for the use of OT approaches with adults with a mental health condition has increased greatly over the past number of years (Arbesman & Logsdon, 2011; D'Amico, Jaffe & Gardiner, 2018; Gibson et al., 2011; Kirsch et al., 2019; Noyes, Sokolow & Arbesman, 2018). A systematic review of fifty-two articles (Gibson, et al., 2011) examined evidence of OT interventions focusing on recovery of community integration and normative life roles for adults with a mental health condition. The authors applied the American OT Association (AOTA) grading system for levels of evidence. Findings reported that evidence for social skills training was moderate to strong, with evidence for life skills and instrumental activities of daily living training, as well as neurocognitive training paired with skills training, to be moderate. Additionally, there was limited but positive evidence for client-centred interventions of high intensity and duration, although evidence was

inconclusive for providing interventions in the natural context rather than in the clinic setting (Gibson et al., 2011).

A second systematic review (D'Amico, Jaffe & Gardiner, 2018) focused upon the effectiveness of OT interventions to improve and maintain performance and participation for people with mental health conditions. Sixty-one articles were selected for inclusion, with findings showing strong evidence for psychoeducation and occupation and cognitive-based interventions, moderate evidence for skills-based interventions, and limited evidence for technology-supported interventions (D'Amico, Jaffe & Gardiner, 2018). Structured psychoeducational programmes which focused upon areas such as illness management, self-management, medication adherence, and problem-solving, were found to be effective (D'Amico, Jaffe & Gardiner, 2018). The use of occupation-based, cognitive, or psychoeducational intervention programmes or practices, focused upon individualized client-centred goals and developing habits and routines, was recommended by the authors for use with people with mental health conditions (D'Amico, Jaffe & Gardiner, 2018).

A recent review of the literature on OT interventions and outcomes in adult mental health (Kirsch, Martin, Hultqvist et al., 2019) highlighted seven categories of intervention:

i) employment/education;
ii) psychoeducation;
iii) creative occupations/activity;
iv) time use/occupational balance;
v) skills/habit development;
vi) group/family approaches;
vii) animal-assisted therapy.

Fifty peer-reviewed intervention studies targeting adults with mental illness were reviewed. The strongest evidence was found for interventions in supported employment, particularly using the Individual Placement and Support model, but promising findings were also reported from occupational therapy interventions in supporting individuals to re-engage in education.

Kirsch et al. (2019) propose that the evidence for time-use interventions within mental health occupational therapy is promising, and that there is a need for more studies with large samples evaluating time-use programmes among individuals with mental illness, to thoroughly investigate their usefulness.

A qualitative synthesis of twenty-two studies by Wimpenny, Savin-Baden & Cook, (2014) examined the effectiveness of interventions by OTs in mental health practice. Four areas were identified as central to effective intervention: i) professional artistry, ii) occupational engagement, iii) new horizons, and iv) inclusion. Within these themes, the ability of therapists to interact with clients based upon their skill, knowledge, and professional competency, as well as the potential for occupation-focused intervention to promote reflection, creativity, challenge, and develop personal meaning and feelings of self-confidence, were seen as key elements of effectiveness of interventions. These interventions offered to support changes in client perceptions of themselves and their future, and could promote participation and sense of belonging within a range of contexts. The authors highlight that intervention selection matched to the individual's needs and implemented within authentic relationships and context was central to the effectiveness of the intervention (Wimpenny, Savin-Baden & Cook, 2014).

A meta-analysis of eleven RCTs on the effectiveness of theory-based occupational therapy interventions in improving occupational performance and well-being among people with a mental health diagnosis (Ikiugu, Nissen, Bellar et al., 2017), demonstrate that occupational therapy interventions were effective in improving occupational performance, and to a lesser degree, well-being. An additional finding was that when a theoretical model of practice was clearly articulated in the intervention study, the effect size of the intervention increased.

2.5.5.2 Recovery-orientated practice in Occupational Therapy

The practice of occupational therapy, like the Recovery model, is based on the philosophy and evidence that individuals diagnosed with a mental health

condition can, and do, recover and lead meaningful, satisfying, and productive lives. Occupational therapy focuses upon a holistic approach to function, participation and partnership, which enables individuals to develop skills, engage in activities of interest, and meet individual recovery goals (AOTA, 2016). Occupational therapy has, at its core, a belief that occupation is essential to the health, well-being and recovery of the individual and that occupation is more than what we do, it is who we are (Dowling and Hutchinson, 2008), and that successful engagement in meaningful occupation is central to an individual's well-being and health (Wilcock, 2006). McKay and Robinson (2011) maintain that there is growing evidence for the importance of occupation to the lives, and importantly, the health of people with mental health problems. Kelly, Lamont and Brunero (2010) found that participants with mental health difficulty identify benefits of occupation that include feelings of social cohesion, meaning, purpose, normalisation, routine, competence, productivity, skill acquisition, and pleasure, as occupations connect people to social networks (Eklund, 2006). Occupational therapy aims to help individuals to realise that recovery is achievable and possible by promoting engagement in their occupation. Occupation presents opportunities for recovery from the consequences of mental health difficulty through experiences (Creek and Hughes, 2008; Lloyd et al., Mee et al., 2004; 2007). Occupation can influence health and well-being, organise and manage time, brings structure and meaning to living, and is the everyday medium in which we do or do not experience social inclusion and occupational justice (Polatajko et al., 2007).

A key concept within occupational therapy is Occupational Balance. Wilcock (2006) states that it is: "*A balance of engagement in occupation that leads to well-being. For example, the balance may be among physical, mental and social occupations; between chosen and obligatory occupations; between strenuous and restful occupations, or between doing and being*" (p. 343). Yerxa (1998) maintains that: "… *to be healthy, (people) need to be taught to create an individualised balance of meaningful variety and redundancy through discovering, developing, and acting on their own interests and by*

participating in the rules, habits and rituals of their cultures" (p. 415). Through occupation, individuals can build their capabilities and establish patterns that support health (Hocking, 2014). Sutton, Hocking and Smythe (2012) suggest that the recovery process is made up of four states of occupational engagement: i) disengagement, ii) partial engagement, iii) everyday engagement, and iv) full engagement. Through an occupation-focused approach, the student can be enabled to structure their routine in a manner that supports health and well-being, promotes engagement in their role as a student, and develops the self-awareness and self-monitoring that are key aspects of self-management.

2.5.5.3 Occupational Therapy Practice in Higher Education

Occupational Therapy practice within HE is still relatively new. However, in response to the need for support within the student body, and supported by equality legislation, there is an increasing number of examples of Occupational Therapy practice within HEIs, primarily based in the USA and Ireland. However, there is limited high quality research around specific Occupational Therapy interventions for students with a mental health condition in HE.

Two systematic reviews have examined the evidence for occupational therapy interventions in employment and education for individuals with a mental health condition (Arbesman & Logsdon, 2011; Noyes, Sokolow & Arbesman, 2018), but both reviews were heavily weighted towards studies related to employment rather than education. In the first review by Arbesman & Logsdon (2011), only four of the 46 studies focused upon individuals in HE (Collins, Bybee, & Mowbray, 1998; Gutman, Kerner, Zombek, et al., 2009; Hutchinson, Anthony, Massaro, & Rogers, 2007) with only two of these conducted by occupational therapists. The authors conclude that although the evidence was limited, structured manualised approaches involving skill development programmes have better outcomes than traditional interventions.

The second review by Noyes, Sokolow & Arbesman (2018), included 57 studies, but only two of these examined SEd (Gutman, Kerner, Zombek, et al., 2009; Kidd, Kaur, Virdie et al., 2014). Although findings from this review indicated moderate evidence for occupational therapy SEd interventions, this was based upon a very limited number of studies. A further systematic review (Spencer, Sherman, Nielsen, & Thormodson, 2018) examined the evidence on occupational therapy interventions for students with any mental illness transitioning to post-secondary education. Although this review explored the initial transition to HE, it also included articles on SEd. Seven articles met inclusion criteria for this review with three reporting on occupation-based SEd programmes (Schindler, 2010; Schindler & Sauerwald, 2013; Schindler 2014), one addressing the Individual Placement and Support approach for education (Rinaldi et al., 2010), another was the systematic review by Arbesman & Logsdon (2011), while two others focused upon transition programmes rather than SEd.

Two of the systematic reviews above (Arbesman & Logsdon, 2011; Noyes, Sokolow & Arbesman, 2018) reported primarily upon the same RCT by Gutman et al. (2009), based upon an on-site occupational therapy programme conducted in a University-based occupational therapy Faculty called the Bridge Program. In this study, thirty-eight participants were recruited from a college service for students with disabilities, the local community college, and community mental health services. The RCT was based upon a small sample size which included one experimental group (n=21) and one control group (n= 18). Although positive findings were reported in terms of enrolment in education and engagement in employment, this was limited by the lack of follow-up beyond six months post-programme to see how this was maintained. Findings also showed significant improvements in pre- and post-tests used to determine learning in each of the modules, but these measures lacked reliability and validity and did not indicate how learning was maintained over time. These findings have, however, been supported by subsequent studies on the Bridge Program (Schindler & Sauerwald, 2013; Schindler 2014). Schindler & Sauerwald (2013) examined outcomes of the

Bridge Program over a four-year period from 2005–2009, through the use of a follow-up questionnaire, and a focus group developed for the programme. The quantitative results from the questionnaire showed a statistically significant difference from pre- to post-test in employment following engagement in the programme, but there was no significant difference in the number of participants in education following the programme. The results were limited by a small sample size (n=48) with an increase in participants from seven to eleven students following engagement in the programme, and no control group used in the study. Schindler (2014) further reported positive findings related to performance and satisfaction in meeting goals. This mixed methods study included a larger sample (n=113) but did not include the use of a control group, so findings lack generalisability.

A number of additional studies are based upon another on-site occupation-based programme for individuals with a mental health condition incorporating SEd (Schindler, 2010; Schindler et al.,2015; Schindler, 2018; Schindler, 2019). Similar to the Bridge Program, referrals are made from the university service for students with disabilities and community mental health services, which is run over two semesters, with students choosing to attend once or twice weekly (Schindler, 2019). The programme is a structured, manualized, skill development program which involves one-to-one mentoring from occupational therapy students completing a Masters degree under the supervision of occupational therapy faculty staff (Schindler, 2019). Findings from one of these studies (Schindler, 2018), which explored service users' perceptions of and satisfaction with the programme, showed that participants benefited from: a) a one-to-one, individualised, ongoing, intervention for as long as needed; and b) a practitioner who is supportive, compassionate, and knowledgeable; and c) concrete, individualized goal-directed activities. A second retrospective study (Schindler, 2019) was conducted between 2008 and 2017 with n=80 UG students with the DSM-V diagnoses such as ADHD, ASD, and various mental health conditions. Data on retention and graduation for students registered with the office for students with disabilities in this period, was used for comparative purposes. Findings showed that n=62 of the

participants continued at the university with a retention rate of 77.5%, compared to a mean retention rate of 83% for students with disabilities. Although change in Grade Point Average was not statistically significant for the overall group, it was found to be statistically significant for the 62 students who progressed through the university. No control was used for the study however.

A recent review of current literature of occupational therapy in HE settings included twenty-five studies and highlighted a range of programme aims, student populations, and modes of service delivery (Keptner & McCarthy, 2020). The authors identified occupational therapists working with student populations including those with mental health difficulty only, those with identified disabilities, and the general student population (Keptner & McCarthy, 2020). The authors further identified roles for occupational therapy within HE such as: consultancy-based, one-on-one and/or group interventions as an independent service on campus, teaching an undergraduate course to help with transition to HE, or providing services in SEd. Findings demonstrate a number of positive outcomes in areas such as higher enrolment in a college course following engagement (Gutman, Kerner, Zombek, et al., 2009; Schindler et al., 2015; Schindler & Sauerwald, 2013), improved individual goal attainment, improved academic skills, increased competency in student role, enhanced social skills and professional behaviours (Gutman et al., 2007), and occupational performance and satisfaction with performance (Keptner, 2017; Keptner et al., 2016; Schindler, 2014; Schindler et al., 2015). However, many of the articles reviewed were descriptive in nature without defined outcomes or were limited by small sample sizes, lack of a control group, or issues with the reliability of measures (Keptner & McCarthy, 2020). Many of the occupational therapy approaches reviewed by Keptner and McCarthy (2020) could be broadly categorised within an on-site SEd model as described by Unger (1990). They are delivered in both one-to-one and group formats, or in a variety of delivery models such as through student services (Eichler et al., 2015; Eichler & Royeen, 2016; Lewis & Nolan, 2013; Nolan & MacCobb, 2006; Quinn, Gleeson, & Nolan, 2014), or through specific curriculum-based

programmes delivered by occupational therapists and occupational therapy students in collaboration with an academic faculty (Gutman & Schindler, 2007; Gutman, Schindler, Furphy et al., 2007; Gutman, Kerner, Zombek, et al., 2009; Schindler, 2010; Schindler & Sauerwald,2013; Schindler 2014; Schindler, 2018; Schindler, 2019). Other approaches have focused upon transition to HE through group interventions or modules embedded within academic curricula (Keptner, 2017; Keptner et al., 2016; Schindler, Cajiga, Aaronson, et al., 2015; Smallfield et al., 2011).

2.5.5.4 Occupational Therapy Self-Management Interventions

As highlighted above, there is a growing body of evidence to support both occupational therapy approaches for individuals with a mental health condition (Arbesman & Logsdon, 2011; D'Amico, Jaffe & Gardiner, 2018; Gibson et al., 2011; Kirsch, Martin, Hultqvist et al., 2019; Noyes, Sokolow & Arbesman, 2018) and mental health self-management interventions (Lean et al., 2019; Mueser, 2002; Petros & Solomon, 2015). However, there is limited evidence of Occupational Therapy self-management interventions.

A systematic scoping review suggests that occupational therapy self-management interventions have been targeted at specific chronic diseases (Richardson et al., 2014), such as visual impairment, diabetes, arthritis, cancer and neurological conditions such as stroke, multiple sclerosis and Parkinson's, as well as multimorbidity (Garvey, 2015; Ghahari & Packer, 2012; Kos et al., 2016; Loh et al., 2013; O'Toole et al., 2013; Pyatak et al., 2018; Raymond et al., 2016). The occupational therapy focus and skillset in task analysis, habits, and routines to support individuals as they implement their plans would appear to be well suited to self-management programmes, and many of the mental health self-management interventions referenced in section 2.5.4 are commonly delivered by occupational therapists. However, there are few examples of studies of mental health self-management interventions, which refer to occupational therapy delivered or conducted by occupational therapists. One example (a case study in an inpatient psychiatric unit) described the usefulness of an occupational therapy group that used a sensory processing approach to support individuals in identifying strategies to

include in their WRAP Wellness Toolbox (Gardner, Dong-Olson, Castronovo, Hess, & Lawless, 2012).

Although not explicitly referred to as a mental health self-management intervention, Action over Inertia (AOI) (Krupa, et al., 2007) is a recovery-orientated occupational time-use intervention delivered by an occupational therapist within Assertive Community Treatment services. AOI uses an individual workbook-based approach, which contains elements of psychoeducation and a range of cognitive and behavioural strategies to promote changes in occupational engagement. It is based upon the Canadian Model of Occupational Performance (Polatajko, Townsend and Craik, 2007) and Recovery models (Deegan, 1988; Anthony, 1993). The programme's main focus is *'… on enabling engagement in activities and activity patterns that contribute to health and well-being for people with serious mental health illness'* (Krupa et al., 2010, p.2). The specific intervention approaches are based upon enabling engagement, behavioural and cognitive-behavioural approaches, psychoeducation, and health promotion (Krupa et al., 2010). It contains seven sections on areas such as: 'Understanding Personal Activity Patterns', 'Making Quick Changes in Activity Patterns', 'Providing Education about Activity, Health and Mental Illness', and 'Supporting and Evaluating Activity Change'. One Randomised Controlled Trial was conducted with a small sample size, using a pre-test / post-test design, with no follow-up to determine whether effects were maintained (Edgelow and Krupa, 2011). Findings showed that participants increased occupational balance by engaging in more activity per day. The small sample size and reported drop-out rates from the intervention group are stated limitations of the study, as were the lack of a follow-up to the study.

Another example of an occupational therapy approach which seeks to enable the development of self-management skills is USC Lifestyle Redesign (Clark et al., 2015), a preventative lifestyle-based occupational therapy intervention with set modular content, which aims to enable individual understanding of everyday needs and challenges, and to establish habits and self-management skills to address these. It is delivered by occupational therapists through a mix

of group and individual formats, including didactic presentations, group discussion, direct experience, and personal exploration (Clark et al., 2012). Lifestyle Redesign was delivered using a combination of weekly two-hour group meetings with up to ten individual meetings in support of the group approach, over a period of nine months within the Well-Elderly study (Clark et al., 2012). Within this study, modules included: 'Impact of everyday activity on health', 'Time-use and energy conservation', 'Transportation utilisation', 'Social relationships' and 'Changing routines and Habits' (Clark et al., 2012). Two large scale RCTs have been conducted into Lifestyle Redesign (Jackson et al., 1998; Clark et al., 2012), but have principally been researched with an elderly population. Clark et al. (2012) conducted RCTs with 460 participants between the ages of 65 and 90 years and showed improvements in bodily pain, vitality, social functioning, mental health, composite mental functioning, life satisfaction and depressive symptomatology.

2.6 Conclusion

Experiencing a mental health condition can have a very significant impact upon student wellbeing, both academically and personally. Mental health self-management interventions have been recommended as part of the move towards recovery-orientated practice within mental health services in Ireland and internationally. Occupational therapy has a significant contribution to make to enabling participation in the student role and in facilitating students to develop practical self-management skills. D'Amico et al. (2018) propose that occupational therapy practitioners should be involved in programme development for people with a mental health condition attending in-patient, outpatient, and community-based settings, to support engagement in recovery and wellness through occupational performance. Packer (2013) further suggests that the occupational therapy focus on individual occupation allows for occupational therapy self-management programmes to provide a deliberate and proactive approach to supporting individuals.

There is very limited research into the application of mental health self-management interventions for college students. This is surprising as self-management is widely acknowledged as a key element in the transition from

secondary to tertiary education, but self-management does not appear to be an area of focus for programme development or research, within the college context. This is also surprising from a mental health perspective, as 15-24 years is a primary age bracket for the onset of mental health difficulty (De Girolamo, McGorry, & Sartorius, 2019; Jones, 2013; Kessler et al., 2007; Mowbray et al., 2005), and is often coupled with a transfer of services, due to age or change of location, and increased autonomy of now being an adult. Additionally, there is very limited research into the use of occupation-focused self-management approaches for individuals experiencing a mental health condition. Schindler (2019) proposes that with their expertise in client-centred and occupation-based approaches and through the use of quantitative and qualitative mixed methods research designs, Occupational Therapy practitioners have the potential to positively contribute to a growing body of literature on SEd outcomes.

This literature review has presented the available research on:

i) the student role in higher education,
ii) the experience of having a mental health difficulty in college,
iii) the prevalence of mental health difficulties among students in higher education,
iv) mental health interventions for college students,
v) mental health self-management and occupational therapy approaches.

Drawing upon the literature at the time in a) mental health self-management, b) mental health occupational therapy, and c) the specific mental health needs of the student population in HE, an occupation-focused and occupational therapy delivered self-management programme for college students experiencing mental health difficulty (*Unilink Self-Management Programme [USMP]* (Lewis, 2012)), was designed for use within the college context. This literature has grown substantially over the past ten years, and this is reflected in the literature review.

The aim of this current study is to understand the experiences of students and staff engaging with the *USMP* in a real-world HE context, through an exploratory case study design (Yin, 2018).

Having examined the literature in Chapter Two, the following research objectives and questions have been established to address the research aim of ***'To understand the experiences, reflections and personal outcomes of student and staff participants using the Unilink Self-Management Programme (USMP) in a real-world HE context'.***

Research Objectives

1. To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme
2. To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme.

Research Questions

1. Do college students with mental health conditions experience significant role-impairment?
2. Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?
3. Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?
4. What are the experiences and reflections of the students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?

Chapter Three presents a detailed overview of the *Unilink Self-Management Programme* which is the focus of this research study.

Chapter Three: Outline of The Unilink Self-Management Programme (Lewis, 2012)

3.1 Introduction

The ***Unilink Self-Management Programme*** *(USMP)* is a recovery-orientated and occupation-focused self-management programme for college students experiencing a mental health condition. The programme was developed through an iterative, clinically based approach in response to an identified need, namely, to support students who are struggling to meet the academic demands of college whilst also managing their mental health issues. This chapter describes the structure and implementation of the *USMP*, focusing upon the conceptual models that underpin the programme, and key features, components and parameters which are integral to the delivery of the *USMP*. It concludes with a description of the training provided for Occupational Therapists delivering the *USMP* as part of this research.

3.2 The Unilink Self-Management Programme (Lewis, 2012)

Prior to presenting a detailed description of the mechanics of the *USMP*, it is useful here to set out the conceptual models that informed the development of this intervention.

3.2.1 Conceptual Models Underpinning the *Unilink Self-Management Programme*

The development of the *USMP* was guided by two over-arching conceptual frameworks: The Person Environment Occupation Model (Law et al., 1996) and the Recovery approach.

3.2.1.1 Person-Environment-Occupation Model (Law et al., 1996)

Packer (2013) suggests that Occupational Therapy's focus upon an individual's occupations allows for Occupational Therapy self-management programmes to provide a deliberate and proactive approach to supporting individuals. Research by Occupational Therapists in the area of self-management is increasing (Clark et al., 2012; Edgelow, & Krupa, 2011; Garvey et al., 2015;

Pyatak et al., 2018; Richardson et al., 2015), but research within the area of mental health self-management appears to be rare, and even more so with regards to Occupational Therapy for students in HE. Occupational Therapists are challenged to demonstrate the distinct value of Occupational Therapy in prevention, promotion, and intervention for mental health (AOTA, 2014), but must also be challenged to develop and use self-management approaches based upon the models and theoretical constructs within our profession (Augustine, Roberts and Packer, 2011; Hand, Letts, and von Zweck, 2011; Wood, 1996). Many Occupational Therapists are delivering generic self-management programmes, and although training and perspective will influence how they deliver these programmes, occupation and Occupational Therapy theory are often not central to this delivery. The focus of the *USMP* is upon enabling students to understand and manage themselves and the occupational performance issues associated with their mental health difficulty (e.g. what they are doing and how they are doing it). The Person-Environment-Occupation (PEO) Model (Law et al., 1996) was chosen to enable this for the following reasons.

Firstly, the PEO Model (Law et al., 1996) provides a structured framework for the student and the Occupational Therapist to understand and address occupational performance related to a student's activities, tasks and roles, by examining the transactional relationship and fit between the Person, the Environment and Occupation (Strong and Reibeiro-Gruhl, 2011). Using the PEO Model (Law, Cooper, Strong et al., 1996), Occupational Therapists and students can address barriers, and focus interventions on the personal, environmental and/or occupational level (Pereira, 2012). The PEO Model allows for a clear approach orientated to the student's current occupations, and an explicit focus upon occupational performance within the student role in HE.

Secondly, the PEO model (Law et al., 1996) describes how people engage in occupations within a given environment over time (Strong and Reibeiro-Gruhl, 2011). The individual is viewed as dynamic and that his / her occupational performances change as the environment changes. This emphasis upon the

influence of environment upon occupational performance is an essential element of Occupational Therapy practice, and particularly relevant in the delivery of an intervention within the student's real-life college context. The concept of occupational performance over time is very consistent with the student journey and the development of students from adolescents to young adults. It also reflects the progression of the student role characterised by changing structures and evolving demands, from initial entry to college, the growth of self-directed learning, and finally towards graduation and transition to work or continuing education. Because the PEO model considers development across the life span and changes over the course of life and life circumstances, therapists can use the PEO to develop an individualised approach for each student, tailored to their particular student role and participation in college life (Strong and Reibeiro-Gruhl, 2019).

Thirdly, the PEO Model is rooted within client-centred practice, which has become a central philosophy in Occupational Therapy practice, emphasising partnership, active client participation, respect for client values, informed decision making, with interventions adapted to meet individual needs (Sumsion, 2000). As a basis for the formation of a genuine collaborative relationship, the PEO model (Law et al., 1996) provides a meaningful format for students and therapists and allows for a shared understanding of the student's occupations and occupational performance. It facilitates understanding of occupational performance issues from the lived experiences of the client and supports them through the intervention planning process (Strong and Reibeiro-Gruhl, 2019). This shared understanding of issues and priorities enables a strong therapeutic alliance and effective working partnership (Strong and Reibeiro-Gruhl, 2019). In the *USMP*, the Occupational Therapist is viewed as an expert in occupational analysis and intervention, and the student as an expert in their own experience.

Finally, the PEO broadens the focus of analysis beyond personal factors and offers guidance regarding potential areas for intervention that involve the environment and occupation (Strong and Reibeiro-Gruhl, 2019). The focus upon performance of daily occupations in the *USMP* aims to enable students

to not only identify the occupations that support health and well-being within their student role, but to actively engage in them. For example, students could be supported to develop anxiety management strategies for examinations, while also developing academic planning and study skills, and accommodated with a smaller venue to complete the examination. The programme aims to give the student a greater understanding of their mental health and its relationship to their occupations, and to empower students to use the many resources and supports that are available in college.

The PEO model is reflected in the content, format, and mode of delivery of the *USMP*, from the initial section where the core principles and concepts are discussed, to a framework structure of suggestions from students and staff under the Person, Environment and Occupation model, to the use of PEO-based worksheets to reflect upon current occupations and to address occupational performance issues. This focus upon occupational performance and the supportive role of the Occupational Therapist is a core approach within the *USMP*. The therapist can enable the student to identify supportive occupations in their student role, address any occupational performance issues, and include occupations as part of an overall college routine. The collaborative nature of the approach and the use of the PEO model as a tool for analysis and intervention for both student and therapist, is fundamental to the programme.

3.2.1.2 Mental Health and Recovery

Recovery principles are embedded throughout the *USMP*. The programme aims to support the student's journey towards discovering personal resourcefulness, meaning, and growth, within and beyond the limits of mental illness (Mental Health Commission, 2008). Deegan (1988) started the discourse around recovery, claiming that rather than individuals experiencing mental health difficulties being rehabilitated, they recovered a new and valued view of self. This involves *'reclaiming of personal control and a positive sense of self'* (Mental Health Commission, 2008, p.7). The *USMP* is aimed at helping people to be who they are, not making them into what we believe they should be (Browne, 2006). The recovery journey is unique to each

individual and is non-linear. Programmes which aim to support individuals must also be non-linear, offering the flexibility to engage at different points of a process, and allowing the person to disengage and re-engage as needed (Deegan, 1988). The recovery literature highlights the importance of "*personal narrative, on people writing their own story, explaining their own unique journey towards recovery and what helped or hindered on that journey"* (Mental Health Commission, 2005, p.13). The focus is therefore on the individual's personally created definitions of mental health, recovery, and occupation, and in the context of this study, upon their student role.

Engagement in occupation and participation, and their connection to mental health and recovery, is a core principle of the *USMP*. Leamy et al., (2011) identified five processes that support recovery: i) connectedness; ii) hope and optimism about the future: iii) identity; iv) meaning in life; and v) empowerment. When reflecting upon these processes of recovery, the importance of occupation in providing opportunities for these to occur and the role that Occupational Therapy can play in supporting an individual's recovery, is clear. The Recovery and Occupational Therapy philosophies are particularly congruent as they both focus upon client strengths and abilities (Rebiero-Gruhl, 2005). With explicit reference to client-centred practice and a focus upon empowering individuals to participate in their occupations, Occupational Therapists are well positioned to accompany individuals on their recovery journeys (White, 2011). Occupational Therapy practitioners can facilitate recovery in many ways, including: teaching and supporting the use of coping skills; helping individuals to identify habits, rituals and routines to support a healthy lifestyle; enabling informed decision-making; increasing awareness of community resources; and enabling individuals to develop long-term planning to meet personal recovery goals (AOTA, 2020). Higher education serves as a natural playground for occupational engagement and participation. Finding and facilitating ways for individuals to engage in meaningful occupations is the challenge for Occupational Therapists working in the area of mental health (Mee et al., 2004). Occupational Therapists utilise the opportunities and community factors that may support engagement in

the student role and enable the individual to overcome the practical problems that may impede it. It is this meaningful engagement in their occupations that can instil hope in individuals that recovery is achievable and possible.

The collaborative relationship between Occupational Therapist and student is a central element of Recovery, the PEO (Law et al., 1996) and the *USMP*. This relationship is based upon mutual respect, valuing the unique lived experience of the student and the therapist's expertise in analysing and enabling occupations. The recovery literature has been very critical of mental health systems and professionals for fostering dependence in clients rather than fostering active participation by empowered individuals who will recover (Rebeiro-Gruhl, 2005). Thus, the existing experience, knowledge and skills of individuals should be valued even though this might be a challenge to some professionals (Mental Health Commission, 2008).

3.2.2 Key Features of the Unilink Self-Management Programme

The *USMP* is a structured workbook-based approach developed by Occupational Therapists, for Occupational Therapists, to be delivered to students within the real-world context of college. It has been specifically designed to enable students with mental health difficulties to understand their mental health and recovery through their occupations, and to empower them to use these occupations to better manage their mental health in the student role. The *USMP* has two main aims:

- To enable students to understand their mental health, recovery, and occupations within the role of being a college student.
- To learn ways of managing their mental health through their occupations.

3.2.2.1 Understanding my Mental Health, Recovery and Occupation within the Role of being a College Student

College presents students with an opportunity to develop not only academic knowledge, but also to learn about themselves and how they engage in the student role. In the context of a mental health difficulty, students can also be

enabled to reflect and learn about their mental health and recovery. In recovery-orientated practice, the uniqueness of each individual's experience, story, and narrative in constructing meaning, is central, rather than focusing on clinical diagnosis (Mental Health Commission, 2008). Recovery belongs to each unique individual who may be experiencing mental health difficulties, and it is up to the individual to define what it entails (Davidson et al., 2005). However, students in HE have been found to lack the knowledge and understanding of their mental health which could enable them to become active self-managers (Becker et al., 2002; Collins and Mowbray, 2005; Karwig, Chambers and Murphy, 2015; Knis-Matthews et al., 2007; Quinn et al., 2009; Salzer et al., 2008).

Sussman and Arnett (2014) differentiate emerging adulthood from adolescence and adulthood across five dimensions: i) identity exploration, ii) feeling-in-between, iii) entertaining possibilities, iv) self-focus, and v) instability. Although these dimensions may be part of the development of many students in coming to college, they each have implications for the mental health of students (Auerbach et al., 2018). HE is often a time when students may be experiencing a mental health difficulty for the first time (Jones, 2013; Kessler et al., 2007; Mowbray et al., 2005). It is also likely to be the first time that they begin to explore their identity, both as a student and as an adult, of which their mental health may be a large aspect. They may now be expected to take more responsibility for their own health and well-being and, increasingly, it is a time when they are disclosing a mental health difficulty to academic and support staff for the first time, to avail of reasonable accommodations. For these reasons, supporting students in this process of self-discovery and exploration becomes essential at this stage of their lives. Experiencing a mental health difficulty can have common impacts upon students' engagement in the student role, as outlined in Chapter Two. However, each student's experience of a mental health difficulty is still unique, and they are often engaging in highly varied student roles, with a myriad of academic, professional, social, leisure and other non-academic tasks and activities. The *USMP* focuses on enabling students to develop a personal

understanding of what mental health and recovery means to them, and further explores the impact that their mental health can have on their student role. It provides a format for a student to reflect and discuss what mental health and recovery means to them as individuals, and to develop personal definitions of these concepts.

The programme further allows students to develop an understanding of their occupations and the core Occupational Therapy tenet of a connection between occupation, health, and recovery (Creek and Hughes, 2008; Kelly, Lamont and Brunero, 2010; Lloyd et al., 2007; Mee et al., 2004; Polatajko et al., 2007; Wilcock, 2006). As with recovery, it is the individual who defines the meaning and understanding of the occupations within their student role. The Occupational Therapist and the student explicitly explore the meaning of occupation and examine the key principles of the PEO model and how it relates to their student life from the outset of the programme (Law et al., 1996). In other words, throughout the sections of the programme, the student is asked to reflect upon their occupations and occupational performance using the PEO model as a framework. This provides a basis for understanding how their mental health may impact upon their student role and suggests ways to address this. The *USMP* places a focus upon the importance of their occupation to their recovery, and the interconnected relationship between mental health and occupation in a student's recovery journey. This understanding of personal mental health and occupation empowers individuals experiencing a mental health condition to become active self-managers of their student role, which is the second key feature of the *USMP*.

3.2.2.2 Learning ways to Self-Manage within the Student Role

The ability of students to manage themselves in the student role has significant implications for both well-being and academic success (Eisenberg, Lipson and Posselt, 2016). The development of self-management skills strengthens students' ability to manage the demands of college (Canadian Association of College and University Student Services and Canadian Mental Health Association, 2013). HE presents as an opportunity for students to

develop these self-management skills within a supportive system, when it is perhaps the one time in their lives where their work, leisure, social networks, and professional supports are located within the one inter-connected context (Royal College of Psychiatrists, 2011). Building upon the student's understanding of their mental health, recovery, and occupation, the *USMP* further aims to enable students to develop ways of self-managing within their student role, through identification of occupations that support this, and enhancing the student's occupational performance.

Occupational Therapy practitioners recognise that health is supported and maintained when clients are able to engage in occupations and activities that allow desired or needed participation in home, school, workplace and community life (AOTA, 2008; Wilcock, 2006;). The *USMP* aims to not only support the identification of strategies and occupations that can promote health and well-being, but also to promote the fit between the Person, the Environment and Occupation. Thus, occupational performance can be facilitated, bringing health benefits derived from occupation, and learning derived from these experiences in college. The Occupational Therapist utilises the opportunities and factors that may support performance and enables the individual to overcome the practical problems that may impede it. The emphasis is placed on how students manage themselves in what they are doing or want to do, rather than on how they solely manage their condition, and how they are emotionally coping with their lives. Many colleges have now articulated graduate attributes which focus upon personal development in parallel with the development of professional skills and academic knowledge (College Strategic Plan, 2020). The use of a self-management approach, and the learning implicit within it, is particularly relevant in the HE context, where learning is facilitated, ideas are nurtured, and independent thinking and reflection is respected and valued.

3.2.3 Components of the *Unilink Self-Management Programme* (Lewis, 2012)

A reproducible programme requires a full description of the intervention and an understanding of its components, in order that the intervention may be delivered faithfully, allowing for any planned variation and for future implementation (Medical Research Council, 2008). Consequently, the following is a description of the structure of the *USMP*.

The *USMP* workbook is divided into six sections (Appendix 19), with each section containing a balance of educational material, worksheets to prompt reflection, explorations of current and previous occupational engagement, and goal setting / planning material (Table 3.1). The student retains the workbook at the end of the programme and if the student wishes to take copies of materials prior to finishing the programme, the Occupational Therapist can provide these.

Table 3. 1: Overview of the Unilink Self-Management Programme

Section Title	Section Goals	Content	Resources
Section One: Introduction	• Develop personal definitions of mental health, recovery and occupation. • Understand the Person Environment Occupation model (Law et al.,1996) • OT and Student share definitions of mental health, recovery and occupation.	• Programme Overview and Aims • Student and OT discuss recovery occupation, mental health and recovery and review other definitions from workbook. • Student defines what the concepts of recovery, mental health and occupation in workbook mean to them. • OT outlines the PEO Model based upon workbook content • Students are asked to complete assessments in preparation for Section Two.	• Definitions provided within Section One of workbook • Supplementary readings on recovery and occupation. • Outline of PEO Model in Section One of workbook • Weekly Routine worksheets and the Interest Checklist (UK)

Section Two: The things that I need to do to engage in my student role and to look after my mental health	• Understand concepts of occupational balance and routine • Identify occupations that are important to have in routine • Identify and address occupational performance issues • Formation of a routine within student role	• Review questions on current routine. • OT and student discussion on routine and occupational balance • Student develops list of occupations that are important to have in their routine • Student and OT discuss student's list of occupations and address occupational performance issues. • Student establishes routine based upon identified occupations • Student uses goal-setting sheet to focus upon occupational engagement	• Questions in workbook to structure review of routine. • List of suggestions of occupations in student role in workbook • Information on activities within college and locality • Goal-setting worksheet • Routine formation worksheet • Supplementary readings on routine and occupational balance • PEO tasks analysis worksheets
Section Three: The things that may contribute to my <u>not</u> engaging in my student role	• Identify aspects of student role that impact upon mental health	• Student and OT reflect upon the student's current and previous occupational engagement in the student role in order to identify the aspects that may be negatively affecting their ability to engage in their day-to-day activities • Student reviews content in the workbook on what other students, staff and literature say about aspects that can impact upon mental health. • Student develops list of aspects that impact negatively upon their student role • Student and OT problem-solve issues in the student role that the student has identified • Student identifies goals to work on prior to the next meeting	• Reflection sheet with aspects of the student role that can impact upon mental health. • Goal-setting worksheet

Section Four: The signs that I am not engaging in my student role and possibly becoming unwell	• Understand the impact of mental health upon their engagement in the student role. • Enable student to identify signs that they are not engaging in the student role	• Student and OT reflect upon the student's current and previous occupational engagement in the student role to identify ways in which his/her mental health can impact upon their engagement in the student role. • Student reviews content in the workbook on what other students, staff and literature say about how mental health can impact on student role. • Student develops list of ways that their mental health can impact upon their student role	• Reflection sheet on ways that mental health can impact upon the student role • Goal-setting worksheet
Section Five: Personal and practical Strategies for engaging and re-engaging in my student role.	• Student to develop ways in which they can re-connect with their student role • Identifying the formal and informal supports that the student has within and outside of college	• Student identifies personal and professional supports within college or externally. • Student and OT reflect upon the student's current and previous student role to identify strategies to re-engage in the student role • Student reviews content in the workbook on what other students, staff and literature suggest as strategies. • Student develops list of personal strategies	• Information on support services within college and in locality • Reflection sheet on personal strategies for re-engaging in student role • Goal setting sheet • • PEO tasks analysis worksheets
Section Six: Review: Overview of the strategies and concepts covered in the programme.	• Review all of the sections to connect (or integrate) sections and update personal lists formed	• Review previous worksheets from the other sections and update as required	• Review card was developed to enable the student to keep a record of learning with them in college

3.2.3.1 Section One: Introduction - Discussion of the key concepts of recovery, occupation, mental health, and the Person Environment Occupation model

Section One introduces the central concepts which underpin the *USMP*, and the aims and objectives of the programme. The student is asked to develop personal definitions of mental health, recovery, and occupation, and to share these with the Occupational Therapist. Recovery has been viewed as an individual journey of finding meaning in life (Anthony, 1993), which is best defined by those who have lived experience of disability and recovery (Stoffel, 2011). By empowering students to develop their own definitions of mental health and recovery, they are being challenged to reflect upon their own recovery journey and their attitudes towards mental health. Onken et al., (2007) view the right to define one's journey and experience as a primary mechanism in recovery. Students are asked to further explore and define occupation as a central concept of the *USMP*. By exploring occupation, the student is introduced to its connection to health and well-being (Wilcock, 1998a; 1998b; 2006), and the impact that mental health can have upon occupational engagement.

The PEO is then introduced as a framework which underpins the programme. To enable students to develop their own personal definitions, they are asked to write or draw any words or images that help explain what these concepts mean to them. To support this, the student is provided with quotes and ideas from various sources in the literature which illustrate these concepts. The Occupational Therapist and student then discuss these definitions in order to develop an understanding of each other's perspectives in the collaborative relationship that is core to the programme's delivery. At the end of Section One, students are asked to keep a record of their weekly routine and to complete the Interest Checklist (UK) (Heasman and Brewer, 2008), to inform the discussion and reflection which takes place in Section Two of the programme.

3.2.3.2 Section Two: The things that I need to do to engage in my student role and to look after my mental health

Section Two focuses upon daily occupation, routine, and occupational balance. Students are asked to reflect upon their current routine and the balance of their occupations. The Occupational Therapist and student then discuss these reflections and move towards the student identifying the occupations that they feel are important to have in their routine. A list of suggested occupations is provided in the workbook under the headings 'Personal Skills', 'Managing my Environment' and 'My Occupations', in line with the PEO (Law et al., 1996). The student is asked to reflect upon their previous and current occupational engagement, and to add suggestions under these headings, including interests that they have highlighted on the Interest Checklist (UK) (Heasman and Brewer, 2008). The student then prioritises the occupations that they feel can support their mental well-being and can enable them to complete academic tasks in order to succeed in their student role. The Occupational Therapist and student then use goal-setting sheets, routine planners, and task lists, to assist them in integrating these occupations into a plan for the coming week. While identifying the occupations that make up their routine, the Occupational Therapist examines in more detail the student's occupational performance in these areas and addresses any barriers / issues using the PEO Model (Law et al., 1996) as a guiding framework.

This section was included to focus upon the student's current routine and occupational performance and to enable the student to build a healthy routine within their student role, based upon their chosen occupations. The Occupational Therapist facilitates reflection, explores the student's suggested occupations, and then focuses upon their performance in daily life. This section draws upon literature in the areas of mental health occupational therapy (Arbesman & Logsdon, 2011; D'Amico, Jaffe, Gardner, 2018; Kirsh, Martin, Hultqvist et al., 2019; Petersen, Bjørkedal, Torsting et al., 2019), occupation-focused self-management (Clark et al., 2012; Edgelow & Krupa, 2011), mental health self-management approaches (Canacott et al., 2019; Dalum et al., 2018 ; Lean et al., 2019; Petros & Solomon, 2015), and literature

connecting occupation and health (Kelly, Lamont and Brunero, 2010; Polatajko et al., 2007; Wilcock, 2006; Wilcock & Hocking, 2015; Yerxa, 1998).

3.2.3.3 Section Three: Identifying the things that may contribute to my not engaging in my student role

Section Three aims to enable students to understand when they are not engaging in their student role, and to identify aspects of college life that impact negatively upon their ability to do so. It provides students with a format to reflect upon the times when college has impacted upon their mental health and to identify the particular aspects of student life that contributed to this. To support this reflection, Section Three of the workbook contains a reflection sheet, a list of suggestions for aspects of college life that can negatively impact upon mental health, gathered from staff and students in HE. The student develops their own personal list based upon this reflection, and the Occupational Therapist and student then problem-solve these situations as a basis for developing strategies for future engagement. For example, students may identify 'financial problems' or 'exam pressure', which the Occupational Therapist and student can then work through to develop budgeting skills or study skills and anxiety management strategies within the programme.

The content for Section Three draws upon mental health self-management and occupation-focused self-management literature, but also upon the identified need for students to develop self-awareness of the impact of mental health difficulties upon their student role, and to develop the knowledge of how to respond to periods of mental ill-health (Hunt and Eisenberg, 2010; Furnham et al., 2011; Merritt et al., 2007; Reavley et al., 2012; Wei et al., 2013).

3.2.3.4 Section Four: The signs that I am not engaging in my student role and possibly becoming unwell

Section Four aims to develop the student's understanding of the impact of their mental health upon their occupational performance, and to enable them to identify the signs that they are disengaging from their student role. Section Four asks students to reflect upon times when they were finding it difficult to

engage in the student role, and to perform their daily tasks and activities. College students do not recognise these experiences of disengagement as a mental health difficulty (Collins and Mowbray, 2005; Karwig, Chambers and Murphy, 2015). Students may be experiencing these issues for the first time (Jones, 2013; Kessler et al., 2007; Mowbray, Collins, Ballamy et al., 2005), and are often unable to connect mental health difficulties to academic problems and do not perceive themselves as unwell (Quinn et al., 2009). This negatively impacts upon the uptake of supports, which are often viewed as essential for students with mental health difficulties to successfully engage in the student role (Knis-Matthews et al., 2007; Salzer et al., 2008). Section Four was included to allow students to reflect upon their occupational performance and to develop the ability to self-monitor their engagement in the student role.

3.2.3.5 Section Five: Personal and practical Strategies for engaging and re-engaging in my student role

Section Five concentrates upon working with the student to develop strategies for managing times when they are experiencing mental ill-health and for re-connecting with their student role. As stated above, college students have been found to not recognise signs of mental ill-health, and furthermore, often do not know how to access campus supports (Becker et al., 2002; Collins and Mowbray, 2005; Quinn et al., 2009). The importance of increasing students' knowledge of supports, should they become unwell, is clear (Hartrey, Denieffe, and Wells, 2017). Section Five begins with the student and Occupational Therapist identifying the formal and informal supports that the student has within and outside of college. The student is then asked to reflect upon current and previous strategies that have helped them to manage times of mental ill-health. As in previous sections, the workbook contains a reflection sheet with suggestions as a guide for the student to identify personal strategies. The Occupational Therapist is a resource to aid with identifying supports within and outside of college, enabling the student to implement the strategies that he/she has identified.

3.2.3.6 Section Six: Review: Overview of the strategies and concepts covered in the programme

Section Six allows the student and Occupational Therapist to review Sections One to Five, and to discuss any amendments to be made to the original content. A review card enables the student to keep a record of the meetings with the Occupational Therapist as a reminder of issues covered in each of the sessions.

3.2.3.7 Additional Resources

The programme contains a series of supplementary resources such as goal sheets, routine formation sheets, PEO tasks analysis worksheets, together with information on sleep, diet, and exercise. The programme also includes resources tailored to the college context where the programme is delivered, such as a 'Things to Do' guide, and a list of professional supports and resources internal and external to the college environment which are updated annually. Students are provided with weekly routine reflection sheets in addition to the Interest Checklist (UK) (Heasman and Brewer, 2008) in preparation for Section Two. Note sheets are also available should the student wish to take notes during the meetings.

3.2.4 Procedure for Delivery of the *Unilink Self-Management Programme*

Clear guidance was provided to the Occupational Therapists for the delivery of the *USMP*. The parameters for delivery were key to the implementation of the programme as designed, so as to address the key features as described in Section 3.2.2. These parameters are outlined below:

Table 3. 2: Unilink Self-Management Programme delivered within the Research Study

Engagement in the programme	• Based upon Occupational Therapy assessment process • Programme introduced to students in response to intervention goals
Format	• Six Sections delivered consecutively • Delivered in one-to-one meetings of 45-55 minutes by an Occupational Therapist • Content can be covered in between 5-8 meetings • Some flexibility in the number of meetings to meet individual student needs and course demands but following structured workbook format. • Each meeting had time devoted to discussing any current issues
Location	• Occupational Therapy Service embedded within the Disability Service of a Higher Education Institution
Content	• Educational content on key concepts in each section. • Student specific content tailored to individual's student role • Each meeting had time devoted to discussing any current issues within the student role.
Core activities within meetings	• Reading content on key concepts in each section of workbook • Completion of worksheets from the workbook during meetings • Personal reflection • Discussion between occupational therapist and student • Focus upon addressing occupational performance issues in identified occupations / strategies • Goal-setting and review • Routine formation
Facilitators	• Occupational therapists working within a college-based Occupational Therapy Service • Collaborative Process
Resources	• Participant Workbook including list of suggestions in each section; • Information on resources within college and locality (presented in line with the headings of the modified Interest Checklist (UK) (Heasman and Brewer, 2008); • Information on support services within college and in locality; • Routine formation worksheets; • Goal-setting worksheets; • PEO tasks analysis worksheets • Health promotion materials developed as resources for the programme (sleep, healthy eating, exercise) and academic skills (essay-writing; presentations; examinations) • The Interest Checklist (UK) (Heasman and Brewer, 2008)

3.2.4.1 Engagement in the Programme

The *USMP* was delivered by Occupational Therapists within the Occupational Therapy Service embedded in the Disability Service of one Irish HEI. To engage in this Occupational Therapy Service, students had to be registered with the Disability Service and have completed an initial needs assessment process with a Disability Officer, in which supports and reasonable accommodations are identified. Based upon an identified need in this assessment process, some students with more complex mental health needs were recognised as needing further support such as Occupational Therapy. Once referred to the Occupational Therapy service, the student completed the Student Profile (an occupation-focused assessment based upon the Person Environment Occupation model) (Law et al., 1996; Nolan, 2011), and collaborative goals were established with the student, to address occupational performance issues identified within the student role. Meetings were held individually to plan interventions for addressing the occupational performance issues identified by the student. The *USMP* was introduced to students as part of the assessment process, and following discussion with their Occupational Therapists, students chose to engage in the programme to meet their personal goals as part of the Occupational Therapy Process.

3.2.4.2 Format

The *USMP* is an individualised workbook-based approach designed to be used in face-to-face meetings between a student and Occupational Therapist, with the workbook format being used to shape the reflection, discussion, and learning. The intervention was designed with flexibility in mind, where content could be covered in five to eight meetings, but with the option for additional meetings based upon individual student need. Each meeting was 45-55 minutes in length with at least 30-40 minutes devoted to reviewing the sections of the *USMP* workbook. More than one section could be completed in a meeting, and some sections might necessitate more than one meeting. However, all six sections of the programme must be completed as outlined in the workbook. The individualised approach, in terms of scheduling of meetings, coupled with the on-site location of the service, allowed the

student and Occupational Therapist to build the programme around the constraints of the academic year, which is generally comprised of academic deadlines, examinations and perhaps placement requirements. The process moves at a pace to meet individual needs, thus reflecting the wide variety of learning styles and learning needs of students who engage with the Occupational Therapy Service. That is, the programme fits the students rather than the students fitting themselves into the programme.

To ensure that the student was meeting his/her current demands while engaging in the *USMP*, each meeting allocated time to discuss any current issues / demands in college and to plan how to address these. The format of meetings in the programme was devised to allow the student to focus upon on-going course demands, while also working through the sections of the programme. It was recommended that students be asked what they wished to focus on at the start of each meeting. In taking an occupation-focused approach, sometimes immediate demands needed to be met, rather than rigidly following the format of the programme.

3.2.4.3 Location

The *USMP* was developed to be delivered within the real-world context of a HEI. For this study, the *USMP* was delivered within an Occupational Therapy Service embedded in the Disability Service of an Irish HEI. The primary aim of the service is to enable students with disabilities to engage in their daily academic and non-academic occupations throughout their student journeys (Nolan, 2011). Meetings took place in the private office of individual Occupational Therapists located in faculty buildings on campus.

3.2.4.4 Content

The content of the *USMP* components is described in section 3.2.3. In delivering the *USMP* within this research, the content was as outlined in the programme workbook which included educational content on key concepts such as recovery, occupation, routine, and occupational balance. The *USMP* was designed to be an individually tailored approach, with the content being tailored specifically to the student's role through the use of personal reflection sheets, lists of suggestions developed by students and staff, and

discussion with the Occupational Therapist. Each section focused upon the individual student's experience of their student role, in the context of his/her reported mental health difficulty.

3.2.4.5 Core Activities within meetings

The workbook format was developed to provide a structure to the reflection, discussion, and recording of learning within the programme. An example of a meeting outline (Figure 3.1) was devised to provide Occupational Therapists with a guide to meetings. However, the Facilitator's Manual provided a more detailed plan for each section of the programme. Training proposed that the Occupational Therapist should read the workbook with the student and then discuss the content, making notes as required. The student was asked to complete all worksheets during the meetings, and to discuss these with their therapist. Once the student had identified personalised elements in each section, the therapist and student would discuss any issues with regard to engaging in the student role that were highlighted. Problem-solving and addressing of barriers to occupational performance were envisaged as central aspects to the meetings. The application of learning to the student role was discussed and implemented through the use of goal-setting and routine formation sheets, provided with the programme.

Meeting Outline:

- Go through the workbook in the meeting with the student.
- Each meeting 45-55 minutes in length with at least 30-40 minutes devoted to going through the sections of the USMP.
- Ask the student if they have current demands to meet and agree a time at end of each meeting to address these.
- More than one section can be completed within a meeting. Some sections may take more than a meeting.
- Go through each section in the programme but the student decides how quickly to move.
- Introduction to concepts within each section and personal definitions as outlined.
- Discussion based upon suggestions from workbooks.
- Resource book contains both paper and online resources.
- Establish personalised list as outlined in workbook.
- Student decides to move on or review section – at student's pace.
- Complete the review section at the end of each section.
- Use goal setting sheets and routine to plan occupational engagement. (Completed example sheets in the folder)

Figure 3. 1 – Example of Meeting outline provided to Occupational Therapists in the Facilitator's Manual

3.2.4.6 Facilitators

The programme can be used by Occupational Therapists who have completed the *USMP* training, but it is ideally delivered within an on-site Occupational Therapy Service, by therapists who have a strong knowledge of the student role, student environments, and the resources and supports available within the individual college context. In this research study, all Occupational Therapists worked full-time in the college-based Occupational Therapy Service. The *USMP* focuses upon developing understanding and enabling occupational performance through the dynamic interaction of the Person, Environment and Occupation. The skill set and perspective of Occupational Therapists are uniquely suited to the delivery of the occupation-focused approach in the USMP. Schindler and Gutman (2011) further claim that Occupational Therapists are uniquely qualified to support individuals experiencing mental health difficulties, using their skills in occupational analysis and synthesis to break down the tasks involved in the various roles into component parts. Occupational Therapists provide not only expertise in the area of mental health but, more importantly, expertise in enabling occupational performance, facilitating participation and social inclusion in this college setting.

The collaboration between the student and the Occupational Therapist is central to the *USMP*. Both the student, as the expert in his/her own occupations and lived experience, and the Occupational Therapist utilising his/her experience and knowledge of occupations in a variety of environments, collaborate in achieving meaningful engagement in occupations and learning. Students are viewed as experts in their own life and their mental health, but also in the context of education, in their own learning. Students in HE are often viewed as having achieved a high degree of academic success but nevertheless can experience difficulty in applying previously learned approaches to the demands of the student life in college. In the *USMP*, the student is viewed as bringing specific knowledge of the

demands of his/her course to the collaborative partnership. Rebeiro-Gruhl (2005) asserts that there is a need

> *"to recognise and focus upon the individual's strengths, gifts and residual abilities to enact change, to revere the uniqueness of the individual person and the importance of working with people and not just diagnoses, and to provide choices for one's life path" (p.98).*

The importance of the client-therapist relationship has been long recognised within the Occupational Therapy profession (Palmadottir, 2006). A positive and nurturing relationship with clients is a foundation for Occupational Therapy interventions (Bonsaksen, Vollestad, and Taylor, 2013). Many of the principles of client-centred practice have also been emphasised in the literature on Recovery (Anthony, 1993; Deegan, 1988), which has influenced the development of the USMP and mental health approaches and practices over the past two decades. Recovery-orientated approaches involve the health professional and individual working collaboratively to develop individual self-management plans, by focusing upon the individual's own resources, replacing traditional professional-led programmes (Mental Health Commission, 2005a). To support the formation of a genuine collaborative relationship, the PEO Model (Law et al., 1996) was chosen to frame the workbook sections, as it provides an accessible format for students and allows for a shared understanding of the student's occupation and occupational performance.

3.2.4.7 Programme Completion

As stated earlier, the programme content could be completed within five to eight meetings, but there is flexibility for additional meetings, based upon the student's individual needs and course demands. In this study, following completion of the programme, the student could continue to engage in Occupational Therapy meetings if they wished, with on-going access to supports and resources within the Disability Service and other student services in the HEI.

3.2.4.8 Engagement with Additional Supports outside of the USMP

While engaging in the *USMP*, the reasonable accommodations outlined in the student's needs assessment report were communicated to relevant academic staff in the student's course, to be implemented as support for the student's engagement. As students of the HEI, they also had access to college health services and student counselling services as required. Some students also availed of mental health supports external to the HEI. As such, the research did not attempt to control the supports that a student engaged in, as this was not feasible or ethical within the real-world college context. The additional supports that students engaged with during the research are outlined within the case study design of the research, and this is recognised as a limitation of the study.

3.3 Training for Occupational Therapists in Delivering the *Unilink Self-Management Programme*

3.3.1 Facilitator's Guide

To support delivery of the training sessions, a Facilitator's Guide was prepared for each Occupational Therapist working in the Occupational Therapy Service and participating in the research. The Facilitator's Guide included sections on: i) the PEO (Law et al., 1996) and recovery, and ii) occupation and its connection to health, together with a suggested session plan for each section of the programme, suggested format for meetings, programme information sheets for students, and a list of additional resources for students.

3.3.2 Training Sessions

All Occupational Therapists involved in the delivery of the intervention were trained by the Researcher prior to the beginning of the study, to ensure consistency of delivery. Each therapist was trained using a workshop approach over one day in two separate two-hour sessions. There were two aspects to this training: i) an introduction to the models underpinning this programme, and ii) a practical session focusing on completing the forms and practising the administration of the programme with students. The format of the training sessions involved PowerPoint presentations, small group discussion,

completion of worksheets, practice sessions in using the programme, and question and answers sessions. The core conceptual models with the USMP were outlined and discussed within the training. Therapists were asked to form their own definitions of recovery, mental health, and occupation in preparation for discussing these concepts with students. Therapists were given opportunities to practise using the programme with colleagues within the service through role-playing exercises. This training process was replicated with each new member of staff that joined the service.

3.3.3 On-going Support

The Occupational Therapists in the research study were provided with on-going supervision by the Researcher when using the programme with students. This took place monthly, but the Occupational Therapists could engage with the Researcher outside of these times with any queries they might have.

3.4 Conclusion

The *USMP* was developed to meet an established need amongst students experiencing mental health difficulties, by assisting them in the development of skills to manage themselves in the student role. The programme was specifically designed to enable students to develop practical self-management skills within the student role, by using an occupation-focused approach. This research study was undertaken to explore the experiences of students and staff of using the *USMP*, and the following chapter outlines the research design and methods used to address the research aims and objectives of the study.

Chapter Four: Methodology

4.1 Introduction

The research aim of this study based upon the current literature outlined in Chapter Two is:

> 'To *understand the experiences, reflections and personal outcomes of student and staff participants using the Unilink Self-Management Programme (USMP) in a real-world HE context'*.

This chapter presents the methodology used in this research study and begins by describing the philosophical stance which informed the adoption of a pragmatic research paradigm. Subsequently, the research design section describes the use of an exploratory multiple case study design, using a mixed-methods approach, to examine the personal outcomes of student participants (Research Objective One). It further describes the use of process evaluation, also using a mixed methods approach, as recommended by the Medical Research Council guidance on process evaluations in complex interventions (Moore et al., 2014), to examine the experiences and reflections of students and occupational therapist participants who engaged in the Unilink Self-Management Programme (USMP) (Research Objective Two). The data collection tools and methods, the ethical considerations that were addressed within the study and the analytical process employed to extract findings are then discussed. This chapter concludes by outlining the role of the researcher in the study.

4.2 Research Aim, Objectives, and Questions

Based upon the literature review in Chapter Two and to address the research aim outlined above, the following research objectives and questions were established.

4.2.1 Research Objectives

1. To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme

2. To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme.

4.2.2 Research Questions

1. Do college students with mental health conditions experience significant role-impairment?
2. Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?
3. Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?
4. What are the experiences and reflections of the students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?

4.3 Research Philosophy

Creswell (2014) suggests that a broad research design involves the intersection of an overall philosophy or philosophical worldview, research design, and specific method, and that researchers should make their philosophy explicit and explain their decision to use quantitative, qualitative or mixed methods approaches (Creswell, 2014). There has been much debate around the adoption of Quantitative, Qualitative and Mixed Methods, centred largely on the philosophical and methodological issues between competing perspectives of: a) the scientific world-views of positivism and post-positivism, b) the qualitative response of constructivism, and c) the employment of the multiple research methods associated with a pragmatic world-view.

Positivism and post-positivism have informed research methods within the areas of scientific and healthcare research, with experimental methods such

as randomised controlled trials with meta reviews considered to be the gold standard (Hyde, 2004). Conversely, constructivism is based upon the belief that individuals seek to understand the world they live in, forming subjective viewpoints based upon their experiences. This perspective is commonly associated with qualitative research methods, with researchers seeking to understand the varied meanings that individuals have about the world (Creswell, 2018). In contrast to the positivist /post positivist, and constructivist paradigms, pragmatism is not committed to any one system of philosophy and reality (Creswell, 2018), and is widely cited as an appropriate paradigm for undertaking mixed methods research (Biesta, 2010; Creswell, 2010; Teddlie & Tashakkori, 2009).

4.3.1 Philosophical Stance of the Research Study

The pragmatic stance adopted for this study has been influenced primarily by the recovery and student mental health literature, as well as this researcher's experience of working with students with mental health conditions in HE for the past sixteen years. This study sought to understand the personal outcomes of students using the highly individualised *USMP* intervention, as part of their recovery and educational journeys. However, with the development of occupation-focused approaches within this context, there was also a desire to gather empirical evidence of the impacts of the intervention, using standardised measures of clinical symptomatology and quality of life. In addition, success in HE is often framed in terms of academic attainment, progression and retention, which are common outcome measures used to determine the impact of learning and academic success within HE. To reflect the complexity and uniqueness of the experiences of students and occupational therapists using the *USMP* in a real-world context, a pragmatic approach was also adopted in the use of the process evaluation

4.3.2 Pragmatic Research Approach using a Case Study Design

In pragmatism, the research problem is viewed as the most important concern, rather than the method being dominant (Creswell, 2003). It allows the researcher to choose the methods, techniques, and procedures that best

meet the needs and purpose of the research. Teddlie and Tashakorri (2003a, p.713) define pragmatism as:

"a deconstructive paradigm that debunks concepts such as 'truth' and 'reality' and focuses instead on 'what works' as the truth regarding the research question under investigation. Pragmatism rejects the either / or choices associated with the paradigm wars, advocates for the mixed methods in research, and acknowledges that the values of the researcher play a large role in interpretation of results."

Consistent with a pragmatic paradigm, Stake (1998) maintains that a crucial aspect of case study research is not the methods of investigation, but the individual case. Yin (2018) proposes that case study research should be viewed as an *"all-encompassing mode of inquiry, with its own logic of design, data collection techniques, and specific approaches to data analysis"* (p.61). Case study research involves the in-depth investigation of one or more real-life cases and has traditionally focused upon an individual but can also involve a group, organization, community, programme, process, policy, practice, an institution, or events such as decisions (Yin, 2018).

Case study research can be used for the purposes of theory building or theory affirming, depending on whether the design is exploratory, descriptive or explanatory in nature (Yin, 2018). Descriptive case studies describe an intervention or phenomenon in the real-life context (Yin, 2003), whereas exploratory case studies are used when the outcomes of the intervention are not clear when starting the intervention, and findings can be used to identify the research questions or procedures to be used in a subsequent research study (Yin, 2018). Explanatory case studies attempt to explain causal links in real-life interventions and programme effects.

Yin (2018) further highlights a primary distinction in case study design between single or multiple cases. A multiple case study allows the researcher to explore differences within or between cases. A multiple case study will consist of single-case studies, which are generally presented as separate chapters

or sections, with an additional chapter or section covering the cross-case analysis and results (Yin, 2018). The goal is to be able to replicate findings across cases.

4.4 Research Design

The overall design chosen was mixed methods in a longitudinal study with three data collection phases, where both qualitative and quantitative data were collected.

4.4.1 Case Study Design

To address research objective one (RO1) "**To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme**", an exploratory multiple case study approach was chosen. Case studies have often been used within clinical evaluations; more frequently as part of a larger evaluation, but increasingly as the primary method of evaluation (Yin, 2018). Kielhofner (2006) maintains that *'case studies can be particularly useful for investigating new interventions or interventions that require substantial individualisation or trial and error'* (p.62). The case study approach offers additional insights into gaps that exist in programme delivery or why one implementation strategy might be chosen over another (Crowe, Cresswell, Robertson et al., 2011) and lends itself well to explaining how an intervention is being implemented and accepted, or why a programme is working or not working in a particular situation (Crowe, Cresswell, Robertson et al., 2011; Yin, 2018).

The connection between the case and its real-life natural context, is a core element of case-study research. Neuman (2011) describes that case study methodology *". . . intensively investigates one or a small set of cases, focuses on many details within each case and context. In short, it examines both [emphasis added] details of each case's internal features as well as the surrounding situation . . ." (p. 42)*. In this study, contextual factors are key to the understanding of how students and occupational therapists used the programme, as the *USMP* was delivered within an HE context while students were engaging in their student role. Factors such as varying course demands (e.g. examinations), use of college supports (e.g. counselling), and interactions

with students and staff had to be examined in the study, rather than controlled. In clinical practice, controlling events within the system under investigation may be challenging, meaning that experimental inquiry is not achievable (Fisher & Ziviani, 2004). From an occupational perspective, the interrelationship between the person and their context is a core element of our understanding of occupation (Pentland, Kantartzis, Clausen et al., 2018). Occupational Therapy is interested in the person in their own living environment (Salminen, Harra & Lautamo, 2006). Jónasdóttir, Hand, Misener et al., (2018) posit that researchers fail to recognise the potential of case study methodology for the study of occupation. Case study research is used to explore real life experiences and situations, when the researcher is interested in both the phenomenon and the context in which it occurs (Salminen, Harra & Lautamo, 2006). The complex connection between a case and its context is common between occupational therapy theory and case study research and provides occupational therapists with a methodology that enables the investigation of complex systems in real life contexts (Jónasdóttir, Hand, Misener et al., 2018).

Yin (2018) maintains that case study research greatly benefits from the *"... prior development of theoretical propositions to guide design, data collection, and analysis ..."* (p. 80). However, he further describes that where the knowledge base does not lend itself to the development of good theoretical propositions, that an exploratory case study design may be more appropriate (Yin, 2018). As this research study is based upon a newly developed occupational therapy delivered self-management programme, and due to limited studies in the application of mental health self-management programmes and occupational therapy approaches with a college student population, an exploratory case study design was chosen to reflect the personal outcomes of student participants from engaging in the USMP. A longitudinal case study design was used in this research to provide an appreciation of each of the student's individual engagement in the USMP, but also their personal outcomes over the course of their student journeys. Hence, the cases selected were over three phases of the research (pre-

engagement in the programme, post-engagement and at the twelve-month follow-up). Yin (2018) proposes that exploratory case studies should still be preceded by statements about what is to be explored, the purpose of the exploration, and the criteria by which the exploration will be judged successful. The review of the literature in Chapter Two informed the development of the four research questions and gave a focus to the analysis of the student cases.

An exploratory multiple case study design approach (Yin, 2018) was chosen to explain the multi-faceted phenomena of engaging in a complex intervention within the real-life context of an Irish Higher Education Institution (HEI). Yin (2009) proposes that at the outset of a study, the case must be bounded to clarify what falls within and outside of the case, such as: a) providing the time period covered by the case study, b) a specific description of the individual, group, organisation or event to be studied, c) the types of evidence to be collected, and d) the priorities for data collection and analysis.

The timeframe for implementation of this research study spanned a research period from March 2013 to December 2017. The case was defined as students who engaged in the USMP within one Irish HEI and completed all three phases of the research. While case studies are predominantly used within qualitative studies, there is a long tradition of using both qualitative and quantitative data within case studies (Stake, 1995; Yin, 2014), The triangulation of data within the case studies gathered from the interviews, as well as quantitative data from the measures and audit of case files, yielded a more complete understanding of the case (Gutterman and Fetters, 2018).

4.4.2 Process Evaluation

To address research objective two (RO2) "**To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme.**", a process evaluation was guided by examining the three functions of process evaluations outlined by the Medical Research Council (MRC) guidance on process evaluations of complex interventions, namely, implementation, mechanisms of impact and context (Moore et al.,

2015). Implementation involves capturing what is delivered in practice and how it is delivered. This involves describing the USMP (Chapter Three) and capturing whether the intervention was delivered as intended (fidelity), the quantity (dose; number of meetings), and the reach (whether the intervention reached the intended audience and how (Moore et al., 2015). Mechanisms of Impact involve examining whether the USMP brought about change or not, how these effects might be replicated by similar future interventions (Moore et al., 2015). Context includes anything external to the USMP that may act as a barrier or facilitator to its implementation or effects. Implementation will vary from one context to another, and although this study is based in only one context of an Irish HEI, understanding context is critical in interpreting the findings. (Moore et al., 2015).

4.5 Data Collection Tools

Five data collection tools were used in this study: i) Semi-Structured Interview with Students and Occupational Therapists; ii) the Brief Symptom Inventory (BSI) (Derogatis, 1993); iii) the SF-36v2 (Ware et al., 2007); iv) demographic Information; and v) an audit of Case Notes

4.5.1 Semi-Structured Interview – Students and Occupational Therapist*s*

Semi-structured interviews provide a predetermined but flexible format, which allows the researcher to probe more deeply into issues of interest and allows interviewees to express themselves and define and describe the issues in their own words (Hancock & Algozzine, 2017). Yin (2018) proposes that interviews can be especially helpful by 'suggesting explanations (i.e., the "how" and "why") of key events' (p. 213). Semi-structured interviews were viewed as particularly well suited to this study, as they allowed the researcher not only to examine the predetermined theoretical propositions, but also to probe these areas in greater depth and examine if other explanations were more relevant. The semi-structured interview format also allowed students to explain how and why the *USMP* had enabled them to develop their personal understanding of their mental health, recovery and occupation and their development of self-management skills (research questions two and three). It also allowed students to reflect upon the format of the programme and to

provide details on specific aspects of the interventions (research question four). Semi-structured interviews were also conducted with Occupational Therapist participants to garner their reflections on preparedness and clinical reasoning in using the *USMP*, how they delivered the programme, and their views of the programme format. The Interview schedules are outlined in Appendices 5, 6, 7 and 8.

4.5.1.1 Trustworthiness and authenticity

Interview schedules were developed in line with the research aims and literature and discussed with the Research Supervisor. The final choice of questions was finalised after an initial pilot test. All student interviews were completed by the researcher, audio-recorded and transcribed verbatim. Reflective journaling of the experiences of this research study, and, in particular, the processes of data collection and analysis, was used throughout the period of the study. For example, reflections were recorded upon the interview technique, and thoughts, challenges, assumptions and questions that arose during transcription.

4.5.2 The Brief Symptom Inventory (BSI) (Derogatis, 1993)

The symptoms associated with mental health difficulties can impact upon engagement in the day-to-day aspects of student life and impact on student performance (Eisenberg, Golberstein and Hunt 2009; Knis-Matthews et al., 2007; Megivern, Pellerito, and Mowbray, 2003; Stallman 2010b). The Brief Symptom Inventory (BSI) (Derogatis, 1993) is a measure used to identify self-reported clinically relevant psychological symptoms in adolescents and adults and consists of 53 items covering nine symptom dimensions: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. The global indices measure current or past levels of symptomatology, intensity of symptoms, and the number of reported symptoms, respectively. The BSI (Derogatis, 1993) was selected to provide: a) a baseline mental health status of the students prior to engaging in the programme; b) to evaluate changes in psychological symptomatology pre and

post-engagement ; and c) to review at a twelve-month follow-up session (research questions one and three).

4.5.2.1 Reliability and Validity

The BSI (Derogatis, 1993) is frequently used as an index of clinical improvement and treatment outcome in randomized trials of a wide variety of mental health interventions (Cook et al., 2011). It has also been used to measure the psychological well-being of students in HE internationally (Bennett and Hughes, 1996; Cheng, Leong, and Geist, 1993; Cochran and Hale, 1985; Hayes, 1997). In this study, the BSI was used to provide data on psychological symptomatology, to complement more in-depth information from the semi-structured interviews, and the data from the SF-36v2 (Ware et al., 2007).

In terms of test-retest reliability, the BSI demonstrates consistent measurement across time, with coefficients ranging from .68 to .91 across nine symptom dimension ranges from a low of .80 to .90 across the global indices (Derogatis, 1993). In relation to internal consistency reliability, coefficients range between .71 and .85 across the nine symptom dimensions (Derogatis, 1993). In line with the philosophy of the programme, recovery was not viewed purely in terms of the presence or absence of symptoms. However, the data provided by the BSI (Derogatis, 1993) was viewed by the researcher as complementary to the data provided by the SF-36v2 (Ware et al., 2007) and student interviews, in terms of changes in levels of symptoms impacting upon functioning in the student role.

4.5.3 SF-36v2 (Ware et al., 2007)

The SF-36v2 is a generic health self-report measure of health-related quality of life (HRQOL). In examining how the programme worked for students and to increase the construct validity of the study, the SF-36v2 was chosen to connect a qualitative analysis of programme impact on health and well-being extrapolated from interviews, with a standardised measure of impact on self-reported quality of life across a broad series of domains. SF-36v2 was selected to supplement the mental health specific information provided by the BSI

(Derogatis, 1993), and as a means of providing data in relation to the health-related effects of difficulties experienced prior to the programme (research questions one), and improvements following engagement in the programme (research question three).

Quality of Life (QOL) measures are regularly used in evaluating self-management programmes in the area of mental health (Barbic et al., 2009; Battersby et al., 2013., 2015; Clark et al., 2012; Cook et al, 2009; Cook et al., 2011; Druss et al., 2010; Jonikas et al., 2011; Lawn et al., 2007; O'Toole, Connolly and Smith, 2013;) and have also been commonly used with student populations in HE (Houghton, Keane and Murphy, 2010; Kelly and Grueber, 2010).Responses to items are recorded in eight domains: Physical Functioning (PF), Role Limitations-Physical (RP), Bodily Pain (BP), General Health (GH), Vitality (VT), Social Functioning (SF), Role Limitations-Emotional (RE), and Mental Health (MH). The information obtained from these eight health domains can be further aggregated into the Physical Component Summary (PCS) measure and the Mental Component Summary (MCS) measure.

4.5.3.1. Reliability and Validity

The SF-36v2 was constructed to satisfy minimum psychometric standards necessary for group comparisons, and the reliability of the eight scales and two summary measures has been estimated using both internal consistency and test-retest methods. Published reliability statistics for the SF-36v2 have exceeded the minimum standard of 0.70 recommended and has exceeded 0.80 in most studies (McHorney et al., 1994; Tsai, Bayliss, and Ware, 1997; Ware et al., 1993). Results from clinical studies comparing scores for individuals pre- and post-treatment have largely supported the validity of SF-36v2 scales. The content validity of the SF-36v2 has been compared to that of other generic health surveys (Ware et al., 1993; Ware, 1995). The MH (Mental Health), RE (Role Limitations-Emotional), and SF (Social Functioning) scales and the MCS (Mental Composite Score) summary measure have been shown to be the most valid of the SF-36v2 scales as mental health measures (Ware, Konsinski & Keller, 1994).

4.5.4 Student Demographic information Sheets

Demographic information sheets were designed to gather key demographic data such as gender, year in college, faculty, disability category and how long the student had been availing of the Occupational Therapy Service within the Disability Service.

4.5.5 Case Notes Extraction Tool

To gather data on use of the programme, duration, number of meetings, and data describing student progression and retention within college, an audit of the student case notes was conducted. An extraction tool (Appendix 1) was developed for the study to capture frequency data of the meetings and progression (how often do students engage, how many meetings the programme takes, duration of programme, progression data).

4.6 Ethical Considerations

Ethical permission was sought and granted from the Faculty of Health Sciences Research Ethics Committee in the School of Medicine in Trinity College Dublin, and from the HEI Disability Service Director; written permission to conduct the research was granted by both parties.

4.6.1 Informed consent, benefits of the study and risks to participants

Student participants were contacted by email by an Executive Officer in the Disability Service, who agreed to act as the gatekeeper for this study. The gatekeeper emailed the student participants with a cover letter and a Participant Information Leaflet (PIL) and participants were asked to respond to the Researcher if they wished to participate in the research. As the researcher was working in the Occupational Therapy Service in the research context, none of his clients were participants in this research study to avoid any potential bias. If a student did not wish to participate in the research study, they were still given the option of engaging in the *USMP*. The Researcher arranged to meet with each student participant to answer any questions and explain the aims of the study and obtain signed consent. The consent form explained that participation was voluntary, and participants were made aware that they had the opportunity to withdraw from the project

at any time. Participants were also reassured that their access to the Occupational Therapy Service would not be affected by their decision not to participate in the research. Following this meeting, and on receipt of the consent form, the researcher began the research process by contacting the student's occupational therapist.

The gatekeeper also emailed the staff of the Occupational Therapy Service with a cover letter and PIL inviting them to engage in the study. The gatekeeper informed the Researcher about the staff members who wished to engage in the research. The researcher met with each staff member to obtain signed consent prior to carrying out *USMP* training sessions and focus groups.

4.6.2 Confidentiality

All the personal identifying details from the student files relating to the research were removed by the gatekeeper and each file was given a code at the commencement of the study, thus ensuring confidentiality. This number was used in all subsequent stored data records. Records of the administration of the programme were kept in locked filing cabinets and on a password-protected computer within the Occupational Therapy Service office. The results of the measures were also kept in locked filing cabinets in an office of the Occupational Therapy Service. All clinical notes were anonymised by the student's Occupational Therapist and given a code prior to the audit of the notes. Transcripts of the student and staff interviews and focus groups were made confidential at the commencement of the study by allocation of a code number, and the transcripts were stored on a password-protected computer in an office of the Occupational Therapy Service.

4.7 Data Collection Methods

4.7.1 Recruitment

Recruitment of student participants took place within an Occupational Therapy Service in one Irish HEI over the period 2013-2017. All students who chose to engage in the USMP over this research period and met the inclusion criteria (Table 4.1 below) were introduced to the study by their occupational therapist. Purposeful sampling strategies as described by Patton (2002) were

then used to identify information-rich student and occupational therapist participants. This involves selecting individuals or groups of individuals who are especially knowledgeable about or experienced about a phenomenon of interest (Creswell & Plano Clark, 2011). In this study, students and Occupational Therapists with an in-depth experience of engaging with the USMP were selected to address the research questions outlined in section 4.2.2 above.

Table 4. 1 Inclusion and Exclusion Criteria – Students

Inclusion Criteria	Exclusion Criteria
Students registered with the Disability Service in the HEI with a Mental Health Condition	Students attending the Researcher within the Occupational Therapy Service
Students attending the Occupational Therapy Service in the Disability Service	Students not registered with the Disability Service in the HEI
Students aged 18 or above	Students registered with other disabilities but not a mental health condition

Recruitment of occupational therapist participants also took place within an Occupational Therapy Service within one Irish HEI over the period 2013-2017. All Occupational Therapists who met the inclusion criteria (Table 4.2) were introduced to the study.

Table 4. 2 Inclusion and Exclusion Criteria – Occupational Therapists

Inclusion Criteria	Exclusion Criteria
Qualified Occupational Therapists	Working in other HEIs
Working within the HEI in the research context	Has delivered parts of USMP, but not in full
Completed the Training Sessions for the USMP	

4.7.2 Data Collection Processes

Table 4. 3: Data Collection Process in line with Research Objectives and Questions

Research Objective	Research Questions	Data Sources
RO1: To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme	**RQ1:** Do college students with mental health conditions experience significant role-impairment? **RQ2:** Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme? **RQ3:** Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?	• Semi-structured interviews with students at pre-programme (T1), post-programme (T2) and 12-month follow up (T3) • SF-36v2 Quality of Life Measure at T1, T2, and T3 (Ware et al., 2007) • Brief Symptom Inventory at T1, T2, and T3 (Derogatis, 1993) • Audit of Clinical Notes of referral rationale, student goals, number and pattern of meetings in USMP, and progression data. • Demographic Data

RO2: To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme.	**RQ4:** What are the experiences and reflections of students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?	• Semi-structured interviews with students at pre-programme (T1), post-programme (T2) and twelve month follow-up (T3) • Semi-structured interviews with occupational therapists post-programme • Audit of Clinical Notes for referral rationale and number and pattern of meetings in USMP

4.7.2.1 Semi-Structured Interview - Students

Semi-structured interviews were conducted with student participants prior to engaging in the programme, post-engagement in the programme and at a twelve month follow-up. At the start of each interview, verbal consent was gained from the participant to audio record the interview, and they were also reminded that a copy of the transcript would be available on request. The pre-engagement interview (Appendix 5) included questions in relation to the types of activities that could hinder engagement in the student role and whether the students felt that they were able to recognise the signs that they were not engaging in the student role. Further questions elicited the student's current routine, perspectives on the concepts of recovery, mental health, occupation, and expectations for their student role. The questions in

the interview were generally open-ended and allowed for more in-depth explanation of the views and opinions of the student. The post-programme interview was carried out with student participants after engagement in the *USMP* to re-evaluate how they maintained their mental health and engagement in the student role through their occupation, and to explore their current routine having engaged in the programme. These responses were compared with baseline information from pre-programme interviews. Interview questions were organised under the following headings (Appendix 6):

- **Current Occupational Engagement in the student role** (e.g. What activities do you do in your current daily life, related to college or otherwise, to maintain your health and well-being?) (Pre and Post)
- **Personal Definitions** (e.g. What does the term mental health, recovery and occupation mean to you?) (Pre and Post)
- **Programme Administration** (e.g. Is there anything else that you would like to be included in the programme? Please elaborate) (Post Only)
- **Programme content** (e.g. Rating of Statement - The programme helped me to learn new ways to engage in my student role and maintain my health and well-being) (Post Only)

The twelve month follow-up interview examined current strategies for maintaining health and well-being and engaging in the student / worker role. Questions evaluated how personal outcomes from the programme had been maintained over time since engagement, with an additional heading (Appendix 7):

- **Application of the Programme** (e.g. Since you completed the programme, have you applied any of the techniques and strategies in your daily life, that you discussed with your occupational therapist.

4.7.2.2 The Brief Symptom Inventory (BSI) (Derogatis, 1993) and SF-36v2 (Ware et al., 2007)

The Brief Symptom Inventory (BSI) (Derogatis, 1993) and SF-36v2 (Ware et al., 2007) were completed by students at three different data collection points. Students were given pen and paper questionnaires to complete at a table in the Researcher's office on campus in the HEI. Students were given as much time as needed to complete the measures, and the Researcher was present throughout should the student need clarification of any element. Each paper-based measure was anonymised with a participant identifier (e.g. Student 1, Student 2, etc.)

4.7.2.3 Demographic information

The demographic information sheets were completed by students during the pre-programme meeting to provide background information on the student participants.

4.7.2.4 Audit of Case Notes

The audit of the Occupational Therapist case notes for student *USMP* meetings was carried out using the extraction tool devised for this study. The audit was carried out after data collection was completed to capture a full picture of the students' use of the programme and their progression and retention within college.

4.7.2.5 Semi-Structured Interview – Occupational Therapists

Occupational therapists involved in the research project were interviewed once at the end of the academic year in which they had been using the *USMP,* or, at exit from the service where relevant. In order to minimise bias and to protect the privacy and confidentiality of staff involved in the Occupational Therapy Service, the Occupational Therapists were interviewed by a Lecturer from the Discipline of Occupational Therapy in the HEI, as a neutral person in this study. At the start of each interview, verbal consent was gained from the participant to audio record the interview. They were also reminded that should they wish they could review a copy of the transcript. Transcripts of the student and staff interviews were anonymised by an individual external to the research project prior to analysis, thus ensuring privacy and confidentiality of

the data. These interviews were conducted with reference to an interview schedule, which covered the areas outlined below.

- **Clinical reasoning involved in the use of the programme** (e.g. What criteria informed the decision to use the programme with students?)
- **Programme Format / Administration** (e.g. Do you feel that the resource folders were helpful for the different sections? Were there any other resources that you would include?)
- **Programme Content** (e.g. Do you feel that the content was relevant to the students that you were working with?)
- **Student – Occupational Therapist Interaction** (e.g. Were the strategies developed based upon student experience or suggested by you, the therapist?)
- **Recovery-Orientated practice** (Did you feel that you had sufficient knowledge in the area of recovery-orientated practice?)
- **Occupation-focused practice** (What strategies did you use to facilitate the student's occupational balance and occupational engagement?)

4.8 Analytic Strategy

4.8.1 Analytic Strategy for Student Case Studies

Yin (2018) highlights five analytic techniques: a) pattern matching b) explanation building c) time-series analysis d) logic models and e) cross case synthesis. In a multiple case study, we are reviewing several cases to understand the similarities and differences between the cases (Baxter and Jack, 2008). Cross-case synthesis was used by first examining the results for each individual case study (i.e. student) and only then observing the pattern of results across the case studies.

In this study, individual case presentations were firstly written up to summarise the cases and to detail within-case analysis. Data from the audit of clinical notes (referral rationale, student goals, number and pattern of meetings in USMP, and progression data), was integrated with qualitative data from the student interviews at T1, T2, and T3, and quantitative data from

the SF-36v2 Quality of Life Measure (Ware et al., 2007) and Brief Symptom Inventory (Derogatis, 1993). This provided within each case presentation an in-depth picture of the nature of students' engagement with the USMP and personal outcomes they reported from this engagement. As the data for each case had been collected through longitudinal interviews and repeated quantitative measures, the case summaries were able to capture changes over time.

4.8.2 Analytic Strategy for Process Evaluation

All interviews of students who completed the USMP as well as occupational therapists who delivered it, were recorded and transcribed verbatim. Qualitative data were analysed using thematic analysis (Braun & Clarke, 2006) as outlined in section 4.8.3 below. Quantitative data gathered from the audit of the case notes was summarised using descriptive statistics to provide information on the number and pattern of meetings, duration of engagement in the USMP, and number of sections of the programme completed.

4.8.3 Methods of Data Analysis

4.8.3.1. Thematic Analysis of the Semi-Structured Interviews

Braun and Clark's (2006) six-phase framework for thematic analysis was used in analysing the qualitative data arising from the interviews with students and Occupational Therapists: i) familiarization with the data; ii) generation of initial codes, iii) identifying themes; iv) reviewing themes; v) defining themes; vi) and writing up the thematic analysis.

Step 1: Become familiar with the data.

After transcription, the interviews were re-read while listening to the recordings to become accustomed with the data in the same manner and to get a sense of the main ideas and the overall meaning. The transcripts were then re-read noting initial ideas.

Step 2: Generate initial codes.

Coding was done manually with the various sources of information being coded by segmenting sections of the text into categories and labelling those categories with a term. The data analysis was inductive, as the research

aimed to gain an understanding of the individual perceptions of the programme rather than to prove a preconceived theory. The coding process allowed the Researcher to establish overall themes for the study.

Step 3: Search for themes.

When all of the data was coded and collated, the analysis focused upon identifying broader themes. Tables were devised upon different codes, with mind maps also used to review codes and establish the broader themes. Potential overarching themes and sub-themes were initially devised in this phase.

Step 4: Review themes

In reviewing the potential overarching themes and sub-themes, some were combined, while others were separated into different themes, based upon a review of the coded extracts for each theme, and whether they appeared to adhere to a coherent pattern.

Step 5: Define themes

For each of the main overarching themes, the title of the theme was deduced from the raw data to represent the meaning of the theme. Working titles for themes were developed and refined based upon a review of the coded extracts. Themes and sub-themes were reviewed in relation to the research questions and the overall 'story' of the data (Braun & Clark, 2006).

Step 6: Writing-up

The write-up of the thematic analysis is outlined in Chapters Five and Six. Extracts are used to support each theme and to reflect the overall analytic narrative, in relation to the research questions.

4.8.3.2. The Brief Symptom Inventory (BSI) (Derogatis, 1993)

The data from the BSI (Derogatis, 1993) was scored using the scoring sheets provided, and as outlined in the BSI Administration, Scoring and Procedures Manual (Derogatis, 1993). The quantitative data from the Brief Symptom Inventory (Derogatis, 1993) was uploaded to SPSS (IBM® SPSS® Statistics Base). Given that individual change as opposed to group change was being sought, non-parametric tests, such as the Friedman Test and Wilcoxon signed

rank tests, were eliminated in favour of establishing clinically meaningful changes on a case-by-case basis.

4.8.3.3. SF-36v2 (Ware et al., 2007)

The Quantitative data within each case from the SF-36v2 (Ware et al, 2007) was scored using the PRO CoRE Scoring Software™ (Optum, 2017), and then exported into SPSS (Version 25; IBM Corporation, 2017). As above, individual change as opposed to group change was being sought. Hence, non-parametric tests, such as the Friedman Test and Wilcoxon signed rank tests, were eliminated in favour of establishing clinically meaningful change on a case-by-case basis using norm-based scoring as recommended within the User's Manual for the SF-36v2 Health Survey (2011).

4.8.3.4 Audit of Case Notes

Data from clinical notes was used for frequency data of the meetings and progression (how often do students engage, how many meetings the programme takes, duration of programme, progression data), and the clinical notes were not themed or evaluated in depth. Progression data derived from the audit of the clinical notes was captured in the extraction tool and from there entered into the case study database.

4.8.4 Validity and Reliability in Case Study Methodology

Leading case study researchers such as Stake, Yin, and Merriam have sought to establish case study research not simply as an exploratory method as a prelude to other research methods, but as a robust methodology in its own right (Salminen, Harra & Lautamo, 2006). However, to imbue this level of rigour, it becomes important to justify both the respective study's validity and reliability. Yin (2018) states that the developing case study design can be examined using four tests commonly used in social science research: (a) construct validity, (b) internal validity, (c) external validity, and (d) reliability.

4.8.4.1 Construct Validity

Construct validity involves *"the best operational measures for the topics being explored"* (Hancock & Algozzine, 2017, p.20). The flexibility in terms of data collection methods afforded within case study design is often viewed as a

strength in developing an in-depth understanding of the case. However, critics of case study methods highlight that researchers *'fail to develop a sufficiently operational set of measures'* (Yin, 2018, p.107), which leads to the use of measures that tend to confirm the researchers preconceived ideas. Two strategies were employed in this study as recommended by Yin (2018) to increase construct validity: (a) the use of multiple sources of evidence and (b) the establishment of a chain of evidence. The rationale for the specific choice of measures is outlined above in section 4.5. Within the case study, qualitative data derived from the semi-structured interviews was triangulated with the quantitative data from the SF-36v2, BSI, audit of the clinical notes and progression data, to enhance the construct validity.

The second strategy highlighted by Yin (2018) was to establish or maintain a chain of evidence, from research questions through to the findings, and also to enable the reader to review the findings and to trace them back to the initial research questions (Yin, 2018). The maintenance of an audit trail promotes reflexivity about data collection and ensures reliability of the procedures and the conclusions of the study (Corcoran, 2006). To enable this, Yin recommends the use of a case study database to allow the reader to be able to view *'the raw data that had led to a case study's conclusions'* (p. 235), as part of the chain of evidence. This strategy has been employed within this study to enhance the construct validity, from research questions to theoretical propositions, raw data and then findings within the case study report.

4.8.4.2 Internal Validity

Internal validity refers to how the cause-and-effect relationships between variables can best be established (Hancock & Algozzine, 2017) or as Neuman (2011) explains: *"internal validity occurs when the independent variable, and nothing else, influences the dependent variable"* (p. 292). In case studies, internal validity is mainly a concern for explanatory case studies, when the researcher is aiming to explain a causal relationship and is ensuring that this inference is current (Yin, 2018). Yin (2018) suggests that four analytic strategies are used to increase the validity of inferences being made by the

researcher: *pattern matching, explanation building, addressing rival explanations and using logic models.* Yin (2018) maintains that internal validity is not applicable to exploratory case studies, that are not aiming to explain a causal relationship.

4.8.4.3 External Validity

External validity refers to the fact that *"factors may lead to the generalizability of a study's findings"* (Hancock & Algozzine, 2017, p.60), beyond the immediate study in question. Yin (2018) posits that the basis for generalisation of findings from case studies is analytic generalisation (inference based on the relevance of similar theoretical concepts or principles) rather than statistical generalisation (inference based upon data from a sample of a population). In analytic generalization, existing theory is used as the starting point and is compared with the empirical results, leading to the modification or extension of the theory (Ridder, 2017). The enhancement of external validity is based upon the research design, such as the use of theoretical underpinnings in single-case studies and replication logic in multiple-case studies. In this study, the existing theory relating to student mental health, recovery, mental health self-management programmes and literature on the role of Occupational Therapy in mental health was used to form research questions to be explored across multiple case studies.

4.8.4.4 Reliability of the Case Study Design

Reliability is the level of consistency or repeatability of the case study's findings. Hancock & Algozzine (2017) define reliability as the "*conditions (where) the operations of a study be repeated with consistent results"* (p.20). Yin (2018) posits that the *"way of approaching the reliability problem is to make as many procedures as explicit as possible"* (p.111), and outlines two key strategies in achieving this transparency: the development of case study protocol and use of a case study database. Yin (2018) defines a case study protocol as a "*substantive guide for collecting the data for a case study, highlighted by a set of field questions to be addressed by the researcher*" (p. 466). *He* suggests that it should contain: (a) an overview of the case study; b)

the data collection procedures; c) the protocol questions (the specific questions that the case study researcher must keep in mind when collecting data, d) the potential sources of evidence for addressing each question), and e) an initial outline for the case study report.

A case study protocol was developed to increase transparency and reliability within this case study. The case protocol maintains a link to the case study topic, helps to anticipate problems, and pro-actively plans a format for reporting the case-study (Yin, 2018). Yin (2018) also highlights the value of a case study database, as distinct from the case study report, to allow the reader to view raw data. This contributes both to construct validity in terms of maintaining a chain of evidence in helping the reader to understand how inferences were made, but also greatly increases the reliability of the study. In this study, a case study database was created to organise and document the data collected for the case study. The database was created in Excel to arrange the narrative and numerical data in a usable format.

4.9 Role of the Researcher

In the use of many research methods, the researcher maintains a distance from the participants. However, case study researchers are usually '*immersed in their work'* (Hancock & Algozzine, 2017, p.66). Therefore, the researcher's "*inherent biases and predispositions may prejudice their activities and interpretations of the study's findings*." (Hancock & Algozzine, 2017, p. 67). Crowe, Cresswell, Robertson et al., (2011) maintain that the researcher's background and level of involvement must be articulated to increase transparency and reliability within the study.

The researcher recognises that he has played a role in the development of the Occupational Therapy Service in this research context, and, in recent years, in the development of the *USMP*. As one of only a small number of Occupational Therapists with experience of working in an on-site Occupational Therapy service in HE worldwide, the researcher's many years of experience in this context offered a very unique perspective to apply to the on-going development of this approach for college students. The researcher works with between 100 - 150 students per year and provides supervision to other

Occupational Therapists working in this emerging area of Occupational Therapy practice in HE.

Since the introduction of the *Unilink Self-Management Programme*, the researcher has completed the programme with many students. As mentioned previously, none of these were participants in this research study to avoid any potential bias. Reflexivity refers to the process of self-examination and is important in qualitative research as the Researcher will experience a wide variety of thoughts, feelings, and reactions as part of the data collection (Corcoran, 2006). This was seen as a vitally important element of this research for the reasons outlined above. Reflective journaling of the experiences of this research, and in particular the processes of data collection and analysis, was used throughout the period of the study, to reflect upon thoughts, challenges, assumptions and questions.

4.10 Conclusion

This chapter provides an overview of a pragmatic mixed methods approach chosen for this study, using an exploratory multiple case study design. It further describes the data collection tools and methods and outlines the methods of analysis employed for the different data derived from each of the tools. Chapters Five and Six present the findings in line with the four research questions. Chapter Seven further discusses these findings in relation to the literature.

Chapter Five: Student Case Studies

5.1 Introduction

Chapter Five will provide an in-depth view of students' experiences and personal outcomes of engaging in the Unilink Self-Management Programme (USMP) using ten case studies. It commences with an overview of the student participants involved in the research study. The chapter will then focus upon the presentation of ten case studies of students who engaged in the USMP and completed all interviews and measures used over the course of the three phases of the research study. Personal outcomes of the student participants who completed two phases of the research and one phase of the research will also be presented. These cases will then be used to address the research questions one, two and three based upon the literature review:

1. Do college students with mental health conditions experience significant role-impairment?
2. Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?
3. Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?

5.2 Participant Overview

Participants were all college students registered with the Disability Service in an Irish Higher Education Institute (HEI). Participants were students experiencing mental health difficulties, as outlined in the medical documentation provided by the participants upon registration with the Disability Service. The participants all had previously, or were currently engaged, with psychiatric services and were currently availing of the Occupational Therapy Service embedded in the Disability Service in the Irish

HEI where the study took place. Nineteen of the thirty student participants within this study entered the HEI through the Disability Access Route to Education (DARE) access scheme, resulting in them disclosing a mental health difficulty upon entry to college. The remaining eleven student participants registered with the Disability Service at different points in their college courses. Some of these students had previously been diagnosed with a mental health difficulty (n=7) prior to coming to the HEI, while for others this was the first time that they had engaged with mental health supports (n=4). Participants recruited for the study ranged from first year in undergraduate courses to postgraduate level students. They reported experiencing a variety of mental health difficulties and they had varied durations of previous engagement with the Occupational Therapy Service prior to engaging in the USMP.

Ten student participants completed interviews and measures for **all three phases of the research** (pre-programme – T1; post-programme-T2 and twelve month follow-up – T3). Participants were assigned names using a list of the most popular names in the year 2000 from the Central Statistics Office in Ireland: https://www.cso.ie/en/media/csoie/releasespublications/documents/birthsdm/2000/babiesnames_2000.pdf

Case studies of these students are presented in section 5.4 below. Five of these students identified as male and five as female. One student was in first year in college, three were in their second year, two students were in third year, one in fourth year, and three students were postgraduate students. Six students were diagnosed with depression, two with bipolar disorder, two with generalised anxiety disorder. Two of the students diagnosed with depression were autistic students, and another student diagnosed with depression also had diagnoses of dyslexia and epilepsy. Of note from the case studies was that although all students had connected with a Psychiatrist prior to coming to college, at time of starting the research study, three were engaged with no other mental health supports besides that Occupational Therapy and Disability Service; two attended college-based counselling, three attended the

college-based Psychiatrist, and two engaged with a Psychiatrist and counselling. Students were overwhelmingly using college-based services, with only one (Ciara) attending external services.

Table 5. 1 Participant Overview of the Ten Student Cases

Student Designation	**Gender**	**Year**	**Diagnosis**	**Other Services**
Ciara	F	2	Depression	External Psychiatrist, Student Counselling
Seán	M	PG	Autistic Spectrum Disorder, Depression	College Psychiatrist, Student Counselling
Conor	M	3	Anxiety	College Psychiatrist
Rebecca	F	2	Bipolar	College Psychiatrist
David	M	2	Autistic Spectrum Disorder, Hard Of Hearing, Depression	College Psychiatrist
Luke	M	1	Depression	None
Daniel	M	3	Depression	Student Counselling
Hannah	F	PG	Anxiety	None
Shauna	F	4	Bipolar	Student Counselling
Sophie	F	PG	Depression	None

Of the ten student participants who completed interviews and measures for two phases of the research, seven identified as female and three as male. Three students were in their first year, five were in their second year, one in third year, and one was a postgraduate student. Seven of the ten students had a diagnosis of depression, two were diagnosed with bipolar affective disorder, and one with a generalised anxiety disorder. Of the seven students with a diagnosis of depression, one student reported a hearing impairment, another a diagnosis of ADHD, another an eating disorder.

Of the ten student participants who completed one phase of the research, seven identified as female and three as male. One student was in first year, one in second year, five in third year, two in fourth year, and one was a postgraduate student. Six of the students were diagnosed with depression,

two with an eating disorder and two students with a generalised anxiety disorder.

5.3 Data Collection Methods

5.3.1 Qualitative Data Sets

5.3.1.1 Student Interviews

Twenty-eight students out of the thirty students who agreed to take part in the research, were interviewed individually prior to engaging in the *USMP* (T1). Twenty students who completed the USMP were interviewed at T2 (post-programme) and ten of these students completed the interviews at T3 (twelve month follow-up). The interviews were carried out in the Researcher's office with the duration varying from twenty minutes to one hour. All interviews were conducted with reference to an interview schedule, devised to reflect each phase of the research. Sections in the interviews were included at all phases which related to current occupational engagement in the student role and personal views of mental health and recovery. Additionally, sections on programme administration and content were included in the T2 interview, and a section on application of learning / strategies was included in the T3 interview.

5.3.2 Quantitative Data Sets

5.3.2.1 SF-36v2 (Ware et al., 2007)

The SF-36v2 (Ware et al., 2007) is a generic health self-report measure of health-related quality of life. Although the SF-36v2 was originally developed for administration to large population samples, it has increasingly been used to assess and monitor individual respondents being treated for a wide range of disorders in a variety of treatment settings (Maruish, 2011). It scores participant responses under eight domains of health-related quality of life (HRQOL): Physical Functioning, Role-Physical (i.e., role limitations due to physical health), Bodily Pain, General Health, Vitality, Social Functioning, Role-Emotional (i.e., role limitations due to mental/emotional health), and Mental Health. The information obtained from these eight health domains was

further aggregated into the Physical Component Summary (PCS) measure and the Mental Component Summary (MCS) measure.

The PCS and MCS have been used to reflect change in students' Health Related Quality of Life, while also reducing the eight-scale profile to the two aggregate summary measures without substantial loss of information (Maruish, 2011). A strength of the PCS and MCS measures is their value in distinguishing a physical health outcome from a mental health outcome (Ware & Kosinski, 2001a; Ware, Kosinski, Bayliss, et al., 1995). A low score on the PCS measure indicates (i) limitations in physical functioning, (ii) role participation due to physical problems, (iii) a high degree of bodily pain, and/or (iv) poor general health. A very high score on PCS indicates little or no measured physical limitations or disabilities. A low score on the MCS indicates frequent psychological distress, social and role disability due to emotional problems, and/or poor general health. A high score on MCS indicates frequent positive affect, little or no psychological distress or limitations in usual social/role activities due to emotional problems, and/or good general health.

Norm-based scoring is based upon US population data used in the online scoring software as recommended within the User's Manual for the SF-36v2 (Maruish, 2011). No normative data could be found in the literature for the Irish population. The SF-36V2 Manual (Maruish, 2011) suggests, when considering individual respondent data, that scores within 5 T-score points of the mean be considered within the "average" or "normal" range for the U.S. general population. Thus, if any scores falls outside of the T-score range between 45-55, then is should be considered outside of the average range.

In order to track change and reflect score differences, the concept of minimally important difference (MID) is used to differentiate whether a score difference is important or not, as recommended in the SF-36v2 Manual (Maruish, 2011). Based upon research studies and normative data, Maruish (2011) further proposes a MID of 2 T-score points for the Physical Composite Score and a MID of 3 T-score points for the Mental Composite Score.

5.3.2.2 Brief Symptom Inventory (Derogatis, 1993)

The BSI (Derogatis, 1993) was selected in this study to evaluate not only changes in psychological symptomatology pre and post-engagement in the USMP and at twelve month follow-up session, but also to provide a baseline mental health status of the students prior to engaging in the programme. The BSI includes nine symptom dimensions and three indices of global distress: Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST). These indices reflect a respondent's current or past level of symptomatology, intensity of symptoms, and number of reported symptoms, respectively. As such, they were selected to provide a baseline but also as a means to reflect changes over the course of the study. The BSI Manual (Derogatis, 1993) advises that the Global Severity Index is the scale that is the most sensitive single indicator of distress.

Raw scores on the nine dimensions of the GSI are calculated by summing the values for the items in each dimension and then dividing by the number of endorsed items in that dimension. The PST is calculated based on the total number of non-zero items and reveals the number of symptoms the respondent reports experiencing. The PSDI is calculated by summing the values of the items receiving non-zero responses divided by the Positive Symptom Total, which provides information about the average level of distress the respondent experiences.

Raw scores within each dimension were used to compare with normative data provided in the BSI manual based on four groups each separated for males and females: adult non-patients, adult psychiatric outpatients, adult psychiatric inpatients and adolescent non-patients. Raw scores were converted to standardised T-scores using the normative data for adult psychiatric outpatients. This group was chosen as all student participants had been diagnosed with a mental health condition, were connected to mental health supports and were all currently engaging in college. An individual with a given raw score will receive different T-scores depending upon the population on which the scores are normed. T-scores for the population on the BSI have a mean of 50 and a standard deviation of 10. This means that the

vast majority of individuals from the chosen population would have a T-score less than 70. An operational definition of caseness is proposed in the BSI Manual, that using the reference group of adult non-patients, a T-score of 63 or above on the GSI or a T-score of 63 and above on any two dimensions would be considered a positive diagnosis of a mental health condition or "a case" worthy of further evaluation. This, however, is only provided for the adult non-patient group, and no set cut-off scores for further evaluation are suggested for the other three groups, including psychiatric outpatients, which is used in this study. As such, a change in the T-scores in the case studies reflects positive or negative change without any set cut off point for clinical significance.

5.3.2.3 Audit of Case Notes

To further understand students' experiences in engaging in the USMP, the student case studies include data obtained from the student's clinical notes. This was gathered using an extraction tool developed for the study (Appendix 1) to capture how often students engaged in the USMP, how many meetings the programme took on average, the duration of the programme for the individual, and progression data to reflect personal outcomes.

5.4 Case study presentations - Students who completed three phases of the research

Ten student participants completed interviews and measures for all three phases and the case studies for these - Ciara, Seán, Conor, Rebecca, David, Luke, Daniel, Hannah, Shauna and Sophie - are presented in the section below. The case studies provide background information on students, their engagement with supports in the HEI and engagement in the USMP. The case studies also present students' reported personal outcomes based upon interviews at pre-programme (T1), post-programme (T2) and at 12-month follow-up (T3), personal views of mental health and recovery, as well as any reported changes in quality of life and psychological distress on the SF-36v2 (Ware et al., 2007) and BSI (Derogatis, 1993). The case studies further reflect the students' journeys through college, based upon progression data from the audit of clinical notes.

All ten students were registered with the Disability Service in the HEI, met with a Disability Officer for a needs assessment, and had been referred to the Occupational Therapy Service. In the initial meetings with an occupational therapist, students completed an occupation-focused Student Profile (Nolan, 2011), which was based upon the Person, Environment Occupation Model (Law et al., 1996). Collaborative goals were agreed with students based upon this assessment process, and students were introduced to the USMP based upon their identified goals. All ten students completed the USMP as recommended, moving in order through the six sections of the programme as described in Chapter Three.

Student Participant 1: Ciara

Ciara was a second-year undergraduate student who was diagnosed with depression and engaged with mental health services while in secondary school. During her first year in college, she continued to meet with a Psychiatrist external to college, but also engaged with the College Counselling Service during this time.

Ciara accessed supports within the College Disability Service in October of her second year in college and met with a Disability Officer for a needs assessment. She was referred to the Occupational Therapy Service by her Disability Officer for support around managing her academic demands and attended on four occasions during semester one of her second year, focusing upon assessment using the Student Profile (Nolan, 2011) and managing immediate academic demands. Collaborative goals were established in developing academic skills, routine, managing her mood, and getting work done. Based upon these goals, she was introduced to the USMP at the start of her second semester and chose to engage in the research study.

At her **initial interview (T1)**, Ciara identified exercise as the primary way that she managed her health and well-being, reporting that she went to the gym two to three times per week. She also identified, at T1 Interview, that meeting friends, having a routine, going to the library and attendance at class as other ways that supported her academic engagement. She described signs of her

not engaging in her student role as when she stopped attending class and replying to friends, and when she started drinking more alcohol. Mental health for Ciara involved being able to *'get on with your day-to-day life and achieve what you want to achieve and that you will be happy in yourself',* and she saw recovery as a *'transfer from a bad point to feeling more normal'.*

Ciara engaged in the USMP over the course of six meetings, spread over a three-month period. She engaged in the USMP weekly over the first four meetings, and then two weeks later and then one month later due to end-of-year examinations.

At her **post-programme interview (T2)**, which was just after her end-of-year examinations, Ciara described how her academic year had been challenging: *"I don't know I kind of even while I was doing the programme, I was still kind of having a slightly disastrous year anyway and then like I finally got it together in time for exams".* For Ciara, the USMP involved *"identifying things that I knew already but kind of presented it in a different way".* She described that self-awareness was a key aspect she had taken from the programme: "*Like the main thing I did was raise kind of personal awareness …so like more instinctively …. I think when those triggers happened again then I'd be more aware of what it means and stuff"".* Ciara also highlighted that feeling productive helped maintain her health and well-being: *"I am really into my lists at the moment and just like making lists, scheduling it and whatever and then being able to cross them off so like cause I'm sort of forgetful. And once I have some of that to do I feel productive and when I am productive, I feel much better and that whole thing"*. This was consistent with her view of mental health at T2 "*… it means you are engaging like in all your daily occupations without anything mentally holding you back whereas if you are mentally unhealthy maybe obstacles that are in there that stop you from carrying on".* Recovery for Ciara was like a *"transition period even to start like to get a daily routine again".* She intended travelling for the summer, and described how she was intending to apply her learning from the USMP: "*I am going away on a J1 and I will have the little pocket thing (*review card from the USMP) *and I am going to bring that with me … so like ..just like to have as*

reassurance because sometimes you hear of…….. got really loads going on and that kind of like brings you back to the day that you wrote that out". After returning from travelling, Ciara returned for her third year of college, and she re-engaged in Occupational Therapy meetings on four occasions during this academic year. Occupational Therapy meetings over this period focused upon exam preparation, essay writing, and communicating with her department in requesting reasonable accommodations on essay deadlines.

At **12-month follow-up interview (T3)** at the end of her third year, Ciara reported that she was now taking a year out from her studies on medical grounds before doing her final year, and that she had started working which she viewed as positive, as she explained "*well this year I am not attending college, I am working full time so I think the structure of being in the office from half-nine til half-five every day has had a real positive effect on my mental health and things, that routine".* She reported positive engagement in occupation at this time, which focused on the area of exercise: "*I have just started doing Pilates a few times a week and I go to the gym two mornings a week."* Her view of mental health at T3 involved a sense of engagement: "*mental health would be considered as a measure of how able you are to apply yourself to your whatever your role is in life".* Ciara's view of recovery again focused on returning to normal, but also included engaging with a "*programme or whatever or exercise or whatever it is and you kind of build yourself back up"*.

Ciara's expectations for the student role involved finding "*a balance between study and social life but like maintaining good grades".* She disclosed at T3 that she had to repeat her exams at the end of third year and that in terms of her academics "*I was a bit of a disaster"*. After taking the year out at the end of her third year in college, Ciara returned to complete the final year of her degree the following year and graduated that year. Ciara's engagement in college and work externally, was reflected in positive changes on the Global Severity Index (GSI) as outlined in table 5.2 below from T1, to T2, which was then maintained at T3, even though Ciara had decided to take a year out at T3. This positive change was also shown in the Positive Symptoms Total (PST),

but to a lesser degree on the Positive Symptoms Distress Index (PSDI). There was a minimally important difference (MID) on the Mental Composite Score (MCS) from T1, to T2, which increased further at T3. This indicated less frequent psychological distress and less limitations in activities due to emotional problems. However, there was a negative MID Physical Composite Score (PCS) over the three time periods, indicating greater limitations in physical functioning, role participation due to physical problems, and a higher degree of bodily pain or lower level of general health.

Table 5. 2: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices - Ciara

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	49	40	39	-9	-10
Positive Symptoms Total	52	40	38	-12	-14
Positive Symptoms Distress Index	46	43	43	-3	-3

Table 5. 3: Summary of the Composite Scores SF-36v2 Quality of Life Measure - Ciara

	T1	T2	T3	Change T1/T2	Change T1/T3
Physical Composite Score	65.64	59.5	53.17	-6.14	-12.47
Mental Composite Score	21.75	35.93	40.95	14.18	19.2

Student Participant 2: Seán

Seán was an international student completing a PhD who registered with diagnoses of Autism and Depression. He had engaged with medical and psychological supports over a number of years prior to coming to Ireland, and then with the College Psychiatrist and College Counselling Service while enrolled in his course in the Irish HEI.

He met with a Disability Officer for a needs assessment in September of his first year and was referred to the Occupational Therapy Service. However, he only attended twice in that academic year and the next academic year. He withdrew from his PhD at the end of his second year. He returned to the HEI to start his PhD again in the following academic year, and again accessed supports with the Disability Service, completed another needs assessment and was re-referred to the Occupational Therapy Service. He attended on four occasions and focused upon assessment using the Student Profile (Nolan, 2011), and collaborative goals were established focusing upon academic planning and establishing a routine. Based upon these goals, the USMP was introduced to Seán in February of the academic year he recommenced his PhD, and he chose to engage in the research study.

At **T1 interview**, Seán identified walking, engaging in the academic aspects of his PhD, routine, and self-talk as being key elements of managing his health and well-being. He described mental health as "*when you are at peace with yourself mentally then you can live a healthy life"* and recovery for Seán involved "*getting back to the ideal state*". He particularly highlighted a need for him to further develop his ability to recognise signs that he was not engaging in his student role: *"unfortunately sometimes I don't realise until it is too late and that's when we say like all the people who are helping me in this, just have to come into the picture."*

Seán engaged in the USMP from March of his first year of PhD to March of the following year, over the course of 14 meetings. Meetings took place weekly for six weeks, and then he did not engage for a period of three weeks, and then engaged in the USMP again weekly for another two meetings. Over the summer period he engaged monthly, as he returned home, and the Occupational Therapist was on leave. He re-engaged in the USMP in September, either weekly of fortnightly up to the Christmas break. He then continued the USMP from January through to March on four further occasions, completing the programme in March.

At his **T2 interview**, Seán described his extended engagement in the USMP:

"well actually it was over a year because like there were a lot of things coming and going so also like were not related to the programme which kind of helped to discuss them ..however in any case like with some of the things it took longer to complete, also because of delays from my side .. like how upset I was".

However, he viewed having space between meetings positively, as he felt it allowed him to apply learning from the USMP: *"after four weeks basically you have time to test out strategies, then that kind of works better… I was actually trying them out in real life so that was the thing."* Seán's definition of mental health at T2 involved a more active approach to managing oneself: *"being ok with yourself and being able like to approach life properly. That's the thing and it's also like being able to work on things and it is also like being able to realise things."* This perspective was similar to his view of recovery, again focusing upon '*recognising what has happened'* and '*being able to work on it'*.

At **T3 interview**, Seán was now approaching the end of the third year of his PhD. He reflected upon the USMP and engagement with the Occupational Therapist as an opportunity to identify, develop, and refine his self-management strategies over a period of time:

"…the Occupational Therapist's office is like a lab… It's not like coming here, an hour later there your problem is solved. Things obviously like span over a number of days and weeks and those are like tries and so at the end of the day there is so much that can be done".

Seán's view of mental health now focused upon a core idea of balance and accepting times of good mental health and times that were more challenging:

"Mental health actually like means, I use the word balance a lot yes, but it is true it is about the balance it is about like not losing it at the end of the day. And like in the sense of not going off track totally as long as you accept like sometimes things are going to be rough sometimes going to be smooth sometimes."

He described how he applied this in his daily life and routine:

> "*I try like to do something that is going to work every day and relax either like outside of the desk environment, watching movies at home do something relaxing even go for walks and things like that. I admit like it is not a very diversified programme but at least I try to have a bit of everything every day and that like helps to keep the balance".*

He defined recovery as involving ups and downs: "*it's not like lying down and standing up, life doesn't work like that".* At T3, Séan highlighted that the programme had helped as he had developed an increased ability to *"stop and reassess before it is a problem*". He summarised his engagement in the USMP and application of the learning for the year after finishing the programme:

> "*After that you will still be using it so there has to be a period in which lets say the programme grows on the person that's why you have to follow-up, that is where you actually see how the plot is actually growing, plant something in water and leave it there".*

At T1, Seán described his expectations as being to "*finish my PhD. I want to graduate I want to get into academia"*. He described at T2 , that although he was "*still a work in progress",* that engagement in the USMP had helped greatly: "*I am more mindful of things like I am working towards that way and especially like with the main things which I have like to be getting done here like the PhD work and stuff, it's going on track".* He further reflected this at T3, when he described that the USMP had helped him to meet his academic and personal goals:

> "*It's helped me improve a lot definitely both in the academic area and the social area, self-care, meeting people … especially academic people with the PhD so yes I have come a long way I have met and I feel very good about that".*

This positive progress over the course of the research was reflected on the Brief Symptom Inventory as outlined in table 5.4 below, where there was a positive change on the GSI for Séan from T1 to T2 and was maintained at T3. This was also reflected in the PSDI, but although the PST was lower at T2, it returned to almost the same level at T3. On the SF-36v2 (table 5.5), Séan's

Mental Composite Score showed a positive change from T1 to T2 but below the suggested MID threshold of 3 or more T-score points, but it did show a positive MID from T1 to T3. His PCS also showed a MID from T1 to T2, which then fell marginally again at T3. This suggested less frequent psychological distress and less limitations in activities due to emotional or physical problems. After completing the USMP, Séan engaged in Occupational Therapy meetings for a further two and half years. Meetings focused upon meeting academic demands, application of self-management programme and preparation for PhD Submission, viva, and transition to the workplace post-graduation. Following a six-month extension, Séan completed his PhD and graduated.

Table 5. 4: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices - Seán

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	55	49	49	-6	-6
Positive Symptoms Total	57	53	56	-4	-1
Positive Symptoms Distress Index	52	45	43	-7	-9

Table 5. 5: Summary of the Composite Scores SF-36v2 Quality of Life Measure - Seán

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	45.4	54.82	54.33	9.42	8.93
Mental Composite Score	30.1	31.22	41.9	1.12	11.8

Student Participant 3: Conor

Conor was a third year UG student when he participated in the research study. He engaged with the college-based Psychiatrist throughout his college career, where he was diagnosed with a generalised anxiety disorder. Conor accessed supports through the College Disability Service in March of his third year in college and was referred to Occupational Therapy based upon his initial needs assessment meeting. Within the occupational therapy

assessment process using the Student Profile (Nolan, 2011), he identified self-management and managing academic demands as primary areas that he wanted to focus upon. The USMP was introduced to Conor and he started the programme in May of his third year.

At **T1 interview**, Conor identified connection to family and his girlfriend as well as playing music as the main ways that he maintained his health and well-being. He described the importance of this in providing advice and practical support: *"I suppose that I am speaking with my brother who has been through university that can help a lot. Sometimes he can give me advice on that and my girlfriend who is in the university as well sometimes we'll work on things together."* He described that he did not always recognise when he was not engaging well in college and maintaining his health and well-being, and sometimes was '*thrown into disarray'*, when it could be '*hard to get everything to organise yourself back to normal'.* Conor viewed mental health in practical terms, highlighting that it involved *'knowing when to take a break'* and *'being engaged socially'*. He noted his expectations for college at this point as being " to *get a good mark and be able to gather skills that I find I can use outside of college when I'm finished in college"*. He similarly viewed recovery as *"just getting things back in some kind of order".*

Conor engaged in the USMP for two meetings and then the focus of Occupational Therapy meetings switched to his preparation for end-of-year examinations. He engaged in the USMP for a further six meetings after his examinations and completed the programme.

At **T2 interview**, Conor had chosen to go 'off books' (take a year out) on medical grounds, having passed his third year in college. In reflecting upon the USMP, he highlighted developing an increased self-awareness of his occupational engagement: *"definitely a self-awareness of what I'm doing, am I doing too much, am I doing enough".* He felt the process was about *"pinpointing where it's not working"* rather than having a general sense. He felt that the USMP process for him involved "*clarifying my mind, journaling, and then being calmer and sort of balancing the work and getting what I wanted done and not doing too much because I have a tendency to do too*

much or to drag things out to perfection". He explained this process further: *"I liked when you weren't doing the best and then this thing that might help you and then that suited me that I liked that there were things that I picked off myself and then got help with those and yeah I definitely applied".* His view of mental health and recovery at T2 was in line with other reflections upon learning in the USMP, as he described mental health as being: "*sort of aware of how I'm feeling at the time and knowing and then sort of taking proper actions",* and recovery involving taking "*from the list of responses".*

At **T3 interview**, Conor was in the process of returning for the final year of his UG degree. He now described '*keeping busy*' as being very important to him in maintaining his health and well-being: *"I would do cycling a lot now and occasional walking which I wasn't really doing before and then I guess I'm in music, so I do the work".* He was very positive on the impact of the USMP on his engagement in his student role. He described how he used the physical environment of college to a much greater degree to support his learning: *" Before, I would have avoided that all the time and then socially, I guess socially I'm still not perfect but I am much better and I think yeah".* He highlighted an increased sense of planning in how he engaged in his student role: *"I am way more organised I'm going to the library which I never really did before. I'm going with purpose… which is great because I know what to be doing and when to be doing it".* He reflected on developing occupational self-management strategies such as engaging in exercise, playing music, having a timetable, and being more social through engagement in the USMP, and that the process helped him to implement them: *"I would have had an inkling of them you know getting help and sort of solidifying them as ideas and making them more".* He highlighted that recognising when he was not well and responding to this was an important change: *"I'd drive myself to sickness nearly and then, whereas now like it's happened at one point where I got sick and usually like I hadn't missed any days or anything I'd go and if I was in terrible condition and get worse then it was like I realised ok I got to stop".* His view of mental health was now focused upon actively managing himself: *"feeling relaxed making sure that you look after not just your academic side*

but look after everything like sleep and eating and exercise as well. Don't ignore them because it's going to affect your mental health". Recovery for Conor at T3,involved a sense of looking after himself "*knowing when you have got to give yourself a break".*

At his T1 meeting, Conor identified that his expectations for college were to "*get a good mark and be able to gather skills that I find I can use outside of college when I'm finished in college*". At T2, Conor felt "*very happy with the goals I reached"* in terms of personal, academic and social engagement in the student role. At T3, Conor reflected improvement in his participation in his student role: "*I think so much better in both areas like in academically everything is going well… socially I guess socially I'm still not perfect but I am much better".* After **T3 interview**, Conor continued to engage with Occupational Therapy and attended on four occasions over the course of the academic year and he graduated at the end of his final year. The positive development described by Conor through the interviews was reflected on the Brief Symptom Inventory, where his GSI showed a positive change from T-score of 59 at T1 to a T-score of 35 at T2, which was maintained at a T-score of 34 at T3. These trends were also reflected on the MCS on the SF-36v2 where there was a positive MID from 19.69 at T1, to 38.1 at T2, which further increased to 45.82 at T3. The PCS also showed a positive MID from 50.86 to 63.77 at T2, and also a positive MID from T1 to T3. This indicated less frequent psychological distress and less limitations in activities due to emotional or physical problems.

Table 5. 6: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices - Conor

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	59	35	34	-24	-25
Positive Symptoms Total	63	38	36	-25	-27
Positive Symptoms Distress Index	53	33	30	-20	-23

Table 5. 7: Summary of the Composite Scores SF-36v2 Quality of Life Measure - Conor

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	50.86	63.77	60.38	12.91	9.52
Mental Composite Score	19.69	38.1	45.82	18.41	26.13

Student Participant 4: Rebecca

Rebecca was a second year UG student when she participated in the research. She entered college as a mature student and registered for Disability Service supports upon entry to college, disclosing a diagnosis of Bipolar Affective Disorder. She attended the College Psychiatrist throughout her time enrolled in the HEI. She was referred to Occupational Therapy from her needs assessment in October of her first year for support in managing her academic demands. She completed the Student Profile (Nolan, 2011), with collaborative goals established of organisation, managing procrastination, and balancing college and work life. She engaged in thirteen Occupational Therapy meetings between October and March of her first year. Rebecca engaged in Occupational Therapy throughout her second year in college, which focused upon managing academic demands and placement. At the end of her second year, Rebecca and her Occupational Therapist reviewed her Student Profile (Nolan, 2011) and goals established, and she began the USMP, with the aim of establishing new skills and being more active in non-academic occupations in her student role.

At her **T1 interview**, Rebecca identified that she maintained her health and wellbeing by keeping in contact with friends and family, having a routine, being up at the same time each day and engaging in physical activity such as walking. She highlighted isolating herself from others including professional supports, not meeting deadlines or completing work, and being awake at night as signs that she was not managing herself in her student role. Rebecca's views of mental health at T1 focused both on herself but also her connection to others: *"the absence of symptoms I guess but em being in contact with people having a relationship with people and being well both mentally but also*

I suppose physically so it is a combination of being happy in yourself and being active in the parish or community you are living in". Her view of recovery again focused less upon symptoms, but also that she felt she would not have recovered but "*I am not taking medication anymore".* From an occupational perspective, Rebecca at T1 highlighted the unpredictable and changeable nature of her course, which involved a placement element: *"In some ways it's harder (placement) because it's not like five days a week, it's only two days a week whereas in lectures I would almost always be five days a week and I know I have a timetable …. It's a different type of work, it's a different environment so sometimes it is not as predictable I suppose."*

Rebecca engaged in the USMP over a period of five months from May to October in her second year of college. This involved five meetings in total; two after her end-of-year examinations in May and three at the start of the following academic year in September, as she chose not to engage in Occupational Therapy meetings over the summer months out of term.

At **her T2 interview** at the start of her third year, Rebecca highlighted maintaining a routine as key to maintaining her health and well-being, especially when she was on placement, as she described *"get up in the morning, you go up to work at a certain time, and then you are working from a certain time to a certain time, you come home and you kind of you build in things around that, like time to meet up with people or time to do evening classes"*. She highlighted the development of personal awareness of her occupational engagement in the student role through engagement in the USMP: *"it made me aware that if I felt like I was withdrawing from college or not participating as much as I could that there were supports in place that could help me and there were people that I could go to that it just wasn't me on my own"*. Her view of mental health involved a sense of occupational balance, as she described: *"having kind of a balanced life; not having any one thing too much in excess, getting enough sleep, having a good appetite, being socially connected and also making time for yourself though"*. Recovery as at T1, focused upon fewer symptoms but also being *"more socially engaged and being more self-aware".*

At **T3 interview**, Rebecca had chosen to go 'off books' (a year out). She felt that she had not applied the habits and strategies that she had worked on in the programme, but also queried if this was because she was not engaged in the student role at the time, as she noted: *"To be honest not so much really. Perhaps it's because I am not in the student environment like I'm not in college anymore; that doesn't mean probably still that I shouldn't apply these to my life but I have just forgotten about them in a way yeah."* She highlighted that routine was still very important to her in maintaining her health and well-being but that she would like to be engaging in more active occupations such as exercise. She viewed mental health at T3, as a continuum from *'not the greatest mental health'* to "*good mental health is where you end up in a place where you feel well and you can communicate well".* Although she once again defined recovery in terms of not being on medication, her perspective now included *"reaching a point in your life that on your journey where you are stable and you are doing well".*

At T1, Rebecca highlighted expectations for her student role "*to finish my degree and hopefully get good results in my final years"* but also to "*meet new people from different courses and maybe get contacts through networking*". At T2, she reflected positively on the impact of engaging in the USMP, in helping her to meet her personal goals: *"I was very much interested in recovery because it's an area a topic, I am looking into a lot so it kind of helped me in that regard"*. At T3 however, Rebecca had gone off books, having found engagement in her student role difficult to maintain. She returned to college in the next academic year but withdrew from her final year with an Ordinary Degree (conferred on students who have completed three years of their undergraduate degree). Rebecca's scores on the BSI and SF-36v2 mirrored her journey outlined in the interviews where she found engagement in the USMP positive at T2, but that she had found it difficult to maintain her engagement in the student role at T3. On the BSI, positive change was noted at T2 on the GSI, but this was not maintained at T3, although it was slightly below T1. The GSI and PSDI also showed a positive change at T2, post engagement in the USMP, but again this was not

maintained to the same degree at T3. The SF-36v2 scores showed a negative MID on the PCS from T1 to T2 and T1 to T3, and although there was a positive change below the threshold for MID (3 T-score points) on the MCS from T1 to T2, there was a negative MID from T1 to T3, as outlined in table 5.9 below. This indicated more frequent psychological distress and increased impact upon engagement in activities due to emotional or physical problems.

Table 5. 8: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices - Rebecca

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	41	35	40	-6	-1
Positive Symptoms Total	42	35	41	-7	-1
Positive Symptoms Distress Index	41	36	42	-5	+1

Table 5. 9: Summary of the SF-36v2 Composite Scores - Rebecca

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	60.84	56.14	54.89	-4.7	-5.95
Mental Composite Score	45.52	47.04	38	1.52	-7.52

Student Participant 5: David

David was a second year UG student when he participated in the research. He entered college through the Disability Access Route to Education (reduced points scheme in accessing higher education courses) and registered for Disability Supports upon entry to college, disclosing autism, depression, and a hearing impairment. David engaged with the College Psychiatrist throughout his time in college.

David met with a Disability Officer for a needs assessment in September of his first year, and was referred to the Occupational Therapy Service, to provide support in the transition to college, particularly with regards to the social aspects of student life. In his initial Occupational Therapy meetings, he completed the Student Profile (Nolan, 2011), and established goals in leisure engagement and academic demands. He attended ten Occupational Therapy

meetings during his first year in college in addressing these goals. He re-engaged in Occupational Therapy meetings during his second year in college and reviewed the Student Profile (2011). He re-established goals for the Occupational Therapy process and focused on developing a balance between his academic activities and social development. Following discussion with his occupational therapist, he began the USMP in January of his second year, to meet these goals.

At **T1 interview**, David identified attending lectures and tutorials, running, spending time with his friends, as well as spending time with his dogs as ways that he maintained his health and well-being. Routine was important for David in helping him in "finding *a balance and getting stuff done*", and he felt that he had a good routine in terms of getting up and following the lecture schedule. He identified procrastination, particularly looking at things online, as major signs that he was not engaging in his student role. He reported that he could mostly recognise these signs but that *"it can sort of go unnoticed can go by myself".* If he did recognise these signs, he felt that he would "*tend to panic*" and that it would lead to him not getting work done. David saw mental health as: *"how you feel about yourself and it can go from being moderately happy or really enthusiastic with life to having some dark times or getting quite depressed and suicidal".* His view of recovery reflected a recognition of improvement: *"there has been something wrong and it's improving slowly or otherwise"*

David started the USMP in January of his second year and completed the sections over the course of ten meetings up to February of his third year. He initially engaged in the USMP for four meetings over two months with several cancellations, and then switched the focus of his Occupational Therapy meetings to prepare for his end-of-year examinations. He then did not engage with Occupational Therapy meetings as he went home for the summer months. He returned to college in September and engaged in six further meetings, completing the USMP in February. He then came back to review the programme for three meetings in November and December of his fourth year. He reflected that he moved through the programme "*slowly you know*

but we took time at it I guess it was comfortable at the pace we were going at."

At **T2 interview**, He described how occupation supported his engagement within the student role and in maintaining his health and well-being. *"You know what to do if you are feeling low, that sort of thing ... occupation leads to keeping yourself healthy and you know."* He highlighted specific examples of this of going running, healthy eating and maintaining a good routine. His view of mental health at T2 included aspects of self-management *"I would consider it in terms of emotions and feelings negative or positive but also what strategies you can use to look after yourself".* He reflected that the USMP had been positive in developing resources to actively respond: *"I used to have dips at times but I think in terms of having things that you can refer to was very much helpful there" .* Recovery at T2 for David, involved a much more active sense of self-management "*you are attempting to recover from either through occupation … and seeking professional help, or it could just be you know all by yourself"*

At **T3 interview**, he noted several outcomes from engaging in the USMP: *"I think certain aspects of it you know particularly in trying to keep a routine to keep yourself.. you know functioning basically things like basic structure ..keeping on top of the mental health…being aware of when it might strike and who to contact".* He also highlighted the importance of self-awareness: *"be a bit more aware about it you know rather than just sitting on a chair like pretending everything is fine and actually it might not be, actually just be more aware of what's going on….have a bit more perspective maybe".* However, he reflected that he did not feel self-awareness was an issue for him, but how to respond when he was not engaging in student role: *"I think the recognition is not really the problem it is really the acting upon it."* Mental Health for David at T3 involved a sense of active management and awareness "*keeping on top of things making sure you are engaging but also sort of at least in my own experience keeping an eye on things like depression and dark thoughts and recognising that you don't sort of have to be happy and ecstatic all the time".* As with his definition at T2, David viewed recovery in terms of

self-management *"to get back on top of that and recognising where you might be failing and what actually, you are taking that might be hindering your mental health and sort of reverse that".*

At T1, David highlighted his expectations for college as *"participating in lectures, getting the exams passed or essays done on time, hopefully good marks in them, getting a degree".* At T2, David reported that he had found the support helpful in meeting his goals, but that he was not sure whether it was engagement in the USMP or engagement with general Occupational Therapy overall. AT T3, David felt that he had made progress academically, but that with regards to the social aspects of college that *"I probably find a bit more difficult".* David had graduated from his UG degree and was now studying on a PG course. He highlighted that he was trying to apply structure to his role: "*I'm back in college. ..going well ..very few contact hours but in terms of independent learning….go to the library most days and actually making a plan to get up the days before making out the hours I'm going to do that kind of thing".* Although David described increased participation in the student role, his scores on the MCS showed a negative MID from T1 to T2, and although this rose again at T3, still showed a negative MID from the T1 score. This indicated more frequent psychological distress and increased impact on activities due to emotional problems, especially from T1 to T2. His PCS score, however, rose and showed a positive MID from T1 to T2, and again from T1 to T3, indicating less limitations in physical functioning, role participation due to physical problems, and a higher level of reported general health.

David attended Occupational Therapy meetings on nine further occasions after completing the USMP, focusing upon the transition from college to the workplace / further study, connection to career resources and referral to external supports.

Table 5. 10: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices- David

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	48	49	48	+1	0
Positive Symptoms Total	43	50	48	+7	+5
Positive Symptoms Distress Index	55	47	47	-8	-8

Table 5. 11: Summary of the SF-36v2 Composite Scores

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	50.88	57.85	59.86	6.97	8.98
Mental Composite Score	38.26	22.55	32.63	-15.71	-5.63

Student Participant 6: Luke

Luke was a first year UG student when he engaged in the USMP. He entered college through the Disability Access Route to Education scheme, disclosing a diagnosis of depression. He was not engaged with any mental health supports upon entry to college, as he had been discharged from child and adolescent mental health supports.

He accessed supports with the Disability Service in September of his first year and was referred to Occupational Therapy, based upon his initial needs assessment meeting with his Disability Officer, which showed a need for support in the transition to college, particularly with regards to meeting his academic demands. He engaged in three meetings with Occupational Therapy, and completed the Student Profile (Nolan, 2011), establishing collaborative goals of managing anxiety in the social aspects of college and developing a balanced routine. Based upon discussion with his Occupational Therapist, he started the USMP in December of his first year to assist him in meeting these goals.

At **T1 interview**, Luke highlighted that he maintained his health and well-being by jogging at the weekend, walking the dog and *'hanging out with the lads'.*

He reflected that mental health for him involved '*just being able to function normally'.* He felt that his mental health impacted his learning and *'can get in the way of researching certain things, certain topics',* and although he was able to recognise when this was happening, he did not feel he could do anything about this. He viewed recovery simply as "*being able to look after yourself".*

Luke started the USMP in December of his first year in college. He completed the programme over the next five months, involving twelve meetings. He engaged in the programme mostly every two weeks with weekly engagement over short periods of time.

At **T2 interview**, Luke had just finished his end of first year examination. He noted that he was now re-engaging in daily occupations such as housework and self-care, which he had fallen out of the habit of doing while he was focusing upon his exams. He reflected that during the year, these daily occupations were important to him maintaining his health and well-being, in addition to "*having a pretty good kind of structure for the week based around lectures".*, and he described that he would '*wait until I get home when I have time to myself to do things, but I might go for a jog or do some cooking , clean around the house or whatever'.* Mental health for Luke involved "*general well-being really*". He felt the USMP had been useful in *"doing up the list of different forms of the mechanisms and being able I suppose being able to I guess being able to quickly go to them like just reminding myself that sometimes it feels good to cook something or bake something or just go for a jog or whatever like it was yeah it was good".* At T2, his view of recovery incorporated an acceptance that he may always experience some difficulty, as he described it as "*recognising that your difficulties maybe never will fully go away but you can learn to manage them and cope with them or deal with them".*

At **T3 interview** at the end of his second year in college, Luke reflected back upon his transition to college, and found that the increased expectation and need to manage his demands was challenging in the transition from second-level school to college, as he described: *".. it is very much on you and I mean I*

think I prefer that in the long run. I like the more freedom to it but it does mean that the mechanisms you have to take more on potentially and you have to come up with ways of dealing with it." Luke highlighted at T3, that his daily occupations to maintain health and well-being involved more engagement in college, in addition to strategies at home identified previously: *"Staying active in college would be a big one, going back and feeling even if I am feeling tired I just no you just get up and go even if you are a bit late to a lecture, also during the day to see friends and I can do reading in the library just stay active."* Mental health at T3 for Luke involved *"Just general mental well-being keeping on top of it and being able to get on with your life".* He highlighted that engagement in the programme has *"definitely helped in terms of sorting out work, in terms of academic work and like job work and also a bit of socialising and actually getting involved in societies and things like that which is a good way of setting a plan"*. He found that he used strategies he had identified in the USMP such as engaging in societies, cooking, and going for a jog more automatically in his student life in: "*Setting up the day-to-day plan at the end. Yeah I'm at the point now where it's kind of ..it's just worked into my routine naturally, it's not really a conscious effort it's just things I do anyway but I do remember at the start being conscious of".* At T3, his view of recovery still reflected acceptance that he may not be free from the impacts of mental health difficulty, but that one can "*learn to manage them and cope with them or deal with them and you can get back to your fairly normal life".*

Luke highlighted his expectations for the student role as: "*I intend getting more involved in societies, have been trying to get in contact with (student paper)".* At T2*,* with meeting his personal goals, he reported with regards to the impact of engaging in the USMP that *"it is still a bit soon be sure what… I mean it seems it is a good basis for going forward so possibly".* At T3, he reflected that engagement with occupational therapy had supported his participation in college but that he was unsure if this was due to engagement in the USMP or '*general OT sessions'.* Over the course of the three interviews, Luke reported greater participation in the student role. This increased level of engagement in the student role highlighted by Luke was consistent with a

reduction in the scores on the BSI, with the GSI reducing from a T-score of 46 down to 34. This was also reflected by positive changes on the PST and PSDI. On the SF-36v2 this was again reflected on the mental composite score which showed positive MIDs at T1 to T2, and T1 to T3, with the scores rising from 33.89 at T1 to 39.17 at T2 and up to 48.72 at T3. This indicated less frequent psychological distress, and less impact in functioning and role participation due to emotional problems. Luke completed his degree in four years without any time out of his course.

Table 5. 12: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	46	42	35	-4	-11
Positive Symptoms Total	57	48	37	-9	-10
Positive Symptoms Distress Index	35	34	29	-1	-6

Table 5. 13: Summary of the SF-36v2 Composite Scores

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	54.08	49.81	53.75	-4.27	-0.33
Mental Composite Score	33.89	39.17	48.72	5.28	14.83

Student Participant 7: Daniel

Daniel was a third year mature UG student when he participated in the research. He registered with the Disability Service upon entry to college and following his needs assessment meeting, he was referred to the Occupational Therapy Service but chose not to engage at this time. He was re-referred to the Occupational Therapy Service again following contact with his disability officer in January of his first year, for support in managing stress and anxiety, particularly with regards to class tests and presentations. He completed the Student Profile (Nolan, 2011) and established goals of increasing his social engagement in college and public speaking in giving presentations. He engaged on six occasions with the Occupational Therapy Service over the rest

of his first year but cancelled four scheduled meetings in his second year and did not engage again until the end of his second year to focus upon exam preparation. During his initial two years in college, he also attended student counselling.

At the start of his second semester in third year, he re-engaged with the Occupational Therapy Service. He reviewed the Student Profile (Nolan, 2011), and established a goal to be better able to manage the tasks and occupations of student life, especially in balancing home life, social life and academic work. Based upon these goals, he started the USMP in March of his third year.

At **T1 interview**, Daniel identified that he maintained his health and well-being through engagement in exercise, but also that being able to pick up his son from school was particularly meaningful to him. He identified that within college, he was feeling under pressure with workload: "*I am really really bogged down with seminars tutorials and essays and I use my gaps to try and get these things done"*. He felt that the daily activities in the student role were "*stressful, seminars are stressful , tutorials are stressful, presentations are extremely stressful, group meetings and joint presentations they all stress me out really you know but like I'm getting there, It's a work in progress".* The changing demands in the student role was something that Daniel maintained was a difficulty in forming a routine at T1 interview: *"it is hard to fit a routine because my days are different and essays and ...you know every week is different that I can't do something at the same time on the same day. It's just difficult"*. Daniel viewed mental health negatively at T1: *"I do have a problem with that term because I don't really see myself as having a mental health problem … I associate that term mental health like negatively and with a negative stigma and negative stereotype you know".* His viewed recovery as being *'cured',* but that he was still on medication so he did not perceive himself as recovered.

He engaged in the USMP over the remainder of the third year of his course and the first semester of his fourth year, and completed it over the course of twelve meetings, taking eight months. Throughout the programme, meetings were combined with current course demands such as exam preparation,

dissertation, and making presentations. He engaged with Occupational Therapy on three occasions after completing the USMP, focusing upon dissertation submission and transition to postgraduate study.

At **T2 interview**, Daniel had just finished the first semester of his fourth year UG degree. He highlighted how through engagement in the programme, that he was able to establish structure in his life: "*Once I have structure in my life, I don't get panicked, I don't stress. Things that used to really bother me like insomnia, like being awake half the night worrying about things. Once I have that structure ……. you know this management system like ..once I do that my life runs pretty smoothly".* He said that he had developed strategies in the USMP such as breaking down demands to make the student role more manageable: *"I went on to each module and I wrote out every assignment that was due and the dates and I put them in sequence, I would never have done that before".* He reported that exercise had been one of the strategies identified in the programme which he had applied: *"I did actually go to tennis last week with my son and my wife. That's the first time I have done any physical activity"*. Recovery was now reflected as an on-going process as he described that "*it sounds like it is final but it's not".*

At the **T3 interview**, Daniel had completed his course. He was asked if he had applied any of the techniques and strategies from the *USMP* in maintaining his health and wellbeing in his daily student life since finishing the programme. He reported that he very much still applied some of the strategies that he had learned through engaging in the USMP, and he referenced that the *"diary and the planner is something I do today, so I definitely have employed some of the things that the occupational therapist taught me*". At T3, Daniel again spoke about the meaning of routine for him in being able to develop an approach to managing multiple demands, while maintaining his health: *"Again structure is important to me. If I don't have a structure, I get flustered and am stressed and leads to insomnia and disorganisation…structure is a big one."* At T3, Daniel's view of mental health had moved significantly from T1, which had a negative focus to involve more active management: "*Mental Health you have to maintain it and find solutions to those personal problems whatever you*

need". At T3, Daniel's view of recovery involved more active management *"finding the solutions to those individual problems".*

At T1, Daniel said his expectations for college were *"I just want to continue the way I am going and obviously I'm doing something correctly and just to get good results and maybe get an internship this Summer to do with the field that I want to work in eventually"* . At T2, Daniel highlighted the skills he had developed and the overall impact that engagement in the USMP had upon his participation in college and in meeting these expectations: "*To give you an example I have already done three presentations big presentations with lecturers and stuff and just my organisation"*. When asked about his expectations for the future at T3, Daniel reflected upon his completion of his course, and engagement in the USMP : "*My student role is complete, and I have achieved my goals so I'm living proof that the programme works and that somebody that has a mental health difficulty can make it out the other side"*. Through the interviews, Daniel described being much better able to manage his occupations but there was little change in his GSI score, which negatively changed from T1 (1.06), to T2 (1.38), and showed little change from T1 to T3(1.04). However, in terms of QOL, there was a positive MID in the PCS (35.99 at T1 to 50.27 at T2 to 45.33 at T3) and also from T1 to T3 MCS scores (36.13 at T1 to 36.68 T2 to 45.99 at T3). This suggested less limitations in physical functioning and role participation due to physical or emotional problems, and a higher degree of general health.

Table 5. 14: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices – Daniel

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	49	53	49	+4	0
Positive Symptoms Total	50	49	52	-1	+2
Positive Symptoms Distress Index	47	56	43	+9	-7

Table 5. 15: Summary of the SF-36v2 Composite Scores

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	35.99	50.27	45.33	14.28	9.34
Mental Composite Score	36.13	36.68	43.39	0.55	7.26

Student Participant 8: Hannah

Hannah was a one-year PG student at the time of the research. She accessed Disability Supports in February of the academic year, and following her needs assessment meeting, she was referred to the Occupational Therapy Service. She completed the Student Profile (Nolan, 2011) and she identified goals focused upon academic occupations and sleep hygiene. She attended four meetings which focused upon managing her academic demands. In June, following her end-of-year examinations, she reviewed her Student Profile (Nolan, 2011), and re-established goals to focus upon managing her mental health and routine, while completing her dissertation.

At **T1 interview**, Hannah identified swimming and healthy eating as supportive to her health and well-being but that she was finding it hard to engage in both of these at this time, due to difficulty establishing a routine. She reflected that *"I was probably never good at structuring so my routine"*, but that at UG level the increased structure of the course had helped. She identified signs of not engaging in the student role as "*sleeping in too late, not exercising enough or being active enough during the day, not being able to focus enough to do college work so then I get like stressed about that and stuff".* She highlighted that she was working part-time which involved shift work which would change every week, and that she sought "*set times when I was working because then I could obviously plan a regular week or even if it was different days but the same time that would be easier".* Hannah viewed mental health as a *"combination of being productive and the feeling side of it in terms of stress",* and recovery simply as being *'happy'.*

Hannah started the USMP in June, during the final three months of her course when she was working on her dissertation, in response to an identified area of

managing anxiety and skills in managing academic occupations. She engaged in the USMP weekly over the summer period, over the course of twelve meetings.

AT **T2 interview**, Hannah had just submitted her dissertation and completed her year. With regards to routine at present, she felt that *"I just I am still struggling to get into a routine related to college"*. She noted that her work outside of college was having a negative impact upon her health and well-being at this point due to the nature of work routine*: "It's difficult to maintain kind of regular routine because of work at the minute because of shift work they change every week so kind of but I am hoping to try and find a new job with more regular hours".* Mental health to Hannah was simply *"being able to do"*. She highlighted recovery as involving being able to *"maintain a semblance of stability, proper stability like how do you feel and also like in your actual life"*. She highlighted an increased sense of self-awareness *"just try to kind of step back a bit, to see what might be the other causes for feeling like this …could be maybe feeling tired or stressed about something else"* and that the format of the programme has supported this. She reported that the programme *"helped more with linking with other things so I could see how other things were working".*

AT **T3 interview**, Hannah had graduated from her Masters Programme and was now in the workplace for five months. She reported at present, that she was "*trying to maintain a routine going to the Gym",* to maintain her health and well-being. She highlighted the contribution work had made to her routine, which varied at weekends from the working week: *"I suppose so not at very much at weekends but Monday to Friday is a fairly standard routine".* Upon reflection, she reported that the USMP had provided her "*with lots of strategies which I found very helpful but again I am not sure if I used the strategies".* She reported at T3, that she had mixed feelings for the term mental health *"don't think it has much of a personal meaning to me in terms of like it's …like I don't really tend to…like I know I have struggled with mental health issues before".* At T3, she defined recovery as a "*return to normal".*

Hannah's expectations at T1 for her student role were to "*enjoy college and to be engaged and to get good grades"*, noting that this would involve *"having a more engaged social life or a more varied social life, like I would be out with friends. I suppose I would like to be exploring new things and trying different activities".* She felt that the USMP had enabled her participation in college *"maybe a little bit*", and that it had served as a *"back up like support while I was doing academic things*". Hannah completed her one-year Masters while engaging in the research. She highlighted that she had no issues in meeting her academic demands, but struggled in managing the stress that was involved in this, as she noted: . *"I always got things done regardless of how actually stressed I was. So I couldn't say like I ever missed a deadline or anything like that …… so I didn't have a problem with that*". This was reflected in her BSI scores which increased slightly on the GSI. Her QOL on the SF-36v2, fell across most of the domains, with her PCS showing a negative MID from T1 (70.3) to T2 (65.49) and from T1 to T3 (50.76). This suggested greater negative impact in physical functioning, role participation due to physical problems, and a lower degree of general health. Her MCS did show a positive MID from T1 to T2 (19.35, to 24.1 at T2), and from T1 to T3 (23.36), suggesting less impact upon function as a result of emotional concerns and less frequent psychological distress.

Table 5. 16: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices - Hannah

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	46	47	47	+1	+1
Positive Symptoms Total	42	46	42	+4	0
Positive Symptoms Distress Index	54	51	51	-3	-3

Table 5. 17: Summary of the SF-36v2 Composite Scores

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	70.3	65.49	50.76	-4.81	-19.54
Mental Composite Score	19.35	24.1	23.36	4.75	4.01

Student Participant 9: Shauna

Shauna was a final year UG student, who entered college as a mature student. Prior to engaging in the research, Shauna had progressed through first and second year in college, and then took a year out (off books), before returning to complete third and fourth year. She registered with the Disability Service in the January of her final year, for supports and reasonable accommodations with regards to issues related to dyslexia. She was then referred back to her disability officer by her student counsellor the following March, for support around very high levels of anxiety, difficulties with academic writing, time management, and particularly with regards to her final year dissertation. She was subsequently referred to Occupational Therapy from her needs assessment meeting with her Disability Officer.

She attended Occupational Therapy and established goals from completing the Student Profile (Nolan, 2011) of managing deadlines, exam preparation, and communication with her supervisor. She attended Occupational Therapy on five occasions from March to June in meeting these goals. After exams were completed in June, Shauna and her therapist reviewed her goals for the Occupational Therapy process and these were revised to focus upon procrastination and looking after herself while completing her dissertation, which she had deferred to the end of August. In meeting these goals, the USMP was introduced to her by her occupational therapist and started at their next meeting.

At **T1 interview**, Shauna identified reading, gardening, interacting with people, and college work as occupations that she engaged in that supported her health and well-being. She highlighted stress both related to her college work and external part-time job as a major issue, claiming that *"I don't*

manage it at all". She found that not completing work on time had a major impact upon her health and well-being, and that this was a regular pattern through her first three years in college, with missed deadlines, deferred work and very high levels of anxiety associated with this. In identifying signs that she was not engaging, procrastination and feeling unsure of herself were the main areas that she was aware of. She felt that she *"really wouldn't know what to do you know the way the only thing is what helps is one at the time, that I have latitude to not engage .. so the panic sets in and it works or it doesn't so"*. She felt that she had a routine in her work external to college, but not with regards to her college work, and that this led to difficulty in balancing the two roles. Mental health for Shauna involved: "*kind of balance that you can cope with things that you can manage things ok that you are kind of not driven to the edge of something …. I suppose you can cope because things are more balanced"*. She saw recovery as coming back from difficulty experienced.

Shauna engaged in the USMP over the course of five months (10 meetings). She met weekly with her therapist for the initial three meetings in the USMP, which focused upon the Section One of the programme, in combination with support for her dissertation within each meeting. She then did not engage in Occupational Therapy meetings for the month of August while focusing upon submitting her dissertation. She re-engaged in the USMP in September and continued through Section 2 of the programme over the next three meetings. She completed the remaining sections weekly over the following month, while she was awaiting results to allow her to graduate.

At **T2 interview**, Shauna felt that the USMP had been effective in a number of ways *"I definitely think so yeah I'm just sorry that I didn't have the programme earlier on … I think I would have found it easier to manage the course and got a lot more out of it than just getting through it so I think I would have been a bit more strategic around it"*. She highlighted the focus that she now placed upon balance in her routine, and that rather than completing notes and other work at home in the evenings, that she tried to keep this in college, describing: *"I force myself I finish before five just to do notes before I go*

home". Having a routine allowed Shauna to self-monitor her engagement: "*I have a very kind of structured routine where I have to admit my failings".* At **T2 interview**, Shauna's view of mental health incorporated a stronger connection to physical health, but also the sense of control of her life, as she described: *"mental health means I suppose well-being also physical health how you feel about yourself so I think it is very much I suppose being in charge, about taking responsibility for your life".*

At T2, she saw recovery as experiencing *"a bad patch and getting through it and having a very positive outcome".* Through the programme she reflected upon her current balance between work and study, as she described:

> *"I don't think my work contributes to my health and well-being…. If I had a bad day that would re-enforce about how I feel about myself so I can't be that reliant on having a good or a bad day. I'm thinking the end result is I probably won't … will probably be more focused in changing jobs".*

At **T3 interview**, Shauna had returned to work post-graduation. She felt that she was managing herself in this role at present. She had a routine at this point, but that it was not the routine that she wanted. She wanted to increase her occupational engagement, highlighting that she wanted to go for more walks but that she was both mentally and physically tired from her work day. She felt the main benefit of the USMP was in managing herself in submitting her dissertation. Mental Health to Shauna at T3 involved "*recognising how you feel",* and what may be causing this. She described being on the road to recovery at T3, describing it as "*using the programme I am a completely different person".*

In her interviews, Shauna reflected a journey from feeling that she could not manage her mental health in the student role, to feeling an increased sense of self-awareness and active control in managing her mental health. Her expectation for the remainder of her course at T1 was: *"to get a 2:1 if I can, and to finish my dissertation. It's in the balance now. I don't know if that is a realistic expectation but that is what I would hope for you know*". Her

expectations at T2 reflected a change from an academic focus to exploring potential options: *"Well I suppose my expectations would be to be to use really some of the skills I have gained over the last four years, and to be ok and try to figure out to do something different with them".* In terms of participation in college at T2, she felt that although she didn't have issues completing work, that a change from before engaging in the USMP was that she now found it "*very easy to speak out more now and to be particular in what I have to say so I'm not as fearful as I might have been before"*. At T3, she was reflecting positively on her self-awareness but was still frustrated by the impact of her work upon her well-being . This was reflected on her BSI, where the GSI increased slightly from T1 to T2 but then decreased T3. On the SF-36v2, there was missing data at T2 but a large positive MID from T1 to T3 on the MCS from 32.42 to 50.94 was noted, with a drop on the PCS from 55.6 to 53.63. This indicated less functional limitations and role impairment as a result of emotional concerns and less frequent psychological distress.

Table 5. 18: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices – Shauna

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	50	51	43	+1	-7
Positive Symptoms Total	48	54	49	+6	+1
Positive Symptoms Distress Index	51	48	36	-3	-5

Table 5. 19: Summary of the SF-36v2 Composite Scores - Shauna

	T1	T2	T3	Change T1/T2	Change T1/T3
Physical Composite Score	55.6		53.62		-1.98
Mental Composite Score	32.42		50.94		18.52

Student Participant 10: Sophie

Sophie was a postgraduate student studying a one-year Masters when she engaged in the USMP. She accessed Disability Supports with diagnoses of Dyslexia, Epilepsy and Depression. Following her needs assessment meeting with her Disability Officer, she engaged primarily in assistive technology supports over the initial months of her college year. She was then referred to Occupational Therapy at the end of March for support in goal-setting and strategies around anxiety / stress and to provide academic support particularly on essay structure. In Occupational Therapy assessment (Nolan, 2011), she identified goals of managing academic demands, managing anxiety, improving confidence and communication skills, and developing a more balanced routine. She engaged in six Occupational Therapy meetings between March and June in the academic year, focusing upon academic demands. Following her end of year examinations, Sophie reviewed her goals with her Occupational Therapist, and they discussed engaging in the USMP over the summer months, to focus upon managing anxiety and establishing a balanced routine.

AT **T1 interview**, Sophie identified Pilates, volunteering at a mental health organisation, as well as working part-time as occupations that contributed to her health and well-being. She highlighted that she is very organised and often has '*time management sheets'* made out each morning, but that she struggled to apply this and get into the work. She noted that the level of support at postgraduate study was much different to undergraduate, and that she felt isolated in trying to engage in her work. She did however highlight social contact with other students as very important, although she did not connect with them as much as she would like to: " I *do think it is very important to engage … they may be in a similar situation ….now like you know I suppose none of them are registered with disability, so I do feel they are probably at an advantage*". She reflected being very aware of when she was not engaging in her student role: "*I am very much aware of it and it's terrible it's very frustrating".* She reported doubts about her academic work as being a significant barrier to maintaining a connection with her student role, and

noted the disconnect with her course: *"That is very difficult with that in the back of my head, is this wrong, is this right, I do think it would be a lot more helpful if I had better engagement with the department*". She described that her routine was great in theory and reflected that she was "*usually always on top of everything",* but she felt that currently it was *"not working as well as I want*". Sophie's view of mental health focused upon the impact that mental health difficulties can have, as she described it as "*people experiencing depression, anxiety and also stress … I suppose mental health affects your physical health very much as well .. like I feel it is a kind of a disability, it holds people back from I suppose living life to the full*". Recovery for Sophie involved *"getting your life sorted".*

Sophie engaged in the USMP over the course of eight meetings, over a period of 3 months in the final three months from June to August of her academic year. She engaged in meetings in every two weeks over the period of engagement, with meetings combining the USMP with a focus upon completing her dissertation

At **T2 interview**, Sophie had submitted her dissertation and was awaiting her results. She reflected upon the challenge of postgraduate study, but also how she applied the USMP in this context: "*It's not like an undergrad, you know it's up to you as a person to kind of deal with it on your own and I think that is why it is so important to have the programme."* She viewed engagement in work as very meaningful to her and that it contributed to her health: *"I am very motivated like even I had an interview for a job on Tuesday in the Civil Service and I found out that I was successful. It's temporary like but still …I do my voluntary work in Aware. I do part-time casual work as a waitress which is kind of tough like but I'm very much dedicated to."* She reflected very positively upon her engagement in the USMP, as she described: "*within my own personal life I was more aware because I was amazed by the questions that were there in front of me because as I was just saying like they really were relevant to me even in my own personal life; work wise just I felt that the programme was helping just coping"*. She highlighted the format of the USMP is facilitating her self-awareness: "*we can be experiencing all these things and*

we don't really ..we probably just ignore it like you know whereas when it is there on a page in front of you it makes a lot of sense and you are aware of what is going on around you". In her view of mental health, Sophie again reflected that it involved '*issues around depression and anxiety",* but also that it was important for people to: "*have awareness and be educating themselves about Mental Health".*

At T3, Sophie had graduated from college and had now been working for nearly a year, but reported being very stressed as it was '*a very demanding role"*, with high levels of overtime. She highlighted that she would like to be engaging in more health promoting occupations but this was not possible at present: *"No I don't have time. I should definitely be doing Pilates ..you know that really helps because just physical health overall as well has been you know…no I don't feel a hundred percent healthy at the moment but it is probably because it's the routine at the moment like. It's not really a routine it's work work work".* At T3, she viewed recovery in active terms as *"putting into place or keep in place the supports that you have received so for example with the Unilink self- management programme"*

At T1, she highlighted her motivation for the course was to achieve an education as she was only diagnosed with dyslexia after completing her undergraduate degree and felt this had a significant impact: *"I went through education without any help and then yeah I suppose it is a priority of mine. It's doing the best at education because it is something I have always struggled with you know so yeah*." After the USMP, she described how she now participated in college, with the focus remaining upon the academic aspects of her student role: "*Yeah it did like I mean in certain parts I wasn't great and maybe like keeping in contact with the girls in my course …… I spend a lot of time in the library and things like that I suppose I was just focussing on my self-worth and grades and it was so helpful just to discuss"*. At T3, her expectations were now shifting in the transition to employment: *"to get on my feet get my life together and basically career wise get a job a career that I want to be involved in".* At T3, Sophie reflected back on the USMP as being key to completing her Masters: *"I feel if I didn't have this programme like I*

wouldn't have coped like you know I wouldn't have been productive, I wouldn't have been able to do it". This was reflected in Sophie's MCS, which showed a large positive MID from T1 to T3. Her PCS increase slightly from T1 to T2 but fell again to T3, although this was slightly up on her T1 score. On the BSI, Sophie's GSI increased from T1 to T2, but then fell again to the original score at T3. The PSDI also reflected this trend of increasing from T1 to T2, but then dropping again at T3. The PST showed a positive trend of reducing scores across the three time points. This indicated less functional limitations and role impairment as a result of emotional concerns and less frequent psychological distress.

Table 5. 20: BSI Results: T-Scores Based on Adult Outpatient Psychiatric Norms for the Three Global Indices

	T1	T2	T3	T1/T2	T1/T3
Global Severity Index	62	67	62	+5	0
Positive Symptoms Total	65	63	60	-2	-5
Positive Symptoms Distress Index	55	65	59	10	4

Table 5. 21: Summary of the SF-36v2 Composite Scores

	T1	T2	T3	T1/T2	T1/T3
Physical Composite Score	40.02	43.84	41.07	3.82	1.05
Mental Composite Score	23.54	23.51	36.4	-0.03	12.86

5.5. Cross Case Analysis of the Ten Cases Studies

In this section, the ten case studies will be examined in relation to three of the research questions established that are addressed in this chapter.

5.5.1 Role Impairment

This section presents themes related to Research Question One: "Do college students with mental health conditions experience significant role-impairment?" Through the thematic analysis (Braun and Clark, 2006), four themes were identified 'Issues with Progression', 'Issues with Academic

Engagement', 'Issues with Social Engagement', and 'Difficulty Forming a Routine'. Table 5.22 below gives an overview of the students who identified issues with each theme.

Table 5. 22: Cross Case Analysis from the Ten Case Studies related to Research Question One

	Issues with Progression	**Issues with Academic Engagement**	**Issues with Social Engagement**	**Difficulty forming a Routine**
Ciara	X	X	X	X
Sean	X	X	X	X
Conor	X	X	X	
Rebecca	X	X	X	
David		X	X	X
Luke		X	X	X
Daniel		X	X	X
Hannah		X	X	X
Shauna	X	X		X
Sophie		X	X	X

5.5.1.1 Issues with Progression

Students' mental health impacted upon their progression through college with five of the students (Ciara, Seán, Conor, Rebecca, and Shauna) taking one year or more 'off books' for medical reasons during their student journey. For undergraduate students this tended to be later in their course with Ciara, Conor and Rebecca all going 'off books' after three years and Shauna going off books after two years of her course. Seán extended his PhD by six months, but he had previously registered for his PhD which he had withdrawn from after two years.

5.5.1.2 Issues with Academic Engagement

All ten students highlighted occupational performance issues related to academic activities in the student role. These were often the reason that

students were referred to the Occupational Therapy Service from the needs assessment meeting with their Disability Officer. All but two students (Rebecca and Shauna) identified academic concerns as part of the Occupational Therapy assessment process. Students identified occupation-focused goals related to academic planning and meeting deadlines, attending class, academic writing and giving presentations. Students often connected their mental health with engagement in academic occupations, with five students identifying specific concerns related to their mental health in pre-programme interviews, mostly with regards to managing stress and anxiety in completing demands and engagement in academic occupations.

5.5.1.3 Issues with Social Engagement

Nine of the students identified issues with regards to social engagement as part of the student role. Some students identified this during the needs assessment process; some highlighted issues as part of the Occupational Therapy assessment process, while others highlighted social issues in the pre-programme interviews. Social occupations and social connection were highly valued by students, with four students highlighting expectations at T1 for the student role that involved increased social connection. Students also highlighted social connection as a key aspect in defining mental health at T1 interview, and four students identified engagement in social occupations or finding a balance between social and academic occupations as a goal for the Occupational Therapy process, which led to engagement in the USMP.

5.5.1.4 Difficulty Forming a Routine

Eight students identified difficulties in forming and maintaining a routine in college, describing difficulties in balancing activities in their student role, managing changing routines and timetables, and knowing when to switch off and stop working. This appeared to be more of an issue for postgraduate students and students completing self-directed assignments such as dissertations. Students also highlighted difficulty in balancing academic activities with paid employment outside of college as well as home life. Eight of the ten students identified goals for the Occupational Therapy process

which focused upon routine formation or occupational balance, which again led to engagement in the USMP.

5.5.1.5. Levels of Psychological Distress on the Brief Symptom Inventory (Derogatis, 1993)

The Brief Symptom Inventory (Derogatis, 1993) was used within this study as a method of measuring symptom increase or reduction in reported psychological distress before and after engagement in the USMP, and at twelve month follow-up. However, the BSI has also been used in a variety of clinical settings, not as an outcome measure but also as a mental health screening tool (Derogatis, 1993). The ten case studies outlined above have focused upon the three indices of global distress (Global Severity Index - GSI), Positive Symptom Distress Index - PSDI, and Positive Symptom Total - PST), which are recommended as the most sensitive measure to reflect change across three points of time. Table 5.23 below compares the raw scores for the 10 students in the case studies at T1 (pre-programme) with normative data provided in the BSI manual for Adult Psychiatric Outpatient, and for Adult Non-Patient. This shows that the raw scores for the ten student case studies on the Global Severity Index (GSI) are in line with the normative data for the 'Adult Psychiatric Outpatient', supporting the use of this normative data to calculate T-scores for the case studies above.

Table 5. 23: Comparison of the BSI Raw Mean Scores of the 10 Student Cases with the Normative Data from BSI manual for Adult Psychiatric Outpatient and

for Adult Non-Patient.

	10 Student Cases	Adult Psychiatric Outpatient	Adult Non-Patient
Somatization	0.88	0.83	0.29
Obsessive-Compulsive	2.33	1.57	0.43
Interpersonal Sensitivity	2	1.58	0.32
Depression	1.75	1.8	0.28
Anxiety	1.43	1.7	0.35
Hostility	0.99	1.16	0.35
Phobic Anxiety	0.6	0.86	0.17
Paranoid Ideation	0.66	1.14	0.34
Psychoticism	1.04	1.19	0.15
Global Severity Index	1.18	1.32	0.3
Positive Symptoms Total	33.4	30.8	11.45
Positive Symptoms Distress Index	2.05	2.14	1.29

5.5.1.6 Quality of Life on the SF-36v2 (Ware et al., 2007)

In terms of Quality of Life reported on the SF-36v2 at T1 (pre-engagement in the USMP), the mean T-scores based upon US population data used in the online scoring software are outlined in Table 5.24 below. Six of the domains (Role Physical, General Health, Vitality, Social Functioning, Role Emotional, Mental Health) fall outside of the average range (T-score between 45-55), with four areas falling well below the average range (Vitality, Social Functioning, Role Emotional and Mental Health). With regards to the composite scores, there is a marked difference between the Physical Composite Score which falls within the average range, and the Mental Composite Score which falls well below the average range. Although there is individual variance, this as a group suggested that the students were functionally impacted as a result of emotional concerns and experiencing frequent psychological distress.

Table 5. 24: Mean T-Scores for the 10 Student Case Studies on the SF-36v2 at T1 (Pre-Engagement)

Domain / Composite Score	Mean of the 10 case studies
Physical Function	49.12
Role Physical	43.68
Bodily Pain	51.11
General Health	44.67
Vitality	39.23
Social Functioning	37.79
Role Emotional	30.40
Mental Health	36.48
Physical Composite Score	52.96
Mental Composite Score	30.07

5.5.2 Understanding of Mental Health, Recovery and Occupation

This section presents the themes related to Research Question Two "Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?" Four themes were identified as outlined in table 5.25 below.

Table 5. 25: Cross Case Analysis from the Ten Case Studies related to Research Question Two

	Recognising How I am Feeling	Awareness of What I am Doing	Change in Views of Mental Health	Change in Views of Recovery
Ciara	X	X		
Sean		X	X	X
Conor	X	X	X	X
Rebecca		X	X	
David	X	X	X	X
Luke		X		X
Daniel			X	X
Hannah	X	X	X	
Shauna	X	X	X	X
Sophie	X		X	X

5.5.2.1 Recognising How I am Feeling

Six of the students highlighted developing an increased recognition of how they were feeling from engagement in the programme (Conor, Hannah, Ciara, David, Sophie, Shauna). For Hannah and Ciara, this involved connecting how they were feeling with what was happening in their life or *'triggers'*, and they felt the programme had supported them in establishing these links, as Ciara noted " I think when *triggers happened again then I'd be more aware of what it means and stuff".* Hannah further described an increased ability to *"kind of step back a bit, to see what might be the other causes for feeling like this".* David felt that engagement in the USMP had enabled him to *"be a bit more aware about it you know rather than just sitting on a chair like pretending everything is fine".* Sophie highlighted the positives of engaging in the programme for her in developing her personal awareness "*we can be experiencing all these things and we don't really ..we probably just ignore it".* Shauna highlighted an increasing awareness of her mental health, but expressed frustration at an increasing understanding that her paid

employment outside of college was having a negative impact upon her mental health.

5.5.2.2 Awareness of What I am Doing

Students identified developing increased personal awareness not just at an emotional level, but at an occupational level, with eight of the students referring to how the USMP had facilitated an increased self-awareness related to how they engaged in their daily occupations. This involved an increased understanding of what they engaged in, if this was health promoting, and to what level they were engaging in different occupations.

Students recognised the importance of occupation in maintaining their health (David, Seán, Luke, Ciara), as clearly described by David: *"You know what to do if you are feeling low, that sort of thing ... occupation leads to keeping yourself healthy and you know."* Seán described being more mindful of the "*main things which I have like to be getting done"* in his daily student life. For Luke, it was engagement in daily occupations such as exercise or baking and he felt that the USMP allowed him to quickly remind himself *"that sometimes it feels good to cook something or bake something or just go for a jog or whatever".*

This personal awareness also involved recognising the signs of non-engagement in the student role. Conor described how he had developed an increased awareness of how he was engaging in daily occupations from the USMP, especially in *"pinpointing where it's not working"*. Shauna maintained that having a routine allowed her to self-monitor her engagement through a *"structured routine where I have to admit my failings"*. Rebecca felt her engagement in the programme made her more aware of when she was "*withdrawing from college or not participating"* in her student role.

Students also highlighted an increased awareness of the importance of a balance of occupations in their student life. Conor described his understanding of this which he attributed to engaging in the USMP: "*what I'm doing, am I doing too much, am I doing enough".* Several other students at T2 and T3 (Seán, Rebecca, Hannah) defined their mental health in terms of

balance. This involved establishing a balance of occupations between academics, social connection, time for oneself and self-care tasks. Seán viewed balance of occupations as key to his mental health and engagement in the student role: *"things might not go the way you want them to but it's about ok in general making sure you have the right balance of everything"* Rebecca showed a change in views of mental health from a medical perspective '*the absence of symptoms*', to a functional viewpoint involving balance *"having kind of a balanced life; not having any one thing too much in excess*".

5.5.2.3 Change in Views of Mental Health

Students were asked what mental health meant to them at T1, T2 and T3. Students' views of mental health changed over the course of the interviews. At T1, students defined mental health in different ways. Four students (Rebecca, Hannah, Sophie, David) related this to mental health difficulty and the impacts of this, describing diagnoses and symptoms. Six students (Rebecca, Conor, Hannah, Ciara, Luke, Shauna) viewed mental health in functional terms, in being able to engage in daily academic, social and other occupations, with two students viewing mental health as being able to find a balance of these occupations. Two students (Seán, David) described mental health as being how you felt about yourself.

Many of the students' views changed from before engaging in the USMP to post-engagement and follow-up, with six of the students' views (Sean, Conor, David, Daniel, Shauna and Sophie) describing an increased sense of active management and awareness at T2 and T3. Students described '*taking responsibility'* and '*being in charge'* (Shauna), *'being able to work on things'* (Seán) and developing *'strategies you can use'* (David) to look after oneself, while Conor described it as *'being aware'* and *'taking proper actions'.* For Sophie mental health involved "*how to cope and how to put coping mechanisms in".*

While two students described mental health as finding a balance in life at T1, three additional students (Rebecca, Seán and Hannah) viewed mental health in these terms at T2 and T3. Ciara viewed mental health from a functional

perspective at all three points, as achieving what she wanted to do and engaging in daily activities. Luke's views of mental health remained consistent across interviews focusing upon general well-being and being *'able to function normally'.*

5.5.2.4 Change in Views of Recovery

Students at T1 were asked what recovery meant to them. Many of the students (Conor, Sophie, Ciara, Seán, David and Shauna), viewed recovery as getting back to normal functioning, getting over some difficulty, as David described *"something wrong and it's improving".* Rebecca and Daniel viewed recovery as *"not taking medication anymore".* Luke viewed recovery as *"just being able to look after yourself",* and Hannah's definition was *'to be happy'.*

The meaning of recovery for several of the students changed in line with the change in their perspectives of mental health from T1 to post-engagement in the USMP. Seven of the students (Conor, Daniel, Sophie, Seán, David, Luke and Shauna) described a change in their perspective of recovery as involving more active self-management in *"being aware of 'ok things aren't going great at the moment and take from the list of responses" (Conor),* "*finding the solutions to those individual problems" (Daniel), "realising what happened … and being able to work on that" (*Sean) and *"putting into place or keep in place the supports that you have received"(Sophie).* David described a view that " *you are attempting to recover through occupation"* or by engaging with *"professional help"* . Shauna maintained that she was on the road to recovery *"by using the programme I am a completely different person".*

Students views at T2 and T3 reflected recovery as an on-going process. Daniel's view of recovery changed from focusing upon being '*cured'* at T1, to describing himself as a *"work in progress*" and that recovery "*sounds like it is final but it's not".* Luke also reflected a change in perspective from recovery meaning a "*return to normal"* at T1, to recognising that '*difficulties may never go away*', and that it involved *"cope with them or deal with them".* This change was similar with Seán's as his view changed from a "*return to an ideal state"* at T1 to a view that recovery was not a linear process of improvement: "*it's not like lying down and standing up, life doesn't work like that".* Rebecca

at T1 focused upon less symptoms and not being on medication, and although at T2 and T3, she still sought to not be on medication, she now viewed it as *"reaching a point in your life that on your journey where you are stable and you are doing well you".* For Hannah and Ciara, their views of recovery remained consistent throughout the phases of the research and focused upon getting *"back to your normal self."*

5.5.3 Managing My Occupations

This section presents the themes related to Research Question Three: "Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme? Four themes were identified 'Identifying new occupations', 'Learning new strategies to support engagement', 'Feeling able to respond' and 'Meeting Expectations'. Table 5.26 also reflects other sources of data that complemented these themes; positive changes in quality of life, psychological symptoms, and course completion data.

Table 5. 26: Cross Case Analysis of the Ten Case Studies related to Research Question Three

	Identifying New Occupations	Learning new Strategies to Support Engagement	Feeling Able to Respond	Meeting Expectations	Positive Change in Quality of Life T1/T3	Positive Change in Psychological Symptoms T1/T3	Course Completion
Ciara	X	X	X		X	X	X
Sean	X	X	X	X	X	X	X
Conor	X	X	X	X	X	X	X
Rebecca	X					X	
David	X	X	X	X			X
Luke	X	X	X	X	X	X	X
Daniel	X	X		X	X	X	X
Hannah	X	X			X	X	X
Shauna	X	X		X	X	X	X
Sophie		X	X	X	X		X

5.5.3.1 Identifying New Occupations

All of the students apart from Shauna described occupations that they had identified and engaged in to maintain their health and well-being such as engaging in exercise, mindfulness, baking, completing academic work, watching movies, going for walks, engaging in societies and connecting with

friends and family. Exercise of different types ranging from going to the gym to going for walks or jogs was a primary occupation that students identified and engaged in following the programme, with seven of the ten students referring to it. Four students specifically identified engaging in and completing academic work as positive for their health and well-being. Four of the ten students identified increased engagement in social occupations as an outcome of the USMP.

A number of students (Sophie, Rebecca, Ciara) thought that part-time paid and unpaid work external to college was supportive in maintaining health and well-being as it provided alternative engagement to academic work, structure and social connection. However, at T3, Sophie was now working full time and felt that her work did not allow her to engage in health promoting occupations and that it was *'work, work, work'.* Hannah and Shauna, however, found that work had a negative impact upon their health and well-being, through stress and an inability to form a routine.

5.5.3.2 Learning New Strategies to Support Engagement

All of the students, apart from Rebecca, described strategies that they had learned and applied through the USMP to maintain their health and well-being and engage in their student role. Students described developing occupation-focused strategies with the support of the occupational therapist in the USMP, to enable engagement in these occupations such as breaking down tasks, establishing plans for academic work, using college environments such as the library, connecting with supports and scheduling time for social contact and leisure engagement. Seán viewed this as a process of trial and error supported by the occupational therapist and programme, seeing the occupational therapist's office as a *'lab'* to develop strategies to implement between meetings. Two students (Luke, David), noted that they were not sure if they had developed these strategies through engagement in the USMP or '*general'* Occupational Therapy meetings within the service, which were not part of the USMP.

Students placed a specific value upon being able to structure their time and to plan their tasks. Seven of the students highlighted the importance of routine,

and that the ability to form a healthy, balanced routine was a key outcome from their engagement in the USMP. Routine was something that students tried to implement when there was limited structure within their student lives and this was highlighted especially within postgraduate study by Seán, Shauna and Sophie. Students in general (Sophie, Shauna., Rebecca, Ciara) found that paid employment made it easier to establish a routine. Hannah, however, found the nature of her shift work made balancing college and work very difficult to manage.

At the T3 interview, several of the students (Daniel, Sean, David, Luke, Conor) maintained that they still applied strategies learned within the USMP a year after completing the programme. Hannah and Rebecca, however, at T3 felt that they were not applying the strategies. Hannah described that her changeable and busy work routine did not allow her to engage in health promoting occupations at that time. Rebecca queried if she was not applying some of the strategies, because she was no longer in college and engaged in the student role.

5.5.3.3 Feeling able to respond

Six of the students (Seán, Conor, Luke, Sophie, David, Ciara) highlighted that they had developed an increased ability to respond effectively to signs of difficulty or non-engagement. They reflected on this as Conor described '*taking proper actions'*. Several students referred to the work done through the USMP in establishing strategies and the importance of having the lists of strategies to refer to moving forward (David, Ciara, Seán, Luke).

5.5.3.4 Changes in Quality of Life on the SF-36v2 (Ware et al., 2007)

The scores of the SF-36v2 also reflected outcomes in students of being able to manage their mental health and engage in the student role. On the Mental Composite Score, five of the students showed a positive minimally important difference (MID) of 3 or more T-score points from T1 to T2 on the MCS. However, this increased to eight of the ten students showing a positive MID from T1 to T3 (Table 5.27). This indicates that 50% of students reported less frequent psychological distress and less functional limitations in activities due

to emotional problems, with this rising to 80% of students reporting this improvement from T1 to T3.

Table 5. 27: Summary of Change on the Mental Composite Score of the SF-36v2

MCS	**T1**	**T2**	**T3**	**T1/T2**	**T1/T3**	**Positive change of 3 T-score points T1/T2**	**Positive change of 3 T-score points T1/T3**
Ciara	21.75	35.93	40.95	14.18	19.2	Yes	Yes
Sean	30.1	31.22	41.9	1.12	11.8	No	Yes
Conor	19.69	38.1	45.82	18.41	26.13	Yes	Yes
Rebecca	45.52	47.04	38	1.52	-7.52	No	No
David	38.26	22.55	32.63	-15.71	-5.63	No	No
Luke	33.89	39.17	48.72	5.28	14.83	Yes	Yes
Daniel	36.13	36.68	43.39	0.55	7.26	No	Yes
Hannah	19.35	24.1	23.36	4.75	4.01	Yes	Yes
Shauna	32.42	N/A	50.94	N/A	18.52	N/A	Yes
Sophie	23.54	23.51	36.4	-0.03	12.86	Yes	Yes

On the Physical Composite Score (PCS), five of the students showed a positive minimally important difference (MID) of 2 or more T-score points from T1 to T2. Four of these students showed this positive MID from T1 to T3 (Table 5.28). This indicates that 50% of the students reported less limitations in physical functioning, role participation due to physical problems, and a higher degree of bodily pain or lower level of general health from T1 to T2, with 40% of students indicating this from T1 to T3.

Table 5. 28: Summary of Change on the Physical Composite Score of the SF-36v2

PCS	T1	T2	T3	T1/T2	T1/T3	Positive change of 2 T-score points T1/t2	Positive change of 2 T-score points T1/T3
Ciara	65.64	59.5	53.17	-6.14	-12.47	No	No
Sean	45.4	54.82	54.33	9.42	8.93	Yes	yes
Conor	50.86	63.77	60.38	12.91	9.52	Yes	yes
Rebecca	60.84	56.14	54.89	-4.7	-5.95	No	no
David	50.88	57.85	59.86	6.97	8.98	Yes	yes
Luke	54.08	49.81	53.75	-4.27	-0.33	No	no
Daniel	35.99	50.27	45.33	14.28	9.34	Yes	yes
Hannah	70.3	65.49	50.76	-4.81	-19.54	No	no
Shauna	55.6		53.62		-1.98	n/a	no
Sophie	40.02	43.84	41.07	3.82	1.05	Yes	no

5.5.3.5 Changes in Psychological Symptomatology on the Brief Symptom Inventory (Derogatis, 1993)

On the BSI, as outlined in table 5.29 below, five of the ten students showed a positive change on the GSI from T1 to T2 (reducing scores), with this increasing to six students from T1 to T3. Seven of the ten students showed a positive change on the PST from T1 to T2, and also from T1 to T3 (Table 5.30). Nine of the ten students showed a positive change from T1 to T2 on the PSDI, with eight students showing a positive change from T1 to T3. (Table 5.31).

Table 5. 29: Summary of Change on the Global Severity Index of the Brief Symptom Inventory

GSI	T1	T2	T3	T1/T2	T1/T3	Positive change T1/T2	Positive Change T1/T3
Ciara	49	40	39	-9	-10	Yes	yes
Sean	55	49	49	-6	-6	Yes	yes
Conor	59	35	34	-24	-25	Yes	yes
Rebecca	41	35	40	-6	-1	Yes	yes
David	48	49	48	1	0	No	no
Luke	46	42	35	-4	-11	Yes	yes
Daniel	49	53	49	4	0	No	no
Hannah	46	47	47	1	1	No	no
Shauna	50	51	43	1	-7	No	yes
Sophie	62	67	62	5	0	No	no

Table 5. 30: Summary of Change on the Positive Symptom Total of the Brief Symptom Inventory

PST	T1	T2	T3	T1/T2	T1/T3	Positive change T1/T2	Positive Change T1/T3
Ciara	52	40	38	-12	-14	Yes	Yes
Sean	57	53	56	-4	-1	Yes	Yes
Conor	63	38	36	-25	-27	Yes	Yes
Rebecca	42	35	41	-7	-1	Yes	Yes
David	43	50	48	7	5	No	Yes
Luke	57	48	37	-9	-20	Yes	Yes
Daniel	50	49	52	-1	2	Yes	No
Hannah	42	46	42	4	0	No	No
Shauna	48	54	49	6	1	No	No
Sophie	65	63	60	-2	-5	Yes	Yes

Table 5. 31: Summary of Change on the Positive Symptom Distress Index of the

Brief Symptom Inventory

PSDI	T1	T2	T3	T1/T2	T1/T3	Positive change T1/T2	Positive Change T1/T3
Ciara	46	43	43	-3	-3	Yes	Yes
Sean	52	45	42	-7	-10	Yes	Yes
Conor	53	33	30	-20	-23	Yes	Yes
Rebecca	41	36	42	-5	1	Yes	No
David	55	47	47	-8	-8	Yes	Yes
Luke	35	34	29	-1	-6	Yes	Yes
Daniel	47	56	43	9	-4	No	Yes
Hannah	54	51	51	-3	-3	Yes	yes
Shauna	51	48	36	-3	-15	Yes	yes
Sophie	55	65	59	10	4	Yes	no

5.5.3.6 Meeting Expectations

Students were asked at T1 about what expectations they had for the student role. Students described expectations that crossed over a number of aspects of the student role. Eight students had expectations related to their academics, such as '*finish my PhD'* (Sean), '*get good marks'* (Conor), '*get exams passed and essays'* (David). Two students spoke about *'joining societies'* (Luke), and having a balanced social life and *'getting to know new people'* (Rebecca), while Ciara hoped to be able to balance the social and academic aspects of college. At T2 and T3 interviews, seven of the ten students maintained that they had met their academic, personal and social goals and that the USMP had supported them in doing this. Although they completed their courses, two of the students (Ciara, and Hannah) at T2 and T3 interviews, reflected that they were still struggling to manage their mental health and engage in their student role. Rebecca felt that the USMP had supported her in her understanding of herself and her mental health, and in her recovery, but that she had continued to struggle to engage in the student role, repeating a year, prior to taking an Ordinary Degree when unable to complete the final year of her course.

5.5.3.7 Course Completion

By the end of the research study nine out the ten case study students had completed their undergraduate or postgraduate course, with one student choosing an Ordinary Degree after her third year. Two of the undergraduate students enrolled in a postgraduate course, and two had transitioned into full time-employment.

5.6 Outcomes of Students who completed Two Phases of the Research (T1 and T2)

Ten student participants completed the USMP and engaged in the T1 and T2 phases of the research study. There were three first years, five second year students, one third year, and a PhD student. All of the students were attending a Psychiatrist, either within college (n=7), or external to college (n=3). Depression was the most prevalent mental health diagnosis (n=7), although students also generally had a second diagnosis. Two students reported a diagnosis of Bipolar Affective Disorder, while another student was diagnosed with Generalised Anxiety Disorder.

Three students who completed the USMP, withdrew from their course (Sarah, Amy and Adam). One withdrew after two years, citing course choice as the primary reason at T2 interview, while the other two students completed two years of their courses and did not engage in a follow-up meeting (T3). A reason for withdrawal is not known, but following engagement in the USMP, they each failed a year and took a further year out of studies prior to withdrawing from college.

As outlined in table 5.32, Amy and Adam showed positive changes on the GSI, but of note, their T1 GSI scores were at the highest end of the range of scores for the thirty research participants. Sarah's GSI T-score increased by one from T1 to T2. All three students showed a minimally important difference (MID) of 3 or more T-score points for the Mental Composite Score on the SF-36v2 (table 5.33). This indicated less functional limitations and role impairment as a result of emotional concerns and less frequent psychological distress. Of note, the MCS T-scores for Sarah and Adam were the two lowest of the thirty student participants. Two of the students showed a negative MID of 2 or

more T-score change on the Physical Composite Score on the SF-36v2 (table 5.34). This indicated that all the three students reported greater limitations in physical functioning, role participation due to physical problems, and a lower level of reported general health.

Table 5. 32: Summary of GSI scores from the BSI and T1 and T2 for students who completed two phases but did not complete their college course

	GSI (T1)	GSI (T2)	T1/T2	Positive Change T1/T2
Sarah	43	44	1	No
Amy	60	56	-4	Yes
Adam	64	61	-3	Yes

Table 5. 33: Summary of Mental Composite Scores on the SF-36v2 at T1 and T2 for students who completed two phases but did not complete their college course.

	MCS (T1)	MCS (T2)	T1/T2	Positive change of 3 T-score points T1/T2
Sarah	12.97	18.86	5.89	Yes
Amy	24.59	40.4	15.81	Yes
Adam	9.12	19.82	10.7	Yes

Table 5. 34: Summary of Physical Composite Scores on the SF-36v2 at T1 and T2 for students who completed two phases but did not complete their college course.

	PCS (T1)	PCS (T2)	T1/T2	Positive change of 2 t-score points T1/T2
Sarah	59.33	42.58	-16.75	No
Amy	54.77	55.38	0.61	No
Adam	67.87	55.67	-12.2	No

In the post-programme, interview all three of the students reported benefits from engaging in the USMP. In line with the cross-case analysis of the ten student case studies, Sarah, Amy and Adam described developing an increased personal awareness of their mental health and its connection to occupation in their student lives.

> *"I suppose, by identifying what stops me participating in my student role and coming up with strategies to deal with when that happens have been really beneficial because while I sort of had an idea before actually getting them pinned down properly and thinking about stuff that would make me get back into my student role. I've been able to apply it rather than just kind of thinking 'O something has happened' " (Sarah)*

> *"there were a lot of things on the sheet (list of signs within section 3 'The Signs that I am not engaging in my student role and possibly becoming unwell'), that I wouldn't have thought of, as like early indicators". (Amy)*

> *"definitely more aware of when things are starting to go wrong… so that I can set things in in place before they get disastrous". (Adam)*

All three highlighted how they used occupation to maintain their health and well-being in the post-programme interview. For Sarah and Adam, this focused upon social connection and the meaning she derived from her academic engagement.

> *"just meeting up with friends, you know just during free classes instead of going straight to the library and doing stuff … actually hanging around". (Sarah)*

> *"I definitely try and keep in contact with my friends. I think that's really important you know and that's recreation as well, and I sing in the chapel choir which I think is kind of good for keeping me sort of balanced".* (*Adam)*

Routine was an important aspect for all three students, both positively and negatively. The connection between routine and sleep was especially relevant for Adam and Sarah.

> *It just doesn't work; I've being trying really hard but it kind of … saying when I get up.. then wake up at mid-day saying ' O how did that happen the alarm clock has gone off'." (Adam)*

> *If I don't have a proper sleep, I can't really focus properly, I can't concentrate on really trying to study or anything. I don't have the motivation so I start looking after myself making sure I feel physically healthy … before I can get down". (Sarah)*

Amy, however, at post-programme interview thought that she had developed a positive routine.

> "*I get up in the morning and I go into college and I see people and I go to the library for a little while and then I kind of walk in and I walk back and I go home, I go and make dinner and then my evenings are usually spent online or something*" *(Amy)*

Sarah further described developing strategies through the USMP, to support her engagement in the student role.

> *"Yeah we discussed a lot, breathing exercises and relaxation techniques … and sort of sleep habits and stuff like that. I've been using a lot of them".*

From the analysis of the qualitative and quantitative data, all three students described benefits from engaging in the USMP, although the ultimate outcome was non-progression.

Seven of the ten students who completed the USMP and two phases of the research graduated from their undergraduate or postgraduate courses. Of the seven students who completed their course, one took an extra four years to complete the course, another student took three extra years, and a final student one extra year to complete.

Students who completed two phases of the research identified a number of personal outcomes from engagement in the USMP at their post-programme interviews. A number of the students described that they had developed an increased personal awareness and understanding of their mental health through engaging in the programme.

> *"more sort of aware of how I was feeling and how I was spending my time" (Niamh)*

Aoife and Emma referred to specific strategies that they developed within the programme, some of which they knew already, but were now applying to a greater degree.

> *"I have identified things that I can, you know, use or I can do, that will help me kind of shake out of that and work my way back to fully engaging." (Aoife, student)*

> *"it allowed me to develop certain skills that I already had or that I was using to a far lesser or not very well and I developed them so that I could use them in a more effective way."(Emma)*

Jack and Michael highlighted that they had developed their ability to form a routine through engagement in the programme.

> *"it just became natural for me, so I've tried to keep that going basically since I have been finished; getting up at a good hour, setting one thing to do every day so I don't feel I'm at a loose end when I get up, so definitely routine is still going and it's working well". (Jack)*

> *"I'd say since the term started in September my routine has been better than before; more conscious about like I sat trying to stick to some kind of routine in getting started and going to sleep at a reasonable hour just so far and even trying to not overload myself with things that I want or and expecting to get done in a week; rather than ten things or five things make it two or three." (Michael)*

Lauren reported that she had taken a lot from her engagement with the Occupational Therapy Service and the programme, which she felt had not only

addressed issues and helped with participation at the time she was doing the programme, but that it had also helped in developing 'life skills' for the future, as she described below:

> *"The experience has been brilliant for me and it really has helped an enormous amount. You have no idea how much it has helped. Whether the little card, the workbook, of course it contributed and it also brought up stuff, I mean I could come in and just talk about my problem … it would make me go back and think about things that maybe are more relevant in the long term as life skills than whatever my particular problem of the day or the week are."(Lauren)*

Leah and Michael highlighted how they felt their engagement in the programme enabled their participation in college life overall:

> *"I suppose I got through my second and third year which I did not think was going to happen … I would not have been able to do things like going to the Gym and more basic things like making my lunch and bringing it to college and just taking the stress out of a lot things. It just made it so much easier to actually go to college, go to my lectures." (Leah)*

> *"it's been a big help; I definitely did have practical gaps from secondary school and so and mental health issues and just integrating that with the broader thing the social and personal kind of stuff". (Michael)*

The seven students also completed the BSI and SF-36v2 on a second occasion. As outlined in table 5.35 below, five of the students showed a positive change from T1 to T2 using T-scores on the Global Severity Index on the Brief Symptom Inventory. The GSI is described as the most sensitive indicator of a respondent's distress level, based upon a combination of the information on the number of symptoms and their intensity. The findings suggested that seven of students indicated lower levels of psychological distress from T1 to T2.

Table 5. 35: Summary of GSI scores from the BSI at T1 and T2 for students who completed two phases

	GSI (T1)	GSI (T2)	T1/T2	Positive Change T1/T2
Aoife	48	43	-5	Yes
Jack	39	35	-4	Yes
Niamh	30	35	5	No
Lauren	44	43	-1	Yes
Leah	62	32	-30	Yes
Emma	64	70	6	No
Michael	55	45	-10	yes

As outlined in table 5.36 below, only one of the seven students showed a positive minimally important difference (MID) of 3 or more T-score points for the Mental Composite Score on the SF-36v2, with three students showing a negative MID.

Table 5. 36: Summary of Mental Composite Scores on the SF-36v2 at T1 and T2 for students who completed two phases.

	MCS (T1)	MCS (T2)	T1/T2	Positive change of 3 T-score points T1/T2
Aoife	38.09	37.07	-1.02	No
Jack	50.46	51.96	1.5	No
Niamh	48.74	44.49	-4.25	No
Lauren	40.52	41.08	0.56	No
Leah	19.31	27.96	8.65	Yes
Emma	17.33	15.07	-2.26	No
Michael	32.45	27.32	-5.13	No

As outlined in table 5.37, two of the seven students showed a positive minimally important difference (MID) of 2 or more T-score change on the Physical Composite Score on the SF-36v2. This indicated that a majority of students reported greater limitations in physical functioning, role participation due to physical problems, and a lower level of reported general health.

Table 5. 37: Summary of Physical Composite Scores on the SF-36v2 at T1 and T2 for students who completed two phases.

	PCS (T1)	PCS (T2)	T1/T2	Positive change of 2 T-score points T1/T2
Aoife	46.31	48.19	1.88	No
Jack	60.38	57.69	-2.69	No
Niamh	58.95	62.02	3.07	Yes
Lauren	48.35	37.92	-10.43	No
Leah	48.74	50.05	1.31	No
Emma	46.62	35.27	-11.35	No
Michael	57.85	63.15	5.3	Yes

5.7 Outcomes of Students who completed one phase

Ten students completed one phase of the research study, with one of these students completing the USMP, but not completing the follow-up interview and quantitative measures. Possible reasons for these students not completing the USMP are described in section 6.2.2 in the next chapter.

Nine of the students who completed one phase of the research completed their undergraduate or postgraduate studies. One student withdrew in the first year of his course, but as he did not engage in a follow-up interview, no reason was given for the withdrawal. Six of the ten students took one year or more 'off books' for medical reasons during their student journey. As students did not complete multiple measures or complete follow-up interviews, there was no other data related to personal outcomes.

5.8 Chapter Summary

This chapter outlines the personal outcomes that students who engaged in the USMP described in their interviews. Ten in-depth case studies have been presented to provide a rich description of the student's engagement in the programme, by integrating these personal outcomes with data from the measures of quality of life and symptomatology, as well as progression data.

Students highlighted an increased understanding of their mental health, recovery and occupation over the course of three interviews. They described how their mental health impacted upon their student lives, but also an increased ability to recognise this, and felt able to respond. Students reflected an increased sense of connection between their health and occupation, and a greater ability to engage in occupations that were supportive of their health and well-being. Routine was a key aspect for students in managing their student role, but also something that a number of students found difficult to implement.

The majority of students progressed through their course. The three students who completed the USMP but withdrew from their courses, still maintained that they had derived benefit from the programme. In terms of quality of life, 50% of ten students who completed three phases of the research showed a positive MID on the MCS from T1 to T2 and this rose to 80% from T1 to T3. 40% of students who completed two phases of the research showed a positive MID on the MCS. For the PCS, 20% who completed three phases of the research showed positive MID from T1 to T2 and this rose to 40% from T1 to T3. 20% of the students who completed two phases showed positive MID from T1 to T2. In terms of psychological symptomatology on the BSI, 50% of ten students who completed three phases of the research showed positive results on the GSI from T1 to T2 with this increasing to 70% from T1 to T3. 20% of the students who completed two phases showed positive results on the GSI from T1 to T2.

Chapter Six will now present findings in relation to the process evaluation describing the reflections and experiences of the student and occupational therapist participants.

Chapter Six: Process Evaluation

6.1 Introduction

This chapter presents a process evaluation of the Unilink Self-Management Programme (USMP), which addresses Research Question Four (**What are the experiences and reflections of students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?)**, by examining how the intervention was delivered and received in a real-world college context. To answer this question, this chapter will:

- Quantify the number of meetings students had as part of the USMP.
- Describe the decision-making process involving students and Occupational Therapists in using the USMP.
- Analyse how the USMP was delivered and why it varied from student to student.
- Explore the student participants' perceptions of the programme content, delivery and impact.
- Explore the occupational therapist participants' perceptions of the programme content, delivery and impact.

As discussed in Chapter 4, the process evaluation was guided by examining the three functions of process evaluations outlined by the **Medical Research Council** (MRC) guidance on process evaluations, namely, **implementation, mechanisms of impact** and **context** (Moore et al., 2015). The process evaluation results incorporate both quantitative and qualitative data and accordingly the results are presented in two parts.

6.2 Part One: Quantitative Process Evaluation

As stated in Chapter Four, quantitative data was collected using an audit of case notes completed by occupational therapists delivering the USMP. Part One presents the quantitative data related to recruitment and attendance at meetings in the USMP.

6.2.1 Recruitment to the Unilink Self-Management Programme

Process evaluations also commonly investigate the "reach" of interventions to ascertain if the intended individuals came into contact with the intervention, and how this process happened (Moore et al., 2015). Within this research study, the USMP was delivered to students with a mental health condition, who were attending the college-based Occupational Therapy Service, embedded within a Disability Service in an Irish Higher Education Institute (HEI). Once referred to the Occupational Therapy service by a Disability Officer, the student completed the Occupational Therapy assessment process, leading to collaborative goals being established with the student so as to address occupational performance issues identified within their student role.

The *USMP* was introduced to students as part of this assessment process, and following discussion with their occupational therapists, students chose to engage in the programme to meet their personal goals as part of the Occupational Therapy Process. It must be noted that not all referrals to the Occupational Therapy Service would have a mental health diagnosis. Additionally, over the research period, 40-50% of students engaged with the Occupational Therapy Service for a brief period of one to three meetings to address specific concerns, which are called 'timed interventions within the service'.

Thirty students who engaged in the USMP over the research period (excluding the researcher's caseload) agreed to participate in this study. The number of students referred to the Occupational Therapy Service over the research period is outlined in Table 6.1 below.

Table 6. 1: Number of Students referred to the Occupational Therapy Service during the Research Period

Year	Referred to the Occupational Therapy Service
2013/2014	143
2014/2015	184
2015/2016	243
2016/2017	259

6.2.2 Attendance

Twenty-one of the thirty student participants in the research completed the USMP. Of the nine students who did not complete the programme (table 6.2 below), the average number of meetings was 2.4, with six students attending twice, and four students attending three times. Of these students, two completed the introductory section of the USMP only, and eight students completed two sections of the programme. In terms of duration of engagement in the programme, of those who did not complete the programme the average engagement in the programme was 1.6 months, ranging from one to four months. From the audit of the case notes, four of nine students who did not complete the USMP finished their course during the programme. Five students disengaged from Occupational Therapy and Disability supports. One student cited the reason for this as lack of time due to placement. Two others disengaged at the end of the academic year and did not re-engage in the following year, one transferred course and did not re-engage, and one did not re-engage after his occupational therapist left the service.

Table 6. 2: Duration and Number of Meetings for students who did not complete the USMP

Student Designation	No of Meetings Attended in the programme	Sections Completed	Duration of Engagement with the *USMP*
James	3	2	4 months
Cian	3	2	1 month
Megan	3	2	1 month
Rachel	2	2	1 month
Katie	3	2	2 months
Shane	2	2	2 months
Aaron	2	2	2 months
Ellen	2	1	1 month
Aisling	2	2	1 month

Of the twenty-one, students who completed the programme (table 6.3 below), the average number of meetings was 8.5, with a range from four to sixteen meetings. The average duration for students completing the programme was 6.6 months, with a range from two to twenty-four months. As outlined in Chapter Five, one student (David) completed the USMP over a period of nineteen months (ten meetings), coming back to review it again for three meetings five months later. Excluding this student, the average engagement in the USMP amongst students who completed it, was 5.7 months.

Table 6. 3: Duration and Number of Meetings for students who completed the USMP

Student Designation	No of Meetings Attended in the programme	Sections Complete	Duration of Engagement with the *USMP*
Ciara	6	All Sections	3 months
Seán	16	All Sections	14 months
Conor	8	All Sections	6 months
Rebecca	5	All Sections	5 months
David	10	All Sections	24 months
Luke	12	All Sections	5 months
Daniel	12	All Sections	8 months
Hannah	12	All Sections	3 months
Shauna	10	All Sections	5 months
Sophie	8	All Sections	3 months
Aoife	7	All Sections	3 months
Sarah	7	All Sections	3 months
Jack	4	All Sections	2 months
Niamh	6	All Sections	6 months
Amy	8	All Sections	4 months
Adam	6	All Sections	6 months
Lauren	12	All Sections	6 months
Leah	10	All Sections	4 months
Emma	6	All Sections	12 months
Michael	6	All Sections	5 months
Chloe	8	All Sections	12 months

The guidance for the USMP as outlined in the Facilitator's Manual was to move through the sections of the programme at a pace that suited the student but suggested that the programme could be completed over the course of five to eight meetings. However, eight of the twenty-one students who completed the programme attended for more than eight meetings, ranging from ten to sixteen meetings. This variation is explored further in

section 6.4.3.2.1 below, which describes this variation from the perspective of students and occupational therapists.

6.3 Part Two: Qualitative Process Evaluation Results

Interviews with student participants were carried out at T1 (pre-programme), T2 (post-programme) and at T3 (twelve month follow-up) and with occupational therapist participants post-programme, to provide and in-depth understanding of their experiences of engaging in the USMP, and reflections upon its format, content and structure. Two of the three sections of student interviews at T2 and T3 focused upon programme administration and programme content.

Twenty of the twenty-one students who finished the USMP completed two phases of the research and were interviewed at T2 (post-programme) and ten of these students completed three phases of the research and were interviewed at T3 (twelve month follow-up). Interviews were carried out by the researcher in a college-based office. One student did not respond to contact for post-programme interview at T2.

Six occupational therapists agreed to be part of the research study. Participants were all fully qualified occupational therapists, with experience ranging from two years up to eight years, with an average of 3.3 years. Five of the occupational therapists had either come to work in the Occupational Therapy Service as new graduates or with only limited experience in other Occupational Therapy roles. Participants were assigned names to differentiate between the six occupational therapists who took part in the study, using a list of the most popular names in the year 2000 from the Central Statistics Office in Ireland: https://www.cso.ie/en/media/csoie/releasespublications/documents/birthsdm/2000/babiesnames_2000.pdf.

Within the qualitative component of the process evaluation, the themes and sub-themes are presented according to the process evaluation functions in the **Medical Research Council** (MRC) guidance on process evaluations (i.e. implementation, mechanisms of impact and context). Table 6.4 presents an

overview of the themes based upon student and occupational therapist interviews according to the MRC process evaluation functions. While some themes were based upon data from occupational therapist interviews only (e.g. 'Occupational Therapists' Perceptions of the Training and the Facilitator's Manual'), data was integrated from student and occupational therapist interviews where appropriate, to reflect different perspectives of common themes (e.g. 'Collaborative Relationship between the Student and Occupational Therapist'). Three themes relate to implementation, two themes relate to mechanisms of impact and two themes relate to context.

Table 6. 4: Themes per Medical Research Council (MRC) process evaluation functions

	Implementation	Mechanisms of Impact	Context
Focus	What is implemented and how?	How does the delivered intervention produce change?	How does context affect implementation and outcomes?
Themes	Occupational Therapists' Perceptions of the Training and the Facilitator's Manual • Training and Manual sufficient for Delivery • Recommended Changes to Training Occupational Therapists' Decision to use the USMP • Referral, Assessment and Goal-Setting • Occupational Therapists' views of Student Readiness to Engage in the USMP • Engagement with the Occupational Therapy Service • Letting the Student Decide Unilink Self-Management Programme Content and Delivery	Collaborative Relationship between the Student and Occupational Therapist • Working Together to Personalise the Programme • Occupational Therapist as a Facilitator of the Programme • Individual Relationship with the Occupational Therapist Learning Strategies and Enabling Engagement in Occupation • Identifying what has Worked and Not Worked Previously • Supporting the Application of Strategies in the Here and Now • Benefits of Keeping a Record of Learning.	Enablers to Implementation Service Structure Barriers to Implementation Academic Year Structure Readiness of the Occupational Therapist to Use the Programme

	• Perceptions of Programme Content • Perceptions of Programme Delivery • Recommendations for Content and Delivery		

6.4 Themes Related to the Implementation of the Unilink Self-Management Programme

This section presents the results of the process evaluation relevant to the implementation of the USMP during the research study. It outlines occupational therapists' perceptions of the USMP training and Facilitator's Manual, the decisions to use the programme, and student and occupational therapists' perceptions of the USMP content and delivery.

6.4.1 Occupational Therapists' Perceptions of the Training and the Facilitator's Manual

As described in Chapter Three, occupational therapists received training using a workshop approach over one day in two separate two-hour sessions. They also received a Facilitator's Manual which included sections on: i) the Person Environment Occupation (PEO) model (Law et al., 1996), ii) recovery, and iii) occupation and its connection to health. The manual also included a suggested session plan for each section of the programme, suggested format for meetings, programme information sheets for students, and a list of additional resources for students. This section provides information on the occupational therapists' perceptions of their readiness to deliver the USMP and of the training and manual materials that they received. (Table 6.5)

Table 6. 5: Theme and sub-themes related to training and Facilitator's Manual

Theme	Sub-Themes
Perceptions of the training and the Facilitator's Manual	Training and Facilitator's Manual sufficient for Delivery Recommended Changes to Training

6.4.1.1 Training and Facilitator's Manual sufficient for Delivery

Occupational therapists were asked how prepared they felt to, firstly, introduce and then to facilitate the USMP with students. Occupational therapists generally reported feeling well prepared to introduce and outline the USMP to students.

> *"(The Researcher) had gone through it with us and then I had read through the whole workbook and then like information sheets as well, so it was easy to introduce." (Roisín, OT)*

Occupational therapists reported that the Facilitator's Manual was particularly helpful in delivering the programme.

> *"Definitely the facilitator's manual was brilliant, and it was kind of something that I always had on my desk and even something I would have taken the students through a lot as well just to kind of show them that this is the kind of process and what they were to expect." (Caoimhe, OT)*

> *"I suppose even the booklet for the students, and our own manuals were very clear so I certainly found it very easy to use, you know like it wasn't I felt like encouraged to do. I suppose like we had had like discussions before about the content in July…. between ourselves so I certainly felt prepared anyhow to do it" (Emily, OT)*

The training workshops involved presentations, discussion and practical activities, where occupational therapists would role play as a therapist and a student in delivering sections of the programme, with a number of the occupational therapists reporting this as very helpful.

> *"we had a kind of practice run in the chair that was really good, in terms of seeing how even just kind of someone being the student role gets you a bit because I think you can be a wee bit in terms of how you actual feel sitting in front of someone you have to kind of start it then" (Kate, OT)*

Although occupational therapists generally felt that there was enough training, some highlighted that there was a lot to take on in starting to use the USMP in practice.

> *"I really felt that we did a lot of training and we talked about it a lot , like the concepts and even like our own concepts of recovery and talked about it in a group and talked about it on a one-to-one, there was enough of all that but I think I was only just nervous and there was a lot of new things for me to take on" (Nicole, OT)*

6.4.1.2 Recommended Changes to Training

Occupational therapists felt prepared to do the programme with students having done the training with the other occupational therapists in the service, but also highlighted on-going learning in using the USMP with students. The availability of on-going peer support amongst therapists using the programme was a possible development that was suggested.

> *"maybe it would be nice if we could come together and kind of do it week by week in terms of the small part or parts that I found difficult to do in terms of some practical things". (Kate, OT)*

6.4.2 Occupational Therapists' Decision to Use the Unilink Self-Management Programme

In deciding to use the *USMP* with students, the occupational therapist made decisions on when to use the programme with students, and even when to introduce it to students. They referred to a number of factors that were involved in this decision-making. (Table 6.6)

Table 6. 6: Themes and Sub-Themes for Decision to Use the USMP

Theme	Sub-Themes
Decision to Use the Programme	Referral, Assessment and Goal-Setting Occupational Therapists' Views of Student Readiness to Engage in the Programme Previous Engagement with the Occupational Therapy Service Letting the Student Decide

6.4.2.1 Referral, Assessment and Goal setting

Occupational therapists recommended the use of the USMP if a referral for a student had identified the need for the development and support of self-management skills and the need was supported through the assessment process on entry to the service.

> *"something coming over from the health centre would have been maybe things they were looking at maybe self-management or routine, looking at leisure or balancing, things like that". (Kate, OT)*

All of the occupational therapists highlighted the use of both formal and informal assessments to inform their decision-making in using the USMP with students. On referral to the Occupational Therapy Service, students are asked to complete a standardised occupation-focused Student Profile (Nolan, 2011), which was then reviewed during the initial meetings.

> *"I suppose the decisions that I make in terms of using the programme with people is often we use the Student Profile, where the student identifies their particular concerns and often around the areas of managing self in terms of, you know, their life skills is often an area I*

would see as the most pertinent aspect in terms of maybe why we might do something like the self-management Programme."(Jessica, OT)

In the initial interview with the student the occupational therapists described looking for key areas such as managing their day-to-day routines and the need to be more independent alongside the review of the Student Profile (Nolan, 2011). Some examples given by occupational therapists included:

"… difficulty managing their day-to-day kind of role" (Caoimhe, OT)

".....I want to manage myself or I want to be more independent, or my parents used to do that for me, I want to do it for myself, those kind of things where they are really kind of like flags, if you like, that they are looking for to become more independent and self-manage more."(Nicole, OT)

Goal-setting is an important part of the ongoing occupational therapy intervention process and it is during the establishment of these goals which directly follow on from the assessment process, that the occupational therapists in collaboration with the student would identify self-management as a key issue to work upon within the service. The goals are regularly reviewed with students and during these reviews students collaboratively with the therapists can identify self-management as a goal leading to engagement in the self-management programme.

"… if their goals were related to self-management like learning to manage their anxieties so they can do their activities and if they had goals about having a better routine and things like that I would suggest it to them then." (Roisín, OT)

"on-going discussion during the year like that we almost need to review what had happened". (Emily, OT)

6.4.2.2 Occupational Therapists' View of Student Readiness to Engage in the USMP.

Occupational Therapists made decisions on the appropriateness of the USMP for students. This was based upon the individual student's need but also on the student's readiness to engage in the programme. Readiness was identified by the therapists as a willingness on the student's part to engage through the expression of their interest in the programme or indeed whether the student had sufficient experience of college to understand their need for self-management as a way of managing the college demands.

> *"the student need; so do they really need some management and help and stuff right now and what's their preparedness so you know are they actually ready to take on a little bit of like the idea of self-autonomy, self-determination". (Nicole, OT)*

Occupational therapists also made decisions on whether the student's need could be met through the general Occupational Therapy Service process, or through engagement in the USMP.

> *"to see whether the person is ready for this, whether they need this much in-depth input, or is it more occupation-focused outside of the self-management that they need". (Caoimhe, OT)*

Some of the occupational therapists felt that newer students to college did not understand their own occupational needs within the student role. This led to the students not identifying self-management as an area to work upon.

> *"they don't even know why ….what their issues are and they haven't identified, I suppose, self-management as a priority". (Emily, OT)*

Several of the occupational therapists used the programme when students were engaging well in the student role, as a means to shape learning from previous experience, but Emily questioned this reasoning.

> *"I don't think self- management is just for when things are going hunky dory …… That's not what I think self-management means." (Emily, OT)*

6.4.2.3 Previous Engagement with the Occupational Therapy Service

The decision to use or not to use the programme with students varied for students depending upon their engagement level with the occupational therapy service. Some of the occupational therapists described using the programme with students who had been engaging well with the service prior to the introduction of the USMP, as they felt more confident in going through the programme with students that they knew and could identify issues the student was struggling with such as self-management. However, upon reflection, some said that perhaps this was not a necessary requirement.

> *"probably felt a bit more confident in doing it but I don't think you have to do that but I think knowing the student reasonably well can help with that as I was saying maybe they are kind of struggling maybe with some of the concepts you know you can bring in things that they have mentioned." (Nicole, OT)*

> *"I suppose on reflection it probably could be used with students that perhaps you don't know as well and that you don't have that therapeutic rapport with, that solid relationship with, but I think equally using it with somebody which you have that relationship with is quite a powerful thing as well."(Emily, OT)*

Other occupational therapists felt that inconsistent levels of engagement with the Occupational Therapy Service was a factor in deciding not to use the USMP. Some students only came for crisis management and sporadically engaged with the service making it difficult and inappropriate to introduce a programme like this.

> *"No there were some students that I didn't use it with. Students who aren't very consistent in their engagements, who miss a lot of appointments or they will come in every six weeks or something" (Róisín, OT)*

6.4.2.4 Letting the Student decide

Although all of the occupational therapists felt that they should have a role in decision-making around the use of the programme, several felt that all

students referred to the Occupational Therapy Service should be told about the programme, so as to be able to make an informed decision as to whether they would like to engage in the programme.

> *"I think it is really down to clinical reasoning of the occupational therapist. I definitely think it is important to tell everybody about it, that it's available and it's one of the things in the introductory session that I would have told every student this programme is available." (Caoimhe, OT)*

> *"It is asking them, explaining it to them, 'This is the self-management programme; do you think that this is something that you would find useful as per some of the areas that you have identified on the assessment or as per the goals that maybe they set, so I think it is about informed choice rather than me deciding that this is the programme for them." (Jessica, OT)*

6.4.3 Unilink Self-Management Programme Content and Delivery

Student and occupational therapist participants were asked questions about the content and delivery of the USMP, in order to gain an understanding from their perspectives about the programme. This focused upon its structure, its content, ease of use, key elements of the programme, as well as any recommendations for its development. The themes related to programme content and delivery are outlined below (Table 6.7)

Table 6. 7: Themes and sub-themes related to programme content and delivery

Theme	Sub-Theme
Perceptions of Programme Content	Structured Workbook Format Discussion of the Concepts of Recovery, Mental Health and Occupation within Section One Content within Sections Two to Six Personalising the Content for the Student Perceptions of Programme Resources
Perceptions of Programme Delivery	Programme Duration Frequency of Meetings Individual Meeting Format Responding to Students' Needs Fidelity to the USMP
Recommendations for Content and Delivery	Programme Content Programme Format Follow-up Meetings

6.4.3.1 Perceptions of Programme Content

6.4.3.1.1. Structured Workbook Format

All of the occupational therapist participants were positive about the format and overall structure of the USMP. The division into six sections worked well, offering students a structured framework.

> *"I liked the six sections and the introductory sections (section one) and the other sections were very well done… It was a lovely way to get occupation-focused and to make it a little bit more concrete." (Emily, OT)*

> *"I think the nice thing about the way you have it structured is kind of the simplicity of it and the clarity of it …I think it's actually very attractive the way you have it structured so I think there isn't anything that I would add." (Nicole, OT)*

Students and occupational therapists maintained that the structure of the programme supported reflection and allowed for the sharing of ideas and perspectives.

> *"It is always good I think when you are looking at something to have things that would guide you into the way you should be thinking and I definitely agree with a lot of the suggestions and it's good also to put some things in from my own side, again added to the individual programme"(Jack, Student)*

> *"a kind of a safe way for students to feel like they were being asked a very structured set of questions and being able to share maybe something that they haven't maybe spoken about before". (Caoimhe, OT)*

> *"a nice way to start them brainstorming so I certainly felt it was you know; it was a positive thing". (Emily, OT)*

Students maintained that this structured workbook-based approach could have benefits in reducing students' engagement with services.

"structured programme which has typical application, and which has a workbook that you can keep and consult, I think that could help you both not to allow people to rely on you as much and to be able perhaps spend less time."(Emma, Student)

Occupational therapists highlighted that the activity within many of the sections of the USMP, where students were asked to form their own prioritised list, when they had already reviewed a list of suggestions, seemed repetitive and students did not always see the value in doing this.

"I think sometimes the programme could be a little bit repetitive for students in that you are kind of ticking off the strategies that are given as examples and then you are pulling them in to your kind of top ten and the next stage the students felt they didn't always want to fill out that last page." (Caoimhe, OT)

Occupational therapists and students highlighted the importance of an accessible format, to enable students to engage in the programme. This involved offering students a choice of formats for the workbook and meetings.

"There is text but actually it is visual this is obviously to do with autism … to make a hand book for everyone so what is it, it is about universal design it's kind of like other people it would be good for them but some people need it but others will do it straight away but if there is more of a visual approach" (Sean, Student)

"I suppose I had one student that probably had learning difficulties … you would have some students and they were able to read through the quotes and you know and go through some of the resources. For her she needed almost something that was simpler again." (Emily, OT)

"sometimes people will use highlighters to highlight the speech bubbles based on the terms in recovery in mental health and occupation and then some of them will want to write an essay … it's just working with

what their learning approach is, what works for them really." (Jessica, OT)

6.4.3.1.2. Discussion of the Concepts of Recovery, Mental Health and Occupation within Section One

Section One demands that the therapist and student discuss and gain an understanding of what recovery, mental health and occupation means to the student. It enables reflection upon these key concepts and allows the therapist and student to gain an insight into each other's thinking around these concepts. Although some therapists found it difficult initially to engage with the concepts, they learned to manage this process better and valued the time spent in building the relationship with students.

This discussion was viewed as an important foundation for the programme that contributed to the formation of a collaborative relationship. The discussion in this section was a central element of the USMP for students and staff.

> *"I think the introduction (Section One) is really a lovely section and I think sets up for the rest of the programme". (Kate, OT)*

> *"It was especially lovely to just sit for a session and actually have the conversation, get to know the person … definitely it sets yourself up for a longer relationship with that person …. It was my favourite part of the whole programme." (Caoimhe, OT)*

Occupational therapists explained further that the discussion around recovery and mental health ensured that there was an understanding of where each person was coming from, and this allowed for a better working relationship between occupational therapist and student:

> *"It's good to get their idea of what recovery is and what they are working towards and like what mental health means to them so you can kind of be on the same page because you know what they are working towards and then you can kind of work with that because it is so different for everyone." (Róisín, OT)*

"I think that can positively influence your intervention your interactions with the students when you know really where they are coming from and really where they want to go with it" (Nicole, OT)

Students were also positive about Section One, in line with the occupational therapists' perspectives.

"Definitions, Mental health, Recovery; like it's just, a thing I would never even think of doing and again it is identifying what you think about this". (Ciara, Student)

Occupational therapists felt that they benefitted from their interaction with students, who brought their expertise and perspectives to the collaborative relationships.

"I have learned so much about recovery from talking to people about it and, as I say, that is just through regular meetings but also through self-management as I say I talked to one student about it for about half an hour / forty minutes the other day but it was so interesting." (Nicole, OT)

"I really like even as a therapist you learn a lot from what the students give back to you in the programme like that that changes your views". (Emily, OT)

"Always shocked at what students came out with when they were so informed without even realising it … they were like no I don't think that's right or you know that doesn't suit me you know they were really confident in their own definition which was lovely because they probably never heard of it before that day." (Caoimhe, OT)

Occupational therapists highlighted the benefit of discussing occupation in Section One in enabling a greater understanding, not only of occupation and occupational performance itself but also of what the Occupational Therapy Service and occupational therapists had to offer .

"I think occupation is really a nice one because it frees up the word to be kind of free to use all the time. And just, I think again it brings it

back a little bit to the I suppose the role as an occupational therapist and kind of how they see occupation as something you know can be a support can benefit your health and well-being."(Kate, OT)

"I think the discussion of occupation is really good as well because so many people don't know what occupational therapy is and you get them to think about it before they start going into the lists of different strategies". (Roisin, OT)

Some students and occupational therapists highlighted that the discussion of these concepts needed to be connected to the rest of the programme.

"the first part maybe wasn't as helpful as the later bits, I mean like maybe more of a conversation on what recovery means or what mental health means; like maybe how that is relevant to the rest of the programme rather than having it just there as, ok what do you think of this." (Aoife, student)

"I don't think it should just be in the introduction I think it should bring it all the way through." (Jessica, OT)

Some of the occupational therapists described initial discomfort with regards to discussing these concepts in Section One.

"I felt a little bit uncomfortable talking about it because immediately you are getting very deep into a person's kind of understanding of their mental health from word dot". (Róisín, OT)

"Being honest I definitely wasn't at the start (comfortable). I definitely wasn't and using it and kind of listening to students and learning from them helped along the way and definitely talking with (the researcher) about it … picking up on maybe my own kind of maybe personal stuff I was bringing in to my professional role as well, like maybe what I personally felt about recovery so that was really helpful but definitely at the start I wasn't." (Caoimhe, OT)

Other occupational therapists, however, reported feeling very open to having this discussion around these concepts.

"I feel comfortable with those terms, …… I am an occupational being and I practise what I preach and I think that's very important in being able to have the conversation with somebody." (Jessica, OT)

As occupational therapists gained more experience in using the programme and as they reflected upon their approach, they described becoming more comfortable discussing the concepts within Section One.

"the fact that you were giving back ownership to students about these concepts made it easier. So I mean like the reality is it wasn't up to you to define such and such, like you get their perspective and you always provide your perspective." (Emily, OT)

"I would allow the person to talk a little bit more maybe talk a little bit less myself and I found that that helped as well". (Caoimhe, OT)

Occupational therapists reflected that Section One had positive impacts upon their Occupational Therapy practice.

"I was probably more explicit about it than I would have been, not using the programme. Now I think obviously the principle you know like recovery model guided my practice before but I think certainly ..you know I do think it is nice for students as well to make something like that explicit." (Emily, OT)

"I talk about it (Recovery) more frequently but I talk about it earlier in our interaction so I often talk about it in the first meeting which I probably wouldn't have done when I first was here because I just wasn't that confident but like I suppose I really believe in recovery but I suppose my experience of it would have been more theoretical probably before I came here but I think now I am actually learning to put that into practice" (Nicole, OT)

6.4.3.1.3 Content within Sections Two to Six

Overall, although the therapists were positive about the programme there were times when they described difficulties in relation to how sections of the programme flowed. In particular they described a disconnection between

Section Two (Identifying the things that I need to do to engage in my student role and to look after my mental health), which focused upon daily occupation and Section Three and Four which focused upon times where students had previously experienced difficulty. They reflected that the change from focusing upon enabling engagement in daily occupations in the student role, to reflecting upon previous times where they had experienced difficulty engaging in the student role, was not an easy one, and that they felt these sections addressed very different aspects.

> *"part two is a framework for how we engage on a day-to-day basis to look after our own health and well-being so I think that really can be done with anybody. It doesn't have to be done with somebody who has a disability that will have a difficulty. … but then I think part two and part three and part four is a separate framework." (Jessica, OT).*

> *"I know myself I suppose as an occupational therapist I found section three and section four, particularly section three, a little bit more difficult to manage". (Kate, OT)*

Equally the occupational therapists maintained that students appeared to get confused between Section Two and Section Five (Personal and practical Strategies for engaging and re-engaging in my student role). Additionally, occupational therapists felt students wanted to explore strategies for reconnecting in the student role earlier in the programme.

> *"I think sometimes students get a bit confused about the difference between section two and section five. You have the strategies and then you have the things you do every day but I think they are both important and if you spend a bit of time working out it is ok". (Róisín, OT)*

> *"I definitely think maybe again it is the way I work with students but the last section where it is coming up with strategies and things I felt for some students it was a very long wait to get to that point". (Caoimhe, OT)*

"often time when they were talking about the issues that were arising, the triggers for mental health, how do I know maybe that I'm not feeling well, they wanted the strategies then and not really wait for another two or three sessions to come up with strategies". (Kate, OT)

6.4.3.1.4 Personalising the Content for the Student

Students described the importance of being able to personalise the content of the USMP to their own student life, by initially using the lists and content within the workbook, but then adding their own ideas and perspectives, and with the help of the occupational therapist implementing it within their lives. This sense of personalisation and focus upon what you had to do, was mentioned by many of the students. Therapists also maintained that the ability to tailor the programme to the personal needs of students was an important aspect in its design.

"especially from where I was coming from like the WRAP (Wellness Recovery Action Plan), it was a lot more geared towards my life than general life" (Luke, student)

"Yeah, I thought it was good because I suppose the nature of the programme is, it is like that very much like in my case in particular, that these are the sort of things you have to do yourself" (Leah, student)

"it's, you know, applicable to me and I can use it to, you know, not so much learn but identify things about my role and about myself that I probably wouldn't have otherwise" (Aoife, student)

Students described that the programme covered areas which were important and relevant to them and their student role, but also that covered different aspects of their student life.

"*it was comprehensive so that I could really you know could take into account different parts of my life, as in like you know we would focus on what I needed to do academically and then and look through going through triggers related habits that will tell you, you are not engaging*

actively in your student role or stuff you know. It was pretty useful and concise"(Aoife, Student)

"You kind of get to talking about all the amount of individual things that you know would impact on different parts of your life. I think it was it was much better to kind of focus it that way". (Adam, Student)

"I felt like I kinda I could draw things from the self-management programme to kind of help with my everyday kind of stuff. I felt it was relevant"(Sarah, Student)

All of the occupational therapist participants maintained that tailoring the programme to the individual was important and that the programme allowed for this.

"you know I think that's the ideal myself, the self-management programme it needs to be flexible and tailored to an individual; I would certainly think the programme allows for that definitely". (Emily, OT)

"I suppose the risk of maybe a workbook or a very structured format is that it can seem kind of kind of wooden or not personable I think the kind of the personal part can be important I think the programme takes care of that" (Kate, OT)

The significance of a programme being tailored to meeting personal needs was highlighted by Sophie (student) as she described:

"it was so relevant to my own individual needs and my own mental health well-being I mean, personally like I wouldn't have been able to, I don't want to be dramatic but survive almost like you know without the programme you know" (Sophie, student)

6.4.3.1.5 Perceptions of Programme Resources

Occupational therapists were provided with resources within the programme, such as articles about occupation and recovery, a resource guide to activities within and outside college, and information sheets on areas such as sleep, diet, and exercise. Occupational therapists were also encouraged to use resources from other sources in tailoring the content to the student, if

information was not included in the programme (e.g. information on societies / activities available in the area). As part of Section Two, students were asked to complete two days of the Occupational Questionnaire (Smith, Kielhofner and Watts, 1986) and the Interest Checklist (Heasman and Brewer, 2008). Occupational therapists particularly highlighted the benefit of the Occupational Questionnaire, although they did however note that it did take students time to complete. Some students preferred to copy out sections of their weekly college timetable, which they were used to doing as part of their student role.

> *"I think some students kind of struggle to do it for the three days or whatever even two days would ..even one day because it takes quite a bit of time to fill in and some students would just use the bits that they write out from their routine or timetable thing instead". (Róisín, OT)*

Jessica (OT) suggested that using a weekly chart, like students were used to doing as part of the student role, was something that was more useful. She felt that this was more useful than only completing two days, as she felt that the week within the student role changed so much from day-to-day.

> *"I think the occupational questionnaire is useful but I often prefer an occupational chart of a week because I think you can't chart somebody's occupations daily because the day-to-day aspects change even though I know you have to take a week day and a weekend but they can vary rapidly and I think for some people it is nearly better to have like a type of a visual timetable where people write things in and then you can colour code it out."(Jessica, OT)*

Occupational therapists found that the goal-setting sheets were very useful in the practical follow-through from sessions.

> *"I suppose goal-setting is such a part of our sessions and yeah I do think they were useful". (Emily, OT)*

> *"Yeah I think the goal sheets are really good and I use them a bit with students who are not even doing the self-management programme*

just because of the way it is laid out. It is kind of what resources do you need and what's the plan". (Róisín, OT)

However, it was noted by occupational therapists that some students found the goal-setting format more useful than others, depending on the nature of the goal and their ability to set goals.

"I suppose maybe the complexity of the goal and really how confident the person is in terms of being able to break it down". (Kate, OT)

Students also described the usefulness of the workbook format and associated resources such as the weekly routine sheet or interest checklist, which allowed them to reflect upon occupation and routine.

"It was interesting to look through because a lot of it is stuff I hadn't thought about really. Like the routine sheet kind of showed that I was spending an awful lot of time on the internet and stuff like that, that I hadn't really realised until I had like had a look at it and even the sheet with the hobbies; the interest checklist allowed me to look like actually I would really like to try that at some point and stuff like that.. I felt about" (Amy, Student)

In preparing to discuss the ways that students maintain their health and well-being and in identifying the types of occupation that they use to do this, occupational therapists also described the interest checklist as a very useful resource.

"I think the Interest Checklist was kind of I suppose was particularly good because it lays it out very clearly whether you know you are engaging you're currently engaging in your strong or some interests and like it's very physical straight off." (Kate, OT)

"…because I think if you ask people what they like to do a lot of them really struggle to say because they haven't done it in a long time and when you have that as a kind of a tool to just prompt their memory of what they used to do when they were a kid or something it's good" (Róisín, OT)

A Resource Guide was provided for the occupational therapists to outline activities and resources within college and in the local area. Occupational therapists found this useful, but often combined this with resources that they had found independently.

> *"Well there is the resource guide that we have available too I think as an occupational therapist. I also have my own resources that I find useful." (Jessica, OT)*

Part of the USMP was a pocket-sized summary sheet, which students used as an outcome of the programme. Student participants described the benefit of keeping a log of insights gained, strategies developed and aspects to be aware of from a self-monitoring perspective.

> *"I feel if you did that weekly and kept it with you so that you would have a physical reminder of like ,.. if you are stressing out, if you are feeling down, you know these are the things that you have identified earlier." (Aoife, Student)*

> *"I still have the little card thing they gave at the end the sort of portable card thing yeah and I kind of memorize it and it was handy and I have .. it is good for you know recognising and there was part of that I was as well ok this isn't working, recognising things and I am starting to go off course" (Conor, Student)*

Occupational therapists supported this view that students found the small wallet sized review sheet useful, allowing them to make a record of their learning:

> *"I think for some people that was again very tangible; this is a practical thing that we will work on and in six sessions you will have it filled out and you can take it away and it is something that you can always carry with you if you want to, so I think that was a good resource to have". (Nicole, OT)*

6.4.3.2. Perceptions of Programme Delivery

6.4.3.2.1 Programme Duration

As outlined in Chapter Three, the duration of the programme, number of meetings and the scheduling of meetings could be tailored to the individual. It was proposed in the USMP training, as well as in the Facilitator's Manual, that the programme could be completed in five to eight meetings, but that additional meetings could be scheduled as appropriate. Occupational therapists described that the duration of the programme varied from student to student.

> *"it would vary from student to student, sometimes with taking breaks in between it could take six meetings". (Róisín, OT)*

Some students highlighted that the programme took longer to complete as a result of personal issues or periods of mental ill-health:

> *"well actually it was over a year because like there were a lot of things coming and going so also like were not related to the programme which kind of helped to discuss them ..however in any case like with some of the things it took longer to complete, also because of delays from my side .." (Séan, Student)*

> *"…If I remember rightly a lot of the interruptions ..it was just the nature of how I was managing so like it was …..and so it was how it happened" (Michael, Student)*

Both occupational therapists and students described the freedom to move through the overall programme at a pace that suited the student as being particularly important.

> *"It was really good because it was very flexible, so I never felt under pressure to be at this point; I never felt like O.K. we can't do this now. It was always it was really flexible, and I really liked that". (Conor, student)*

> *"We didn't rush through it, it was at a good pace you know, I think it allows for that like. I think you can do it, like you can literally do it in*

three sessions or you could, you know, do it over three months." (Nicole, OT)

"I could tailor it to my own needs so I think if there was an area that I would want to focus more on I could do that instead of just continuing on with the programme" (Hannah, Student)

Students described that there was balance to be found in covering areas but also moving through the sections:

".. each of those sections you could spend a year discussing so I think there has to be some sort of finite amount of time you want to spend on them otherwise you would just keep on talking about them and the whole Unilink self-management programme about how it applies to your own daily life so I think if it went on for any longer it would really be too much" (Emma, Student)

Occupational therapists felt that the pace at which they progressed through the sections was largely determined by the student.

"I would say primarily the student would have led the pace of the programme; that would be my overall kind of feeling on it". (Emily, OT)

Some therapists noted that some students were more able to take the lead in guiding the programme, and that there was a difference in how mature students used the programme as opposed to younger students, having more skills in structuring their time.

"The kind of older students were much more into the structured format of it and I think probably that was how they were managing college was by being very structured and they liked kind of knowing they were going to be here for five weeks and filling out the programme but as I say the younger students were more kind of a bit ad hoc and a bit kind of 'O help me now' ". (Caoimhe, OT)

6.4.3.2.2. Frequency of Meetings

The frequency of meetings was an important element for students. Some students engaged in meetings weekly, biweekly, monthly, or a combination of

these. Some students maintained that meetings became more infrequent as they progressed through the programme, allowing them to take more responsibility and ownership.

> *"What was good that it was weekly but as well was it became spaced out as well…. actually self-management….. It became more my responsibility as opposed to just doing it because I don't know, I was more aware ..I was kind of more aware I was doing it for myself and that as well so" (Leah, Student)*

Students described having time between meetings to apply strategies and learning in the real-world context as being of importance.

> *"So I think it is good actually like to have time in between the sessions for the simple reason that you actually have to kind of test things on the ground and see how they feel like because again before the review so actually then that happened, it was like a positive". (Seán, Student)*

6.4.3.2.3 Individual Meeting Format

Many of the student participants highlighted the benefit of individual meetings as part of the USMP. Student participants talked about the comfort in discussing personal issues as a benefit of individual meetings.

> *"I suppose what we were talking about, what we were dealing with in the self-management programme I felt it was very personal to me and I know I would have felt uncomfortable with other people in the room". (Rebecca, student)*

A few of the occupational therapists maintained that the students they had worked with would be more comfortable in sharing experiences and views on the concepts in individual meetings as opposed to being in a group format.

> *"A lot of people doing the self- management programme would have a lot of anxiety around sharing their experiences with other people" (Caoimhe, OT)*

Students also highlighted that the individual meeting format allowed for more focus upon areas that were important to them:

" Em, the one on one interaction, you can bring up whatever you want" (Hannah)

"you tend to have more time for the subject in hand and em you focus on the person…….you get everything that you want" (David)

"doing it individually like helped me focus a lot more on everyday stuff" (Sarah)

A few of the students described their experiences of group work but maintained that a group format would not allow them to tailor the programme to their needs, as they preferred the individualized approach of the USMP.

"I'm not a huge fan of groups just because I sound selfish, I know but I like to concentrate on myself and I mean if I'm in a group setting I might concentrate on like helping other people than actually just myself and I don't find the things that I need". (Aoife, student)

"I think very much kind of developed the Self-Management Programme that was suitable for me as an individual em whereas I think about what was done maybe on a group basis is something that might not cater to everyone's own individual needs, so I think on an individual basis it was very good for me anyway." (Jack, Student)

"I would have done things like group therapy and that beforehand. That was helpful in that context, but I think with something like this but the more individual approach I prefer" (Leah, Student)

Each of the occupational therapist participants maintained that the individual meetings were an essential and important part of the USMP approach enabling them to achieve the aims of the programme.

"I think the sessions support the self-management programme and so that is another aspect of it". (Jessica, OT)

"The individual aspect of it is really important because again I think it's again I think a lot of students you know like to work on things that are individual; the situations are individual work". (Kate, OT)

6.4.3.2.4 Responding to Students' Needs

Being responsive to student needs either in terms of their mental health or occupational demands at a given time was built into the design of the USMP. Within the USMP training and the Facilitator's Manual, occupational therapists were recommended to check in with the student at the start of every meeting to see how they were doing at present and how they were managing their current demands, and then respond accordingly. Occupational therapists highlighted the importance of this responsiveness to students' needs during meetings as part of a 'person-centred' approach.

"I tend to do it at the start of the meeting in case they had a lot going on that week and then if there is a week that they have all their assignments due they might not have time to work a brand-new strategy into their routine." (Róisín, OT).

"Sometimes it was kind of incidents like crisis incidents….and you would come in and I suppose it could be if there was a crisis in terms of their mental health where it wasn't quite appropriate to sit down and do the programme" (Emily, OT)

"I think if we are trying to be person-centred then you can't just come in and do the programme if there is something going on with the person and I know we have time to do that but often a person has a lot of things that may have arisen during the week and often just pulling out the self-management programme is not very person-centred." (Jessica, OT)

Students also described how they valued the way their occupational therapist responded to their reported needs, but also that they felt empowered to raise concerns as needed.

"I mean it was mostly entirely up to me and if I had more issues with doing academic work then I would focus more on that than like the programme". (Aoife, Student)

"I think she saw that I needed kind of more supports on my worries about my dissertation like she saw me very upset and things like that so I'd say (the OT) probably felt that it would have benefited me so it was only about once but I would say that it was mainly the programme that we were going through" (Sophie, Student)

"I was glad that was there, that if there was for example say a difficult essay or personal issues that we could focus on that for that session"(David, Student)

However, both students and occupational therapists highlighted that the self-management programme needed to be the major focus of meetings. They recognised that it was challenging when student demands impacted upon getting through the programme content, but that the professionalism of the occupational therapist had a major part to play in achieving the right balance.

"I didn't feel we could spend half a session or three quarters of a session looking at something else and then just dip into it (the USMP) or we could spend a session on the self-management programme without needing to look at other things." (Amy, Student)

"I don't think it would have been as good if we had done about half of the section and come back next week and it was good to get through one section at a time because then you know stayed relevant and like if you kind of left it for a week to finish a section I think you might forget some of the stuff that was in it"(Sarah, Student)

"I think it comes down to the issue on the day whether you have time to do both of them …. that was not always realistic and you want to be able to give something the time it needs as well you don't maybe want to be rushing through, you know either whether an academic issue or I

suppose or the programme you know to give it the time it needs." (Emily, OT)

6.4.3.2.5 Fidelity to the Unilink Self-Management Programme

The USMP provides a structured framework for the student and occupational therapist to work through collaboratively and is divided into six sections. The USMP training outlined this structured process and the Facilitator's Manual provides a session plan for each section of the programme, with suggested format for meetings, programme information sheets for students, and a list of additional resources. However, as this programme is an individually tailored process, where the student can identify strategies and occupations that were personal to them, resources cannot be provided in every possible area or situation. As part of a student-centred approach, students can also choose to move through sections more slowly if they feel there is a need and can also decide to focus upon current academic demands within meetings. This however, presented both students and therapists with a dilemma on occasions. From the audit of case notes, occupational therapists followed the format of the programme structure through the six sections as outlined. Occupational therapists and students described how they used the workbook format within meetings.

"I think the programme has a structure so I think any programme that has a structure is going to be led by the structure so we used the structure throughout pretty much follow it ..used the structure, didn't deviate from it. I think that's what we did. Stayed with the structure"(Shauna, Student)

Some of the occupational therapists highlighted a challenge in being person-centred and at the same time consistent with the programme as outlined.

"That's the challenge within the whole programme because if we are trying to be individualised within the programme we should be individualised for everybody and that often does raise issues about fidelity and fidelity of using the model with people and I think you could go down that conversation and have a really big conversation about

you know should I be trying to do the ticky box thing (lists of suggestions within each section of the workbook), should I be trying to follow it." (Jessica, OT)

6.4.3.3 Recommendations for Content and Delivery

Occupational therapists and students made a number of recommendations for on-going development of the USMP which they maintained would enhance its usefulness.

6.4.3.3.1 Programme Content

Some of the occupational therapists described how they included the development of strategies to enable problem-solving throughout the programme and that they set aside time for reviewing and discussing these within each section.

> *"I think I would continue to bring the strategy development piece into the sections as we go through just from experience of working with students it's, nine times out of ten, too long breaks to get to that point" (Caoimhe, OT)*

Some students felt that more brainstorming in teasing out issues at the start of each section would be of benefit in establishing final outcomes of learning.

> *"I think that would be, because sometimes it can help you to like think of things yourself that you know doesn't work or you know is a problem and then it can be really helpful just to show that O.K. other people had this as well" (Amy, Student)*

A few of the occupational therapists and students suggested that students should be asked to keep a reflective journal of their experience between meetings, to shape reflection and consolidate learning, as well as provide evidence of what had happened over the week.

> *"It might be more that you get the student to write a reflective piece on every section that they essentially have but then are we putting more of an onus on to the work of the student when they have already got enough to do for themselves, so we get evidence whereas you*

could get a lot more evidence from just having the conversation with the student and finding out whether they like it or not." (Jessica, OT)

"I think it would work far better as a sort of a reflective exercise rather than a proactive exercise so that you would say ok you discuss whatever bit you are talking about this week then you go off and you do your reading and you come back and you… well you straddle the elements rather than this is Section Four this is Section Five so you would look back at Section Four in a week ,maybe two weeks or three weeks later and do a third column you know… how are you getting on with that rather than sort of it's a it's a text book." (Lauren, student).

Being able to choose certain tailored sections, relevant to postgraduate students, or students transitioning to the workplace, was suggested by students.

"I think it might have been helpful if there was a section or an optional section even for people who were near the end of their degree and be it that they were that they were just in fourth year and that there were student pressures ……you know pressure in terms of what you do afterwards whether you want to do a management degree or post graduate" (Emma, Student)

6.4.3.3.2 Programme Format

Although highlighting the importance of the personalisation of the USMP Content and Structure and the benefits of the one-to-one meetings, some of the students and occupational therapists identified some benefits to a group and combined individual and group delivery of the USMP in terms of shared learning and support.

"I don't think it would be as personal if it was in a group but I suppose maybe there could be mutual support if it was in a group which might be helpful as well." (Sarah, Student)

"Yeah I was, eh yeah I was thinking that it might be good to see how different people answered the questions and things". (Conor, Student)

"I still think the majority would prefer an individual intervention. I do think for something like that, having a group would be quite powerful and so I think particularly around things like peer support and modelling and ability and self-efficacy." (Emily, OT)

Some of the students and occupational therapists suggested a combined approach mixing the individualised approach with a group format, allowing for the personalisation of the approach, but also drawing upon the strengths of a group approach.

"I think that the group thing might be something that may be optional on the side but like couple of seminars however like the main problem should be done on an individual basis."(Seán, Student)

"I think maybe for some parts you know like trying to figure out ways of, you know, stopping your triggers and stuff like maybe hearing other people's ideas might have been really helpful so yeah I kind of think some parts of it". (Adam, Student)

"It might be useful to have a group for students who completed the programme that they can kind of have a thing where they can check in on how they are doing and if they are still using these strategies but I think but for me anyhow with students it was just so different all kind of working at different paces." (Róisín, OT)

Most of the occupational therapists and some of the students saw some benefit in developing the programme in an online version, while also retaining the face-to-face meetings with the occupational therapist to tease out issues that could arise.

"I suppose one of the nice aspects of the programme is actually being able to tease stuff out and work things out, but I absolutely think it would be lovely to have it online you know for talking about resources .. in time and all the rest maybe that's the way it needs to go but I think there". (Emily, OT)

"The other thing about it the other thing is if it is on line you can keep it and I think it would be very valuable. You can keep one journal section totally private to me for example I think that would really you know that will never be seen by anyone". (Lauren, Student)

6.4.3.3.3 Follow-up Meetings

Student participants identified primarily in the twelve month follow-up (T3) that having follow-up meetings, or a *'top-up every so often'* as Adam suggested, after the completion of the programme, would aid in the application of learning from the programme.

"I probably should organise that myself that I would have had some follow-on meetings with my occupational therapist because I thought 'O I am doing so well now that I am not going to be taking up appointment slot' but I suppose you might just have a drop-in thing that's about twenty minutes long." (Leah, Student)

Nicole (OT) spoke of a student, who had completed the programme previously with another occupational therapist, and with whom she had reviewed that self-management programme:

"She was managing very well but now college is back and she is having a difficult time so we took out the self-management we actually took it out and said well where the signs are, how are you looking at the signs that you are engaging, or what are the good things that help you engage." (Nicole, OT)

6.5 Themes Related to the Mechanism of Impact

This section presents the qualitative themes relevant to the mechanisms of impact (i.e. the factors which contributed to the delivered intervention producing or not producing change) (Moore et al., 2014). Student and occupational therapist participants referred to specific aspects of the intervention that contributed to maintaining health and well-being and engagement in the student role. Themes were identified in relation to the collaborative relationship with the occupational therapist (Table 6.8).

Table 6. 8: Themes and sub-themes related to mechanism of impact

Theme	Sub-theme
Collaborative Relationship between Student and Occupational Therapist	Working together to personalise the programme Occupational Therapist as a facilitator of the programme Individual relationship with the occupational therapist
Learning Strategies and Enabling Engagement in Occupation	Identifying What has Worked and not Worked Previously Supporting application strategies in the here and now Benefits of keeping a record of learning

6.5.1 Collaborative Relationship between Student and Occupational Therapist

6.5.1.1 Working Together to Personalise the Programme

The format of the USMP was based upon individual meetings between student and occupational therapist. The importance of the collaborative relationship within these meetings was highlighted by both students and occupational therapist participants.

> *"Everything that we did together, me and (the OT) worked really well and helped me grow into my student role". (Daniel, student)*

Participants described how the workbook provided a scaffold by providing suggestions, but that the collaborative relationship between the occupational

therapist and student was key in refining them and making them useful as part of the student's overall self-management.

> *"the general ideas might have been things that are on a sheet or things that the students knew already but then it is the fact of kind of teasing them out … kind of joint thing that maybe the student having an idea, me having an idea and kind of sharing it and it, kind of, it sort of developing I suppose often again it was about the student choosing kind of the strategies that they wanted to implement." (Kate, OT)*

> *"It's me beginning with the sheet and then we discussed what was going on and then if I wanted to look something up we could, or if she felt that kind of this wasn't quite as important but we could discuss it later that was also kind of, we could discuss it and work together to kind of put it together." (Amy, student)*

A number of students also highlighted the active role they had in bringing their own ideas to the discussion within the USMP.

> *"It was a collaboration between the two of us but you know I suppose we had equal kind of input and there was guidance from the occupational therapist but then it was very much, I suppose, shaped by my answers and my own experiences." (Jack, student)*

> *"I think jointly is a good set up. I think having my own side of things added in with the professional I think it is a good mix so" (Luke, student)*

Occupational therapists were viewed as bringing professional knowledge and expertise to the collaborative relationship between themselves and the students.

> *"I could appreciate that the actual occupational therapist that I was assigned to, had expertise in the areas of certain disabilities that I am having to deal with and I just found (she) was very empathetic and open to listening and had a lot of time for me."(David, student)*

This professional knowledge was also described by occupational therapist participants as being important to share with the students:

> *"When I talk to students and I always do try to get them to think of recovery and get them to read the terms in the self-management programme because I think it is fundamental for them to understand where maybe I'm coming from as a therapist and thinking it is great for me to have the knowledge in my head but really the knowledge has to be in their head as well"(Jessica, OT)*

6.5.1.2 Occupational Therapist as a Facilitator of the Programme

Most student participants described the occupational therapist as a facilitator in working through the USMP. This involved going through the programme content, but then also facilitating and supporting the discussion:

> *"you know (the OT) was more like a guide like she listened like to what I had to say …so I think it is good like to have somebody who is kind of guiding but …not imposing but on the other hand was not letting me ramble on so like so I do think the dynamics worked really well" (Sean, student)*

> *"She just gave me a work sheet questionnaire kind of thing ,… and go through it with me and then I would go off and do it myself and then kind of discuss but it was all my input but she was kind of guiding me through it". (Ciara, student)*

Other student participants agreed that the engagement in the programme was guided by their occupational therapist, but they also maintained that they could have led this more if they chose to:

> *"Mostly by the occupational therapist but I know I could have led it any way I wanted to, but I am happy with what I did, and the structure of the programme really helped". (Hannah, student)*

The importance of the occupational therapist as a guide within the collaborative relationship was also highlighted by student participants:

"It definitely was a collaboration and I feel that was important. I feel like I could not have led it because if I had led it, it would have ended up never ending and I probably would have mulled over certain areas and then neglected other areas so I feel like you don't want it to be led by someone else but you need it to be.and to be getting ongoing feedback on it and monitoring" (Emma, Student)

Leah maintained that the occupational therapist acted as a guide to begin with but then went on to describe a change in the relationship, as she herself took on a leadership role as they progressed through the programme:

"Kind of coming towards the end like its much more you are leading it but there is stuff said by the OT, but it does feel a bit more like a guided path towards it"(Leah, Student)

Occupational therapists highlighted the importance of the process being led by the student as the USMP was "*part of their recovery journey'.* For occupational therapists, this involved:

"taking the lead from the student and the therapist (was) there to support them in wherever there is a concern". (Jessica, OT)

Other occupational therapists, however, described being unsure of how much to guide the student, using gentle probing instead.

"I suppose that's a kind of a difficult area. …well do you force it on them like, it's their self-management experience so do you try to encourage them to go off and read something or do you try to look something up while they are there or, you know, or do you kind of leave it to them". (Nicole, OT)

6.5.1.3 Individual Relationship with Occupational Therapist

Student participants maintained that the personal relationship with the occupational therapist was seen as a key aspect in enabling the discussion of the issues addressed in the programme*:*

"It was more personal, and I know (the occupational therapist) and myself you know developed a trust a bond that was personal and so

again it worked very well for me and I kind of opened up you know once there was trust there; I opened up and I felt comfortable talking." (Daniel, student)

"I do I mean for me it really helps with the one on one rather than with like a bunch of people plus you know it is more personal, the person knows more about you more about how you relate to these things, it's easier for them to help you develop strategies from what you kind of like identified" (Aoife, student)

Occupational therapists described that some students needed more support in certain aspects of the programme, such as reflecting upon previous experiences.

"a couple of students needed a lot more prompting to talk about things so actually when it comes to things like the warning signs that they might be becoming unwell students would be less comfortable talking about that". (Róisín, OT)

Occupational therapists described how the programme had helped them to focus upon the individual and person-centred care.

"The self-management programme really helped to kind of personalise it and to make me understand that it was very unique to each person that I worked with". (Caoimhe, OT)

6.5.2 Learning Strategies and Enabling Engagement in Occupation

6.5.2.1 Identifying What has Worked and not Worked Previously

Occupational therapists maintained that the reflection upon the students' past engagement in occupation was a key element of the USMP approach in developing personalised strategies.

"Yeah I think the big thing with recovery and the self-management programme I think …. you are looking kind of at students' experience and like previous experience and things that worked in the past as well as things that hadn't worked or things that belong in the past". (Kate, OT)

"really helped for them to reflect… what are they doing with me like with the therapist but also what are they doing for themselves like what can they be doing or what is their potential" (Nicole, OT)

Students referred to engagement in the USMP as leading to an increased sense of awareness of their occupation and of themselves as students, which better enabled them to respond to their life stressors.

"definitely more aware of when things are starting to go wrong… so that I can set things in in place before they get disastrous". (Adam, Student).

"I suppose, by identifying what stops me participating in my student role and coming up with strategies to deal with when that happens have been really beneficial because while I sort of had an idea before actually getting them pinned down properly and thinking about stuff that would make me get back into my student role. I've been able to apply it rather than just kind of thinking 'O something has happened' ". (Sarah, Student)

"It (the programme) just it really helped me to see what kind of makes me tick, I suppose, and what makes me work to the best of my abilities on a daily basis, such as being able to identify those things is great; so I knew what I had to do and what I shouldn't do so I think definitely it did help in all walks of my life really." (Jack, Student)

Occupational therapists maintained that they also had an important role in enabling the student to develop self-awareness.

"I think we also have a role as occupational therapists to kind of support the person to understand who they are and if we think of developmental frame of reference then you also have to consider that the person is on their own self-awareness journey."(Jessica, OT)

6.5.2.2 Supporting the Application of the Strategies in the Here and Now

Students valued the relationship with their occupational therapist in supporting engagement in occupations and in applying strategies discussed in the programme.

> *"Yes I think that was crucial and I think because and I can only speak for myself but I think because these activities and these things are things that people really struggle with you need to have someone who is actively engaging you, engaging but not forcing you to engage but encouraging you to engage on a one-to-one basis especially in areas like motivation and in self-direction when you have actually someone there that is keeping you accountable in some way."(Emma, student)*

Students described how the occupational therapist provided a counterpoint in developing and implementing strategies. This was an evolving process of identifying strategies, trialling them in their student lives, and then reviewing and refining these.

> *"I did find it helpful to have the occupational therapist there …it's just a good way to vocalise it, so you can hear yourself saying this is what you did …just having a second opinion is just …like sometime you would go this didn't work and it would be a case of did you try anything else. No so you kind of go ok…….so it is helpful to have someone else to challenge you like are you actually trying, you have got to be more honest with someone else sometimes than you are with yourself so yeah it was good to have the OT there." (Leah, student)*

> *"Working on strategies …. not just about strategies you can use but can change, it is an evolving process".(Séan, student)*

Occupational therapists viewed themselves as having a dual role in working through the sections in the USMP with the student, but also focusing upon enabling engagement in occupation and explicitly discussing its connection to health.

"our role is two-fold; obviously to work with them through the self-management programme but our role as occupational therapists is obviously to keep the focus on occupation…. What I find helpful is in working at this is looking at the roles so bringing it back to roles." (Nicole, OT)

"It is definitely occupation-focused and often how I describe it to people is bringing it back to what, bringing it back to occupational therapy and really what occupational therapy is about. We are occupational therapists, we are concerned with the activities you do on a day-to-day basis and how that links to health and well-being, how that links to identity how that links to role, how that links to often our mental health." (Jessica, OT)

"I think around being able to actually identify something and being able to articulate it and maybe being able to process it and being able to break things down and being able to select and choose appropriate courses of action maybe that suit the person." (Kate, OT)

6.5.2.3 Benefits of Keeping a Record of Learning

Both student and occupational therapists highlighted the benefit of the workbook in writing down ideas, reflections, barriers and potential solutions. Occupational therapists maintained that writing out reflections and learning was an important step in the process, rather than having a discussion only or indeed the occupational therapist writing out the student's goals and reflections within the meetings.

"I think actually writing is a lot more powerful even than typing or seeing a goal being typed and things like that I think that's really.. obvious in terms of how it's printed, it's great". (Kate, OT)

Participants also described the usefulness of the process of writing, in that it created a record that could be revisited in future meetings, or between meetings, and then amended based upon their experiences.

"the fact of writing down first and then like afterwards I can make amendments re structure so kind of it was like a bit unstructured at first but actually when I could have an overview I could visualise it better". (Séan, Student)

Students maintained that having these reflections, insights, and developed strategies easily accessible as an outcome of the programme, enabled them to recognise periods of low mood or non-engagement in the student role and respond as needed:

"Having it down really helps because you know if I kind of, if I get into a state where I am kind of like down and I don't know what to do, instead of my thinking oh what can I do now I can just take it out and look at it and say O.K. I can try this, this and this" (Sarah, Student)

Emma felt that having a workbook-based approach could have benefits in reducing students' engagement with services.

"structured programme which has typical application and which has a workbook that you can keep and consult, I think that could help you both not to allow people to rely on you as much and to be able perhaps spend less time".

6.6 Themes Related to Context

This section presents the qualitative themes from the staff and student interviews relevant to the context, namely, factors external to the USMP programme that could act as an enabler or barrier to the USMP implementation and outcomes (Moore et al., 2015). These themes and sub-themes are outlined in table 6.9 below.

Table 6. 9: Themes and subthemes related to context

Theme	Sub-theme
Enablers to Implementation	Service Structure
Barriers to Implementation	Academic Year Structure Readiness of the Occupational Therapists to Use the Programme

6.6.1 Enablers to Implementation

6.6.1.1 Service Structure

Occupational therapists maintained that the way the Occupational Therapy Service is structured allowed for an on-going individualised approach such as the USMP. A key focus of the occupational therapy service is that it is flexible and individually tailored to meet the needs of individual students. Consequently, the individualized nature of the USMP programme sits nicely within this philosophy.

Occupational therapists highlighted that the USMP was in line with the service's focus upon students as occupational beings, and the need to support them developing throughout their educational journey.

> *"I think fine if you want to create a programme that is really driven and its really focused and if you were maybe determining it's efficiencies and finances were an issue with maybe that is a totally different ball game but I think within the context of how the service is structured and is set up this programme works nicely . It is flexible person centred within the context of the student environment we are trying to work for the student here. We are not like trying to give them a six-week session and say off you go toddle off because our occupations change from one year to the next and I think that is the other aspect that we have to consider. Transitions happen within college as well and a person's mental health or their own journey as a student is going to change not just because of the occupations that they engage in but also their own personal development as well and the*

connections that they establish within college for themselves too all of those contextual aspects have an impact on their ability to manage their student role and manage their own health and well-being" (Jessica, OT)

"I think the programme is absolutely suitable to use in here but I think the reality is it is ideal is the service is set up .. like students are coming in first and foremost being students and not students with mental health issues" (Emily, OT)

6.6.2 Barriers to Implementation

6.6.2.1 Academic Year Structure

A number of the occupational therapists referred to the challenge of using the programme within the academic year as often the students were under pressure with a number of academic demands such as examinations and assignment deadlines.

> *"it just gets very busy once February and March comes so I think there are times that it's harder; you are more focused than just the day-to-day job". (Emily, OT)*

Occupational therapists made decisions not to do the self-management programme in cases where students had pressing academic demands that would impact on its completion. They maintained that students often wanted to address other demands, rather than to engage in the format of the programme.

> *"some of the students who were maybe not at a point where they could think about those things yet and they were very focused on just the more basic like I have an essay in two weeks". (Róisín, OT)*

Indeed, occupational therapists found that there was a difference in how they used the programme depending on the time of year and the demands that the student had at the time.

> *"I know I am working the programme very differently with them as I have done with the other students because with the other students it was around the time of the exams so it was a little bit I think it was*

very different because as I suppose you were there to support them as in ..Self-management building but also just checking in in terms of are they on track for different things, for their exams." (Kate, OT)

Students also raised an issue about continuing the programme out of term time, when many would return home or travel abroad for work experience, meaning that that they could not engage in the programme.

"The only thing was, what I couldn't control was we took a break for the Summer and so then it was a big long gap between some sections but that wasn't bad though I felt everything was in control. It was fine… but I had forgotten a lot of the stuff was reminded of it but it was ok yeah" (Rebecca, Student)

Of the nine students who did not complete the USMP, two disengaged from the Occupational Therapy and Disability Service Supports at the end of the academic year and did not re-engage in the following year; another transferred courses and did not re-engage. This break in connection to college may have contributed to non-completion of the programme.

6.6.2.2 Readiness of the Occupational Therapists to Use the Programme

The Occupational therapists reported varying degrees of readiness to firstly introduce and then engage in the Unilink Self-Management Programme with students. A number of the Occupational therapist participants felt their level of experience of using the USMP and their overall experience as an occupational therapist influenced when and with whom they chose to introduce the programme.

"Was I putting my prejudice, not prejudice, my bias kind of in deciding well yes they are ready no they are not ready and also because it was very new to me…. not that I didn't think the programme was good but more how to get used to using it." (Nicole, OT)

6.7 Summary

This Chapter outlines the key findings of the USMP process evaluation. Occupational therapists described how the training and resources were useful

in delivering the programme. The decision to use the programme with students was a complex one for the occupational therapists, based not only upon the assessment and goal-setting process with the students, but also on other factors such as the timing in the academic year and the demands that the student had at a given time. The occupational therapist participants also reported that they made judgements based upon how ready they perceived the students were to engage in the programme. Other occupational therapists strongly felt that it should be an informed decision by the student to engage in the USMP, with the therapist providing a comprehensive introduction to the programme.

Overall, both students and occupational therapists positively received the USMP. The individualisation of the programme in terms of number of meetings and duration of the programme was valued by students and occupational therapists. The one-to-one meeting format, personalisation of the content to each student, the ability to switch focus from the USMP to current academic demands, and the additional resources with the programme, were viewed as important aspects by both students and occupational therapists.

The collaborative relationship with the occupational therapist and the focus upon supporting previous and current occupational engagement were considered to be core elements of the USMP in terms of promoting change. In particular, both students and occupational therapists highlighted the sharing of opinions around the concepts of mental health, recovery and occupation as an important foundation for a collaborative relationship and as a positive experience for them. Suggestions were made with regards to training and supporting therapists on an on-ongoing basis in delivering the programme.

Chapter Seven: Discussion and Conclusions

7.1 Introduction

This study is particularly timely given the increasing trend of reported mental health conditions amongst the student population in higher education (HE) (Auerbach et al., 2018; Bruffaerts, Mortier, Kiekens et al., 2018; Ibrahim, Kelly, Adams, & Glazebrook, 2013; Jenkins, Ducker, Gooding et al., 2020; Pedrelli, Nyer, Young et al., 2015). In addition, on-going reports maintain that this student need far exceeds the resources available through student supports (Bartlett, 2014; Castillo & Schwartz, 2013; Centre for Collegiate Mental Health, 2016; Eisenberg, Hunt & Speer, 2013; Fox, Byrne and Surdey, 2020; Thorley, 2017).

Higher education has been highlighted as a key time in students' lives, not only from an educational perspective, but also in supporting students with mental health conditions on their recovery journey (Hunt and Eisenberg, 2010; Royal College of Psychiatrists, 2011). Ireland has one of the highest rates of diagnosed mental health conditions in Europe (OECD, 2018), with ever-increasing numbers of students accessing disability supports in their institutions (AHEAD, 2019). This is of particular note as Ireland also has very high participation rates in HE by international standards. Levels of support vary within HEIs, mostly in the form of college-based supports, but an underdeveloped mental health system in Ireland (OECD, 2014; Seanad Public Consultation Committee, 2017) is leading to increased pressure upon college students and college-based support services (AHEAD, 2018; Fox, Byrne and Surdey, 2020; Psychological Counsellors in Third Level Colleges in Ireland, 2021).

Schemes such as the Disability Access Route to Education (DARE), which offers a points reduction on course entry for applicants who meet the established criteria for having a disability, have contributed to this situation (DARE, 2018). Nineteen of the thirty student participants who took part this study entered the HEI through the DARE scheme, which requires them to disclose a mental

health condition upon entry to college. The remaining eleven student participants registered with the Disability Service at different points in their college courses.

This final chapter will review the aims of the research and summarise the main findings from the student cases presented in Chapter Five and the process evaluation outlined in Chapter Six. The chapter will discuss the findings in relation to the four research questions established in the context of the current literature. It will further outline the contribution that this research makes to the evidence-base for mental health self-management and the role of occupational therapists in HE. The strengths and limitations of this research will then be discussed, considering the risk of bias within the study. The chapter will conclude with suggested areas of future research.

The overall research aim was *"To understand the experiences, reflections and personal outcomes of student and staff participants using the Unilink Self-Management Programme (USMP) in a real-world HE context"*. This aim was subdivided into two objectives: i) To explore the personal outcomes of student participants from engaging in the Unilink Self-Management Programme and ii) To explore the experiences and reflections of students and occupational therapists in using the Unilink Self-Management Programme. Having reviewed the current literature, four research questions were established to meet these objectives:

- Do college students with mental health conditions experience significant role-impairment?
- Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?
- Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?

- What are the experiences and reflections of students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?

7.2 Findings in the Context of Current Literature

The research explores the personal outcomes of ten students who completed the Unilink Self-Management Programme (USMP) and engaged in all three phases of the research study, through the analysis of ten case studies. Summary outcome data is also presented for the other students who engaged in one or two phases of the study. It further explores the findings of the process evaluation based upon the twenty students who completed the USMP and two phases of the research, as well as six occupational therapists who were part of the study.

7.2.1 Research Question One

Do college students with mental health conditions experience significant role-impairment?

The findings of this research are consistent with the international literature highlighting significant role impairment amongst college students who experience mental health difficulties and diagnosed mental health conditions. Experiencing a mental health condition has been shown to impact upon engagement in the student role with regards to academic attainment, progression, and social connection with other students, leading to reduced levels of quality of life and increased levels of reported psychological symptoms (Alonso et al., 2018; Arria, Caldeira, & Vincent, 2013; Auerbach et al., 2018; Dooley et al., 2019; Eisenberg et al., 2009; Horgan et al., 2018; Jenkins et al., 2020; Kessler et al., 1998; Mojtabai et al., 2015; Storrie et al., 2010). This is in line with the findings of a study of role-impairment in incoming first year students by Alonso et al. (2018), using an adapted version of the Sheehan Disability Scale (Leon et al., 1997), which looks at role-impairment in the areas of home management/chores, college-related and other work, close personal relationships, and social life. This study found that 42.9% of students with at least one mental health condition reported severe

role-impairment, as compared to 10% of students without a mental health condition. It also found that students with three or more mental health conditions were five times more likely to report severe role-impairment (Alonso et al., 2018).

The presence of a mental health condition prior to college matriculation is associated with both reduced levels of entry to HE and higher likelihood of withdrawal (Auerbach et al., 2016). The majority of the thirty student participants (86%) reported that they had a mental health diagnosis before coming to college. Twenty-nine of the thirty student participants (97%) completed their first year in college and progressed to second year. This compares favourably to the progression data within the institution as a whole over the research period which varied from 88% to 94% (Mitchell, 2020). This is significant as although Ireland has relatively high retention and progression rates internationally (HEA, 2019; OECD, 2016), withdrawal is most likely to occur in the first year of study (Blaney and Mulkeen, 2008; Yorke and Longden, 2008). Experiencing a mental health condition is associated with lower rates of progression and retention in college throughout the student journey (Auerbach et al., 2016; Bartlett, 2014; Collins and Mowbray, 2005; Hunt, Eisenberg and Kilbourne, 2010; Kessler, 1995; Mojtabai et al., 2015; Reilly, 2019).

Four students (13%) withdrew from college during the study; one in first year, one in second year, and two after completing two years. Three of these students had completed the USMP. One of these students reported at post-programme interview that he was in the process of withdrawing due to the course not meeting his expectations. Nevertheless, he reported positive engagement in the USMP, and good ability to engage in his student role. The two other students withdrew after the post-programme interviews and no reason was cited for withdrawal, but they each failed a year and took a further year out of studies prior to withdrawing from college.

The findings in this study showed that fifteen of the thirty students took additional time to complete their undergraduate or postgraduate courses. Twenty-one of the thirty student participants in the study completed the

USMP. Of these twenty-one students, eleven took additional years to complete their course. This is in line with the study by Arria, Caldeira, and Vincent (2013) which found experiencing a mental health difficulty can be linked to interruptions in participants' course progression. However, the findings of this study are not in line with a secondary finding of Arria, Caldeira, and Vincent (2013), that students entering college with a pre-existing mental health diagnosis are not at risk of interruptions to the course progression, given that 86% of the student participants in this current study reported a diagnosis prior to coming to college. These additional years (repeat or 'off books' on medical grounds) happened to a greater extent in the later years in college, with ten of the fifteen students going off books in their third year or final year in college.

The findings from the cross-case analysis of the ten student cases are consistent with international literature that experiencing a mental health condition is associated with substantial impairment in academic performance (Auerbach et al., 2016; Bruffaerts et al., 2018; Eisenberg, Golberstein, and Hunt, 2009; Erskine & Harmon, 2021; Lipson & Eisenberg, 2017; Stallman, 2010). Fusar-Poli et al. (2020), in their scoping review, identified academic/occupational performance as one of their fourteen core domains that define good mental health in adolescents and young adults. All ten students highlighted occupational performance issues related to academic activities in the student role. These were often the reason that students were referred to the Occupational Therapy Service after the needs assessment meeting with their Disability Officer. Academic concerns were also highlighted by most students in the Occupational Therapy assessment process, with students identifying occupation-focused goals related to academics such as academic planning and meeting deadlines, attending class, academic writing and giving presentations. Students often connected their mental health with engagement in academic occupations, with the cross-case analysis showing that five of the ten students maintained that academics impacted negatively upon their mental health in pre-programme interviews, mostly with regards to managing stress and anxiety in completing demands

such as assignments and examinations. This is consistent with literature from the general student population in HE, (Dooley, O'Connor, Fitzgerald et al., 2019; Erskine & Harmon, 2021), highlighting academic demand as the most common stressor for students.

Social connection is another key aspect of student well-being (Dougherty, 1996; Eisenberg, Lipson and Posselt, 2016; Ekelman, Bazyk & Bazyk, 2013; Laidlaw et al., 2015; Leach, 2014, Megivern, Pellerito, and Mowbray, 2003; Royal College of Psychiatrists, 2011). The social aspect of college can be even more important for students experiencing a mental health condition. Students share in their academic learning with each other and have been found to be important sources of support (Bernardon et al., 2011; HEA et al., 2019). It also involves students' connections with support services, academics, and others within the college environment and it can also be a difficult space for students in terms of navigating disclosure and stigma. The findings of the cross-case analysis show that nine of the students identified issues with regards to social engagement as part of the student role. Some students identified this as part of the needs assessment process with their Disability Officer; some highlighted issues as part of the Occupational Therapy assessment process, while others highlighted issues in the pre-programme interviews of this research. Social occupations and social connection were highly valued by students, with four students highlighting expectations for the student role that, at pre-programme interview, involved increased social connection. Students also highlighted social connection as a key aspect in defining mental health at pre-programme interview, and four students identified engagement in social occupations or finding a balance between social and academic occupations as a goal for the Occupational Therapy process, which informed the decision to use the USMP.

The cross case-analysis showed that eight students identified difficulties in forming and maintaining a routine in college, describing difficulties in balancing activities in their student role, managing changing routines and timetables, and knowing when to switch off and stop working. This appeared to be more of an issue for postgraduate students and students completing

self-directed assignments such as dissertations. Students also highlighted difficulty in balancing academic activities with paid employment outside of college as well as home life. This is particularly significant given that over half of Irish students in HE are in paid employment at some stage during the academic year (Erskine & Harmon, 2021), and that approximately one in five students reports paid employment as a significant stressor in their lives (Dooley, O'Connor, Fitzgerald et al., 2019; Erskine & Harmon, 2019). Eight of the ten students identified goals from the Occupational Therapy assessment process which focused upon routine formation or occupational balance, which again led to engagement in the USMP.

Findings showed that the raw scores for the ten student case studies on the Global Severity Index (GSI) of the Brief Symptom Inventory (Derogatis, 1993) are in line with the normative data for the 'Adult Psychiatric Outpatient', supporting the use of these normative data to calculate T-scores for the case studies above. The GSI is described as the most sensitive indicator of a respondent's distress level, based upon a combination of the information on the number and intensity of symptoms, with the lower T-score associated with higher levels of psychological distress.

Quality of Life (QOL) has been identified as a key indicator of understanding the impact of health and health interventions on individuals' lives, and QOL measures such as the SF-36v2 (Ware et al., 2007) are regularly used in evaluating self-management programmes in the area of mental health (Barbic et al., 2009; Battersby et al., 2013., 2015; Cook et al., 2009; Cook et al., 2011; Druss et al., 2010; Jonikas et al., 2011; Lawn et al., 2007; O'Toole, Connolly and Smith, 2013). They have also been commonly used with student populations in HE (Houghton, Keane and Murphy, 2010; Kelly and Grueber, 2010). The findings at pre-programme showed that in six of the domains (Role Physical, General Health, Vitality, Social Functioning, Role Emotional, Mental Health) the mean of the ten student cases fell below the average range (T-score between 45-55), with four areas falling well below the average range (Vitality, Social Functioning, Role Emotional and Mental Health). With regards to the composite scores, there was a marked difference between the

Physical Composite Score (PCS) which falls within the average range, and the Mental Composite Score (MCS) which falls well below the average range. Nine of the student cases fell below the average range on the MCS, with T-scores ranging from 19.35 to 45.52, with a mean of 30.07 for the ten students. Of students who completed two phases of the research, eight students fell below the average range on the MCS, with T-scores ranging from 12.97 to 50.46, with a mean of 29.01. Nine of ten students who only completed one phase of the research fell below the average range on the MCS, with T-scores ranging from 16.54 to 52.79, with a mean of 30.51. These findings indicate that across all three groups of student participants, individuals experienced frequent psychological distress and greater limitations in activities due to emotional problems.

Being a student is a highly valued role for students (Ennals, Fossey and Howie, 2015), and this was clear within the case studies. Students highlighted that engagement in college life provided structure, social connection, academic achievement and preparation for the future (Ekelman, Bazyk, & Bazyk, 2013; Knis-Matthews et al., 2007). Students with a mental health difficulty experience significant role impairment across a number of areas (academic, progression, social, quality of life, psychological distress), and the findings of this research support the findings of previous literature in this regard. In supporting students, it is important to first get an understanding of the complex, varied personal journeys of these students through higher education from the initial transition to college, progressing through engagement in the student role, to the transition out of college to employment.

7.2.2 Research Question Two

Do college students with mental health conditions develop an increased understanding of their own mental health, recovery and occupation by engaging in the occupational therapy delivered Unilink Self-Management Programme?

Students' understanding of their own mental health has been recognised as being a key aspect that shapes the experiences of students with mental health

conditions in higher education (Ennals, Fossey and Howie, 2015; Hartrey, Denieffe & Wells, 2017). Students are often transitioning to adulthood with an emerging understanding of themselves, their health and their occupation. There is an increased expectation of students to be able to manage themselves and this involves an increased understanding of who they are and what they do.

From the cross-case analysis, it was clear that students' views of mental health changed over the course of the interviews. At the pre-programme interview, students defined mental health in different ways. Some definitions described diagnoses and symptoms and the impacts of these, while others viewed mental health in functional terms, in being able to engage in daily academic, social and other occupations and finding a balance between these. At post-engagement and follow-up, students' views of mental health appeared to change involving an increased sense of control in '*being in charge'* (Shauna). Students' views now also focused upon active management and awareness in using strategies and taking actions. Students' desire to manage their mental health independently is significant, in terms of how readily students access supports in college. Accessing disability supports and accommodations in HE often requires students to disclose a clinical diagnosis, and although the role of appropriately trained staff has been highlighted (Collins & Mowbray, 2005; Murphy, 2017; Venville, Street, and Fossey, 2014), the students' decision to access supports is often framed by their understanding and acceptance of their disability, in this case mental health (O'Shea and Meyer, 2016).

Recovery has been proposed as a personal, individual process, which is best defined by the individual who has lived experience of disability and recovery (Stoffel, 2011). Recovery-orientated approaches should enable people to be supported as individuals on their own personally defined journey to be who they are, rather than who others feel they should be (Browne, 2006). Recovery for students in this study at the pre-programme phase was a varied concept with some students focusing upon '*getting back to normal functioning*' or '*getting over'* some difficulty, while others viewed it in clinical

terms as not taking medication anymore. Only one student viewed recovery in practical terms as being able look after oneself. However, the meaning of recovery for several of the students changed from pre-programme to post-engagement in the USMP, with a clear change in their perception of recovery as involving students in becoming more active self-managers of themselves and their mental health. Students' views at post-programme and twelve month follow-up also reflected on recovery as an on-going process, of coping, times of feeling well and times not feeling well, and acceptance of these times. The discussion on the meaning of recovery to the student and occupational therapist in Section One was viewed positively for the formation of a therapeutic relationship, but also ensured that the USMP was orientated to the individual's view of recovery. There was no set definition of recovery that students had to adhere to as part of the programme, but the discussion incorporated various different perspectives of recovery from the mental health literature.

Students do not always possess a level of self-awareness in recognising and responding to mental health issues (Collins and Mowbray, 2005; Karwig, Chambers and Murphy, 2015; Quinn et al., 2009). Developing student knowledge of self and available supports should they become unwell, is key (Hartrey, Denieffe, and Wells, 2017) as students often do not recognise the signs of being unwell or know how to access help (Becker et al., 2002; Collins and Mowbray, 2005; Furnham et al., 2011; Hunt and Eisenberg, 2010; Merritt et al., 2007 Quinn et al., 2009; Reavley et al., 2012; Wei et al., 2013). It is particularly important that students know how and when to access supports. Academic accommodations have been shown to be amongst the useful supports for managing symptoms for students with a diagnosed mental health condition (Dougherty et al., 1996; Megivern Foster, Pellerito, and Mowbray, 2003; Knis-Matthews et al., 2007; Quinn et al., 2009; Murphy, 2017). However, students need to know when and how to approach course and college service-based supports to avail of these. As the USMP was delivered within an Occupational Therapy Service, embedded in a disability service, this ability to recognise when their mental health is impacting upon their student

role, is particularly significant. Findings from the cross-case analysis and summary data from students who completed two phases, show that students developed an increased recognition of how they were feeling and the causes for this, as a basis for being able to meaningfully respond.

Findings also show that students connected their mental health with their occupations. Over the course of the interviews, students increasingly described mental health as *'being able to function normally'* (Luke), achieving what you wanted to do, engaging in daily activities, and finding a balance of occupations in their lives. Students also identified an increased personal awareness at an occupational level, with eight of the students from the cross-case analysis referring to how the USMP had facilitated an increased self-awareness related to how they engaged in their daily occupations. This involved an increased understanding of what they engaged in, if this was health promoting, and to what level they were engaging in different occupations. Students also highlighted an increased awareness of the importance of a balance of occupations in their student life.

7.2.3 Research Question Three

Do college students with mental health conditions develop self-management strategies and learn to manage their occupations through engagement in the occupational therapy delivered Unilink Self-Management Programme?

Students highlighted how they engaged in occupation to maintain their health and well-being, but furthermore, the strategies that they developed from the programme to support this engagement. Engagement in occupation can provide numerous benefits for individuals with mental health conditions. It can identify benefits such as social cohesion, meaning, purpose, normalisation, routine, competence, productivity, skill acquisition, and pleasure, as occupations connect people to social networks (Eklund, 2006; Kelly, Lamont and Brunero,2010), and establish patterns that support health (Hocking, 2014). Occupational therapy has, at its core, a belief that occupation is essential to the health, well-being and recovery of the individual and that

successful engagement in meaningful occupation is central to an individual's well-being and health (Wilcock, 2006; Yerxa, 1998).

Findings showed that students in this study identified occupations that they engaged in to maintain their health and well-being, such as engaging in exercise, mindfulness, baking, completing academic work, watching movies, going for walks, engaging in societies and connecting with friends and family. Paid employment was an important element of the student role for four of the students. They viewed work as supportive in maintaining health and well-being as it provided a sense of competence and engagement, structure and social connection. However, at twelve month follow-up, students identified that trying to balance work with their student life had a negative impact upon their health and well-being, through stress and the inability to form a routine. This is consistent with the studies by Laughman, Boyd & Rusbasan (2016) and Park & Sprung (2013) showing negative associations as a result of the conflicting demands between work and academics on the psychological wellbeing of college students.

Findings of this study also showed that students developed strategies through engagement in the USMP to maintain their health and well-being and engagement in their student role. Students described developing occupation-focused strategies with the support of the occupational therapist in the USMP, such as breaking down tasks, establishing plans for academic work, using college environments such as the library, connecting with supports and scheduling time for social contact and leisure engagement. They developed these strategies over time and through their application in their real-world student lives. At twelve month follow-up, half of the students reported still applying these strategies, while others felt that their role had changed from a student role to worker role and that some of the strategies were not as relevant to their lives at that time. Students highlighted the supportive role of the occupational therapist in the identification and implementation of strategies as part of the USMP. The evidence-base for occupational therapy's role with individuals experiencing mental health difficulties has grown significantly over the past twenty years (Arbesman & Logsdon, 2011; D'Amico,

Jaffe & Gardiner, 2018; Gibson et al., 2011; Kirsch et al., 2019; Noyes, Sokolow & Arbesman, 2018). This has highlighted the use of occupation-based interventions and intervention programmes or practices, focused upon individualised client-centred goals and developing habits and routines.

Students placed a specific value upon being able to structure their time and to plan their tasks. The student role in higher education places a significant demand on students to manage their time, varying from structured timetables to highly self-directed activities. Students in this study highlighted significant difficulty in forming healthy routines, and in developing occupational balance within them. Occupational therapists have been recognised as having the skill-set to support recovery by helping individuals to identify habits, rituals and routines to support a healthy lifestyle (AOTA), and there is emerging evidence of this in several time-use interventions (Krupa et al., 2007). Seven of the student cases highlighted the importance of routine, and that the ability to form a healthy balanced routine was a key outcome from their engagement in the USMP. Routine was something that students struggled to implement when there was limited structure within their student lives and this was highlighted especially within postgraduate study.

The scores of the SF-36v2 also reflected outcomes of students being able to manage their mental health and engage in the student role. On the Mental Composite Score, five of the students from the cross-case analysis showed a positive minimally important difference (MID) of 3 or more T-score points from pre-programme to post-programme on the MCS. However, this increased to eight of the ten students showing a positive MID from pre-programme to twelve month follow-up. This indicates that 50% of students reported less frequent psychological distress and less functional limitations in activities due to emotional problems, with this rising to 80% of students reporting this improvement from pre-programme to twelve month follow-up. Due to small sample sizes these findings are only indicative. Other studies of mental health self-management interventions found no significant improvement in Quality of Life (Barbic, Krupa, Armstrong, 2009; O'Keefe et al., 2016; van Gestel-Timmermans H, Brouwers EP, van Assen MA, van

Nieuwenhuizen, 2012), but some did show improvement (Cook et al., 2012; Jonikas et al., 2011).

In terms of psychological symptomatology, five of the ten students from the cross-case analysis showed a positive change from pre-programme to post-programme on the Global Severity Index (reducing scores), with this increasing to six students from pre-programme to twelve month follow-up. Seven of the ten students showed a positive change on the Positive Symptom Total from pre-programme to post-programme, and also from pre-programme to twelve month follow-up. Nine of the ten students showed a positive change from pre-programme to post-programme on the Positive Symptoms Distress Index, with eight students showing a positive change from pre-programme to twelve month follow-up. Students who completed two phases of the research also completed the BSI on a second occasion. Seven of the students showed a positive change from pre-programme to post-programme using T-scores on the Global Severity Index on the Brief Symptom Inventory. Overall, 60% of the students who completed the programme and attended the post-programme meeting, reported lower levels of symptomatology on the Global Severity Index. All these results are only indicative of improvements which supplement the qualitative data from the interviews. Several RCT evaluations of other mental health self-management interventions have demonstrated positive symptom related outcomes (Cook et al, 2012; Cook et al. 2013; Jonikas et al, 2011), but others have not had a significant improvement in symptomatology (O'Keefe et al., 2016; Canacott, Moghadda & Tickle, 2019).

One of the main outcomes for college students is progression through their college course, and from the HEIs' perspective, retention and progression are key aims. The HEA report on completion rate of Irish students who entered HE in 2007/2008 (HEA, 2019), stated a completion rate of 76% for all students in HE, with this rising to 83% for Universities, and a completion rate of 85% within the HEI context for this study. Experiencing a mental health difficulty has been shown to impact upon academic attainment and retention amongst college students (Auerbach et al., 2016; Bartlett, 2014; Collins and Mowbray,

2005; Hunt, Eisenberg and Kilbourne, 2010; Kessler, 1995; Mojtabai et al., 2015). A study by Reilly (2019) showed a completion rate of 72% of students in the research context who had disclosed a mental health condition through the college's Disability Service. Higher levels of educational attainment are associated with positive health outcomes in the general population (Cutler, & Lleras-Muney, 2010; Feinstein et al., 2006; Goldman & Smith, 2011; Spittel, Riley & Kaplan, 2015), and the development of the USMP aimed to enable students to participate in their student role and avail of these opportunities.

By the end of the research study, nine of the ten student case studies had completed their undergraduate or postgraduate course, with one student choosing an Ordinary Degree after her third year. Two of the undergraduate students enrolled in a postgraduate course, and two had transitioned into full-time employment. In reflecting upon their expectations for the student role, seven of the ten students from the cross-case analysis maintained that they had met their academic, personal and social goals and that the USMP had supported them in doing this. Although they completed their courses, two of the students (Ciara, and Hannah) reflected that they struggled to manage their mental health and engage in their student role at post-programme and twelve month follow-up interviews. Rebecca felt that they USMP had supported her in her understanding of herself and her mental health, and in her recovery, but that she had continued to struggle to engage in the student role, repeating a year, prior to taking an Ordinary Degree when unable to complete the final year of her course. Within this research study overall, twenty-five of the student participants (83%) completed their course while 81% of the research participants who completed the USMP graduated from their course with one student taking an ordinary degree after three years of her course. Three student participants who had completed the USMP withdrew from college, either immediately post programme, or subsequently. However, these three students reported positive benefits from engagement in the USMP at T2 interview, and all showed positive MID on the MCS composite score on the SF-36v2.

7.2.4 Research Question Four

What are the experiences and reflections of students and occupational therapists of the process of engaging in the Unilink Self-Management Programme?

Findings showed that both students and occupational therapists positively received the USMP, in terms of programme structure, content, delivery and personal outcomes from engagement.

Occupational therapists felt the training and resources were useful in delivering the programme, but the use of the programme varied greatly amongst therapists. Therapists cited a number of reasons for this such as how prepared they felt to use the programme, academic pressures for students, perceived readiness of students to engage in the programme and their own level of experience as an occupational therapist and in using the USMP. Therapists' clinical reasoning determined the use of the USMP in many cases rather than the student making an informed decision to use the programme or not. The pressures of the academic year were often cited by occupational therapists as a reason to not introduce the USMP to a student, believing it to be a commitment to a large number of meetings.

Based upon the principles of client-centred practice (Law, 1998) and recovery, the collaborative relationship between occupational therapist and student is a core aspect of the USMP. Establishing a supportive, empowering relationship is central to the Occupational Therapy profession and is a basis for meaningful intervention (Palmadottir, 2006, Taylor, 2008; Bonsaksen, Vollestad, and Taylor, 2013). Partnership, active client participation, and respect for client values are all central aspects in client-centred practice (Sumsion, 2000). The format of the USMP was based upon individual meetings and the collaborative relationship between the student and professional occupational therapist. This reflected the definition of self-management support by Bodenheimer, Wagner, & Grumbach (2002) who maintained that this involved a fundamental change from patient-professional relationship to a

collaborative partnership. The formation of a collaborative relationship has been identified as a core aspect of mental health self-management interventions (Kralik et al., 2004; Lean et al., 2019). The use of peer-delivered self-management programmes has been proposed as an effective model of self-management delivery (Lorig & Holman, 2003). A number of mental health self-management interventions are delivered by trained peer facilitators. However, there is limited evidence comparing the effectiveness of lay-led and professional-led interventions (Griffiths et al., 2007).

Findings showed the importance of the collaborative relationship within these meetings for both students and occupational therapists. Participants described how the workbook provided a scaffold by providing suggestions, but that the collaborative relationship between the occupational therapist and student was key in refining them and making them useful as part of the student's overall self-management. Findings showed that students felt comfortable and able to have an active role in the programme, bringing their own ideas to the discussion within the USMP. Most student participants described the occupational therapist as a facilitator in working through the USMP. This involved both going through the programme content, but then the occupational therapist facilitating and supporting the discussion. Other student participants agreed that the engagement in the programme was guided by their occupational therapist, but they also maintained that they could have led this more if they chose to. Students were viewed by occupational therapists as bringing expertise and perspectives to the collaborative relationship. Occupational therapists further highlighted the importance of the process being led by the student as the USMP was part of their recovery journey. In particular, both students and occupational therapists highlighted the sharing of opinions on the concepts of mental health, recovery and occupation as an important foundation for a collaborative relationship and as a positive experience for them.

The USMP was designed to be a highly individualised approach in terms of structure and content. The individualisation of the programme in terms of number of meetings and duration of the programme was valued by students

and occupational therapists. The one-to-one meeting format, personalisation of the content to each student, and the ability to switch focus from the USMP to current academic demands and the additional resources within the programme were viewed as important aspects by students and occupational therapists. There has been criticism that 'recovery' has been co-opted by mental health professionals in rebranding existing approaches and models of practice as 'recovery orientated' without bringing about the change needed in mental health services (Beresford, 2019). The USMP emphasises recovery not simply in language, but in the individualised structure, on-going contact, personalised content, and collaborative partnership with students in helping them to develop self-management skills applicable in their student life. This individualisation reflected Anthony's (1993) focus upon the idea of personal recovery, describing it as '*… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles*.(p.527). Individualisation has been highlighted as a core aspect of recovery-orientated approaches, mental health self-management interventions (Lean et al., 2019) and Occupational Therapy approaches (D'Amico, Jaffe & Gardiner, 2018; Schindler, 2018). This is in line with the work of Wimpenny, Savin-Baden & Cook (2014), who maintain that selecting occupational therapy interventions that match the individual's needs and are implemented within authentic relationships are central to the effectiveness of an intervention.

Being responsive to student needs either in terms of their mental health or occupational demands at a given time was built into the design of the USMP. Within the USMP training and the Facilitator's Manual, occupational therapists were recommended to check in with the student at the start of every meeting to see how they were doing at present and how they were managing their current demands, and then respond accordingly. Occupational therapists highlighted the importance of this responsiveness to students' needs during meetings as part of a 'person-centred' approach. Students also described how they valued the way their occupational therapist responded to their reported needs, but also that they felt empowered to raise concerns as needed.

The one-to-one format and overall structure of the USMP was well received by students and occupational therapists, who viewed it as enabling collaboration and supporting reflection and learning. Both highlighted accessibility as a key aspect of the programme which allowed for personalisation in terms of pace of progress through meetings, number of meetings, and the format of the meeting being focused upon the workbook or based upon discussion. Mental health self-management interventions have been delivered in a variety of group and individual formats. Benefits have been proposed for group formats such as shared learning, peer-support and reduced costs, while one-to-one interventions can offer more opportunity for personal tailoring of approaches (Newman et al., 2014). Findings from the audit of case notes showed that occupational therapists followed the format of the programme structure through the six sections as outlined, but that some students needed more support in certain aspects of the programme and moved at a different pace. Although this personalisation of the programme was viewed positively, findings showed two issues: a) fidelity to the programme as set out in the Facilitator's Manual and knowing the limits of flexibility in terms of programme structure; b) recognising the difference between completing the USMP and occupational therapy meetings in general. Many of the students engaged in occupational therapy meetings prior to engaging in the USMP, and so worked upon strategies to enable engagement in various occupations. Two of the students at twelve month follow-up, when reflecting back upon positive outcomes in meeting an occupational therapist, described being unsure if it was due to engagement in format of the USMP or general meetings within the Occupational Therapy Service. This ambiguity was further exacerbated by students and occupational therapists pausing engagement in the USMP, in response to an identified need such as an essay deadline or an upcoming examination. The training and Facilitator's Manual outlined that the USMP involved six sections to be completed in order. However, the occupational therapists needed to be responsive to student needs with regards to the pace of completion. The USMP is designed to be an on-going engagement with students, not limited by a set number of meetings. Although having a number of weeks between meetings was viewed as a

positive by some students, in allowing them to apply strategies and engage in occupations identified, pauses of a number of months did not facilitate meeting the self-management aims of the programme. Recommendations with regards to increased definition of USMP structure, while allowing for some personalisation of the number of meetings, duration of the programme and time between meetings, are outlined in section 7.5 below.

Occupational therapists and students found Section One of the USMP in particular a very positive experience, through discussion of what recovery, mental health and occupation meant to the student. It was viewed as a very effective way of forming a collaborative relationship, based upon a shared understanding of each other's views on recovery. Occupational therapists found the discussion helped them to make recovery explicit within their work with students, and provided a mechanism to empower the students to feel that their views and ideas were valued. This shared understanding of issues and priorities enabled a strong therapeutic alliance and effective working partnership (Strong and Reibeiro-Gruhl, 2019). These findings were consistent with the work of Winsper et al. (2020) in highlighting the importance of promoting a working alliance to enable individuals to reach their recovery goals.

There was a set structure to be followed within the programme including discussion of key concepts, identification of occupations, and reflection upon previous positive and negative engagement. However, the USMP allowed for a high degree of personalisation in supporting students to engage in their chosen occupations. Students described the importance of being able to personalise the content of the USMP to their own student life, by initially using the lists and content within the workbook, but then adding their own ideas and perspectives, and with the help of the occupational therapist implementing it within their lives. This sense of personalisation and focus upon what they wanted and had to do in their student lives, was mentioned by many of the students.

7.3 Strengths and Limitations

To the researcher's knowledge this is the first study of an occupational therapy delivered self-management programme for college students with mental health conditions. The USMP was developed organically in response to an established student need within the practice setting of a disability service in an Irish HEI. The research was carried out within the practice setting of the Researcher.

7.3.1 Researcher/ Therapist

There were strengths and limitations to carrying out this research in a practice setting where I work, combining the roles of therapist and researcher. Occupational therapy provision in higher education is a relatively new role within the profession, with the service I work in being one of the first in the world. I have been involved in the Occupational Therapy Service since its establishment and have been actively involved in many of the developments, including the USMP.

Carrying out this research has been challenging as I have continued, for the most part, to work full-time throughout this entire PhD. Not only have I maintained a work role, but the role has expanded greatly and the numbers using the Occupational Therapy service have increased significantly, from 130 students to 440 students per year. The Occupational Therapy role has been combined with a Disability Officer role, encompassing needs assessment and the provision of reasonable accommodations, as well as the core occupation-focused approach that we had previously used. Within my role, I work with between one hundred to one hundred and fifty students per year.

Since the introduction of the Unilink Self-Management Programme, I have worked through this programme with many of them. As mentioned previously, none of these were participants in this research so as to avoid any potential bias. This removed a large number of potential participants who could have taken part in the research. Additionally, I have been extremely conscious not to influence colleagues to participate in the research or to use

the USMP with students, focusing rather upon the provision of training and on-going support as requested.

7.3.2 Recruitment

Recruitment to the USMP was based initially upon a referral to the Occupational Therapy Service being made, based upon the needs assessment process with the Disability Officer. Subsequently, the occupational therapy assessment process, using the PEO based Student Profile (Nolan, 2011), informed occupational therapists' decision to introduce the USMP to students. All of the occupational therapists felt that they should have a role in decision-making around the use of the programme. However, the therapists reported varying degrees of readiness to firstly introduce, and then engage in the USMP with students. Therapists highlighted a lot factors in choosing to use the USMP such as course demands and student readiness. This may have led to a low proportion of students using the USMP, and therefore impacted on the number of students that could be included in the research study.

7.3.3 Data Collection and Analysis

As an exploratory study, this research study is based upon a small sample of participants. The collection of data at three different points of time from the students as well as data from the occupational therapist, using a variety of data collection methods, provided a huge amount of data on each participant. This was challenging but provided an in-depth analysis of their personal outcomes and experiences over a prolonged period of time. This contributes to the knowledge base in occupational therapy delivered self-management in higher education, but the lack of a control group and delivery in only one research context affects the generalisability of the results.

The study had its challenges, with the original sample size of thirty students at T1 (pre-programme), reducing to twenty students at T2 (post-programme), and to ten students at T3 (twelve month follow-up). From T1 to T2, four students finished their courses and five disengaged from Occupational Therapy Supports and did not complete the USMP programme, and so did not participate in the post-programme and follow-up interviews. From T2 to T3,

three students had withdrawn from college, with seven students not responding to contact to complete the follow-meeting at T3.

However, this led to sixty sets of data over the three phases of the research in addition to the data sets from the six occupational therapists. The research aimed to understand the personal outcomes and students over a prolonged period of time, hence the follow-up taking place at twelve months post engagement. Many of the students were no longer attending the Occupational Therapy Service at this point, and indeed several of the participants had completed their course.

The individualised nature of the USMP led to questions about fidelity in how it was delivered by different therapists, and with different students by the same therapist. The use of an exploratory case-study design has aimed to provide an in-depth view of how and why the USMP was implemented and the personal outcomes that this led to. Any future effectiveness studies of the USMP would need to set out clear protocols and procedures for the delivery of the programme, and the limits to the individualisation in ensuring fidelity.

My background with the Occupational Therapy Service and development of the USMP is outlined in section 4.9, to increase transparency and reliability within the study, as recommended by Crowe, Cresswell, Robertson et al., (2011). Various strategies including the omission of students that I met as a therapist, the use of a gatekeeper for both students and staff, and the recruitment of an Occupational Therapy lecturer unrelated to the service to carry out the interviews with the occupational therapists, were used to counteract bias in the study. Reflexivity has been essential throughout data collection and analysis to reflect upon thoughts, challenges, assumptions and questions (Corcoran, 2006).

7.4 Implications for Practice

7.4.1 Occupational Therapy Mental Health Self-Management Interventions

Occupational therapy's role in the delivery of self-management interventions has increased over the last decade, but has mostly been targeted at specific

chronic diseases (Garvey, 2015; Ghahari & Packer, 2012; Kos et al., 2016; Loh, Packer, Chinna, & Quek, 2013; O'Toole et al., 2013; Pyatak et al., 2018; Raymond et al., 2016; Richardson et al., 2014). Many Occupational Therapists are delivering generic self-management programmes, and although training and perspective will influence how they deliver these programmes, occupation and Occupational Therapy theory are often not central to this delivery.

Occupational Therapists are challenged to demonstrate the distinct value of Occupational Therapy in prevention, promotion, and intervention for mental health (AOTA, 2014), but must also be challenged to develop and use self-management approaches based upon the models and theoretical constructs within our profession (Augustine, Roberts and Packer, 2011; Hand, Letts, and von Zweck, 2011; Wood, 1996). The focus of the *USMP* is upon enabling students to understand and manage themselves and the occupational performance issues associated with their mental health difficulty (e.g. what they are doing and how they are doing it). The Person-Environment-Occupation (PEO) Model (Law et al., 1996) was chosen to enable this to happen.

Self-management interventions have been recommended for individuals with mental health conditions in various policy documents and guidelines (DOH, 2006, 2020; NICE, 2014a, 2014b), but have not been routinely incorporated into mental health service provision within Ireland and into occupational therapy practice using occupational therapy models of practice. Research by Occupational Therapists in the area of self-management is increasing, but research by the profession in mental health self-management is rare, and even more so with regards to occupational therapy for students in higher education.

The USMP aims to be an occupation-focused self-management programme, which places the focus upon changing a person's quality of occupational performance in the *"here and now",* to maintain health and well-being (Fisher, 2013). Occupation-focused self-management offers the individual a format to reflect upon personal experience and gain insight into his / her occupation

and performance and to enable the learning that can occur from this. Focusing on a student's occupational performance in his / her current student life within an overall self-management approach, not only promotes engagement in the student role, but allows for reflection and learning based upon this engagement. This allows students to learn when doing, based upon the idea that in order to learn from an experience the individual must first be able to engage in the experience. This approach aims to go beyond medical management of a condition, to enabling students to reflect upon the tasks and activities that make up their student role and how these contribute to their health and well-being. To enable this, the content and design of any programme needs to be personalised to the individual and their student role. An occupation-focused perspective, with its emphasis upon the environmental supports and barriers to occupational performance, allows for self-management to move outside of the individual and promotes an understanding of the dynamic interaction between the person, environment and occupation. An emphasis is placed upon how students manage themselves and the functional implications that their condition can have on what they are doing, rather than on how they solely manage their condition and how they are emotionally coping with their lives.

Occupation-focused self-management helps the person to develop an understanding of themselves as occupational beings and to understand how they can function, even in the presence of a mental health difficulty or other disability. The student is asked to reflect upon their occupational performance at that point in time, and to work with the Occupational Therapist to address barriers to this occupational performance. Through the development of a student's understanding of their occupational performance, in the context of a mental health difficulty, this type of occupation-focused approach allows the student to identify the facilitators and barriers to engagement within the person-environment-occupation interaction. Within an occupation-focused self-management approach, Occupational Therapists can work collaboratively with the individual, analysing and reflecting upon the student's current occupational engagement and, if required, offer various approaches to

facilitate engagement. The student must be viewed as an equal partner in identifying the daily occupations that are important to him / her in maintaining health and well-being and engaging in the student role. The collaboration of the student, as an expert in his or her own life, and the skill-set of the Occupation Therapist in evaluating and influencing this occupational performance, is central to this occupation-focused approach. In helping the individual to frame their engagement in the student role and in the performance of their occupations, through the PEO (Law et al., 1996) framework, the Occupational Therapists can help the individuals to become architects of their own occupation, thus facilitating on-going occupational engagement. This perspective of self-management appears very congruent with McKay and Robinson's (2011) suggestion of skills development through occupational engagement and suggests that the role for Occupational Therapists, with their focus upon occupation and facilitating occupational performance, is well positioned to enable the individual to engage in his / her chosen occupation. This is an essential aspect of an approach to enable students to engage and stay in college, and is connected to the student role. Engagement in the student role offers all students an opportunity to learn and reflect upon their personal experiences. Through the development of a student's understanding of their engagement in the context of a mental health difficulty, this type of occupation-focused approach allows the person to identify the facilitators and barriers to engagement within the person-environment-occupation interaction. By utilising occupation as a means of promoting healthy coping and problem-solving skills in college students, an Occupational Therapist can help address issues in occupational performance that may lead to mental health concerns in the future (Keptner, Harris, and Mellyn, 2016).

Occupational therapy theory and the person-environment-occupation interaction are explicit within the programme. Many of the mental health related self-management programmes reviewed in Chapter Two are generic in structure, focusing upon health and wellness in broad terms, or focusing upon specific illness management techniques. Occupational Therapists offer much

in delivering self-management approaches, due to their theoretical perspectives and skills and understanding of the dynamic PEO interaction. However, when dealing with students with a mental health disability, they need to move away from the delivery of generic self-management programmes to approaches that use occupational therapy theory and skill set, and most-of-all places occupation at its core.

7.4.2 Occupational Therapy Approaches in Higher Education

This research adds to the evidence-base for occupational therapy approaches within higher education (Arbesman & Logsdon, 2011; Gutman, Kerner, Zombek, et al.,2009; Keptner & McCarthy, 2020; Noyes, Sokolow & Arbesman, 2018), and the use of individual practical support for students experiencing mental health difficulties, as highlighted by Murphy, McKernan, and Heelan (2016). More specifically it adds to the evidence-base for the use of occupation-focused approaches, in this case the *USMP,* to enable occupational performance in the tasks and activities of the student role, as well as the learning that can come from reflection upon this. There is an ever-increasing number of students in higher education disclosing a long-term mental health difficulty and registering with college Disability Services in Ireland (AHEAD, 2019).

Approaches such as the *USMP* can provide a format for facilitating these students to engage in college, and in tandem, develop practical self-management skills to manage themselves as students, and their health and well-being. By providing self-management programmes such as that which is the subject of this research, students can be empowered to use supports and reasonable accommodations as required within higher education in a more constructive way, based upon increased awareness of themselves as students and as occupational beings, and of the ways that they work best. Self-management literature talks of activated individuals who are actively engaged in managing their own health and well-being. Occupation-focused self-management aims to also activate individuals, both in terms of their occupation, and engagement in the student role.

In terms of the appropriateness of self-management approaches within the college context, in the research there was a clear sense of student participants wanting to become active managers of their health and their roles. This research is based within a HEI Setting, where a focus is placed not only upon academic learning, but also personal development. The ability of students to manage their health, role, and challenges that arise within student life is key to well-being and success in college (Canadian Association of College and University Student Services and Canadian Mental Health Association, 2013; Eisenberg, Lipson and Posselt, 2016). From the student perspective, engagement in the student role offers many opportunities as well as challenges (Royal College of Psychiatrists, 2011). The student role in higher education is highly varied, involving an expectation of students becoming increasingly autonomous, perhaps learning to balance academic pursuits with social life, manage a household, engage in new interests, form new relationships and possibly take on part-time work. Engagement in occupation throughout the student role, however, enables individuals to learn and develop new skills for increased competence (Yerxa, 1998). McKay and Robinson (2011) suggest participation through occupation provides an opportunity for the development of a sense of meaning, increased self-esteem, skill acquisition, and improved sense of identity. Occupational engagement allows for the development of personal and practical self-management skills, and furthermore, the fostering of self-determination and self-advocacy and, most importantly, the instilling of hope. Through occupation within the student role, students can be enabled to not only build academic knowledge and professional skills, but through their experiences and on-going reflection, to cultivate the personal self-management skills that are seen as a fundamental part of occupational intervention (Reed 2015) and that are fundamental to recovery. The student evolves and changes throughout higher education, meaning that self-management requires the ability to evaluate new situations, new demands, and new roles. The recovery approach and self-management assumes that students are experts in managing their own role. Within this educational context, students are viewed as not only the experts in their own health, but in their student role, their

course and of how they learn. Students who have entered higher education in most instances have a high level of academic attainment, but have not developed the self-management skills to be able to apply it to college. In using an occupation-focused self-management approach, the elements of reflection, learning, and development of self-awareness appear to fit well with not only the philosophy of self-management and recovery, but also in the educational paradigm, and especially where there is a focus upon experiential learning.

7.5 Recommendations

As an exploratory study, this research sought to understand the experiences of students and occupational therapists in using this new complex intervention. Based on the findings of this research a number of recommendations have been made for the development of the programme prior to further evaluation, as well as the implementation of the USMP in the higher education context. Suggestions for future research in the area are also included below.

7.5.1 Recommendations for Implementation of the USMP

7.5.1.1 Recruitment

- Publicly available Information: Information should be made publicly available about the USMP to allow for more informed student decision-making.
- Additional Referral Criteria: To assist the students and the occupational therapists in deciding when to use the USMP in response to student goals, additional criteria for referral to USMP should be included in the needs assessment process when a student registers with the Disability Service, and in the Occupational Therapy assessment process using the PEO based Student Profile (Nolan, 2011).
- Timing of Engagement: The USMP should be used with students at all levels and stages of their course, and personalised to their student role.

7.5.1.2 Training and On-Ongoing Education

- Training: Therapists were positive about the group training and resources provided for using the USMP, especially with regards to the practical role-play elements of the training. However, therapists felt challenged in using the programme with students, and in discussing key concepts with students. Therapists also highlighted their own personal development having used the USMP with a number of students.
- Reflection upon Application of Training**:** An enhanced training process should be devised in the use of the USMP, incorporating increased practical elements of role-playing in the delivery of sessions. The training process should be developed to include the therapists practically applying the USMP with a number of students before coming back to complete the training and sharing experiences and learning with other therapists.

7.5.1.3 Programme Delivery / Content:

- Professional Delivery: The USMP should be delivered as outlined by qualified occupational therapists working within the higher education context.
- Programme Structure and Fidelity**:** The programme should be delivered following the structure of six sections outlined in this study. Personalisation of content and timing of delivery can vary depending on the student's learning needs and course demands while completing the programme.
- Reflective Journaling between meetings: Occupational therapists and students suggested that students should be asked to keep a reflective journal of their experience between meetings, to shape reflection and consolidate learning, as well as provide evidence of what had happened over the week.
- Online Format: The programme should be developed into an online format to increase students' access to the content discussed within meetings and materials used, when students are applying learning

between meetings. As part of an online development, it was also suggested that the students should keep reflective diaries and activity records between meetings. Student participants felt that, although they were able to give ideas and insights within meetings, they perhaps also needed more structured ways of reflecting upon their occupation and performance prior to meetings, so that this could be discussed in more depth with the Occupational Therapist.

- Individual Meeting Format: The programme should be delivered using the individual meeting format based upon the collaborative relationship between the student and the occupational therapist.
- Defined follow-up meeting**:** Students and occupational therapists noted that students often continued to engage with Occupational Therapy following completion of USMP. At the twelve month follow-up interview, students discussed how they were now engaging in occupations to maintain their health and well-being but also how they were now applying learning from the USMP to changing life demands and role. The use of a defined follow-up meeting with students to reflect upon learning, and to support its application to their student life, should be included.

7.5.2 Recommendations for Future Research

- To build upon this exploratory study with a full-scale trial using a framework such as the Medical Research Council framework for evaluating complex interventions (2008).
- For the programme to be researched in other Higher Education Institutes to focus upon the transferability of the approach.
- To expand the number of student participants so as to further investigate the trends in improved Quality of Life on the SF-36v2 (Ware et al., 2007), and decreased psychological symptomatology on the Brief Symptom Inventory (Derogatis, 1993).
- This research examined how student participants' views of mental health, recovery and occupation developed through engagement in the USMP over a prolonged period of time at T1, T2 and T3. A future

area of research would be to examine how students' views of mental health, recovery and occupation change over time without engagement in a programme such as the USMP, potentially through naturally developing maturity within higher education.

- In future, evaluations of the programme should include more outcome measures focused upon occupational performance and time-use with students, to explore their use of occupation and routine.
- To examine the experience of students in higher education who need to take time out from studies as a result of mental health difficulties, as highlighted by this study and that of Arria, Caldeira, and Vincent (2013). HEIs have long focused upon supporting students to increase levels retention and graduation (Eisenberg, Lipson, and Posselt, 2016). Research into this key transition point for students experiencing mental health difficulties, would inform the development of supports and systems to make this as seamless as possible.

7.5 Conclusion

Students in higher education are often viewed as privileged, but in completing this research I have felt that the privilege has been mine to partner the student participants on their journeys through college, and also through their journeys of recovery. It is also a privilege to be an occupational therapist in the position that I have, working with students in a college-based service. I believe passionately in Occupational Therapy's role in higher education and in the occupation-focused self-management approach to supporting students with mental health difficulties and the part played by this approach in their recovery.

Student life and college life is full of opportunity for students to engage, learn and develop. It is also an unbelievably rich place for an Occupational Therapist to work. There are opportunities to work, refine and develop approaches, and also to learn from the experiences. This has enormously influenced my research, my learning and belief in the value of Occupational Therapy approaches in college,

and more specifically in the benefit of occupation-focused approaches. My hope is that the USMP and this piece of research will increase the profile of occupational therapy in higher education, and lead to a sharing of the expertise of occupational therapists with a wider audience.

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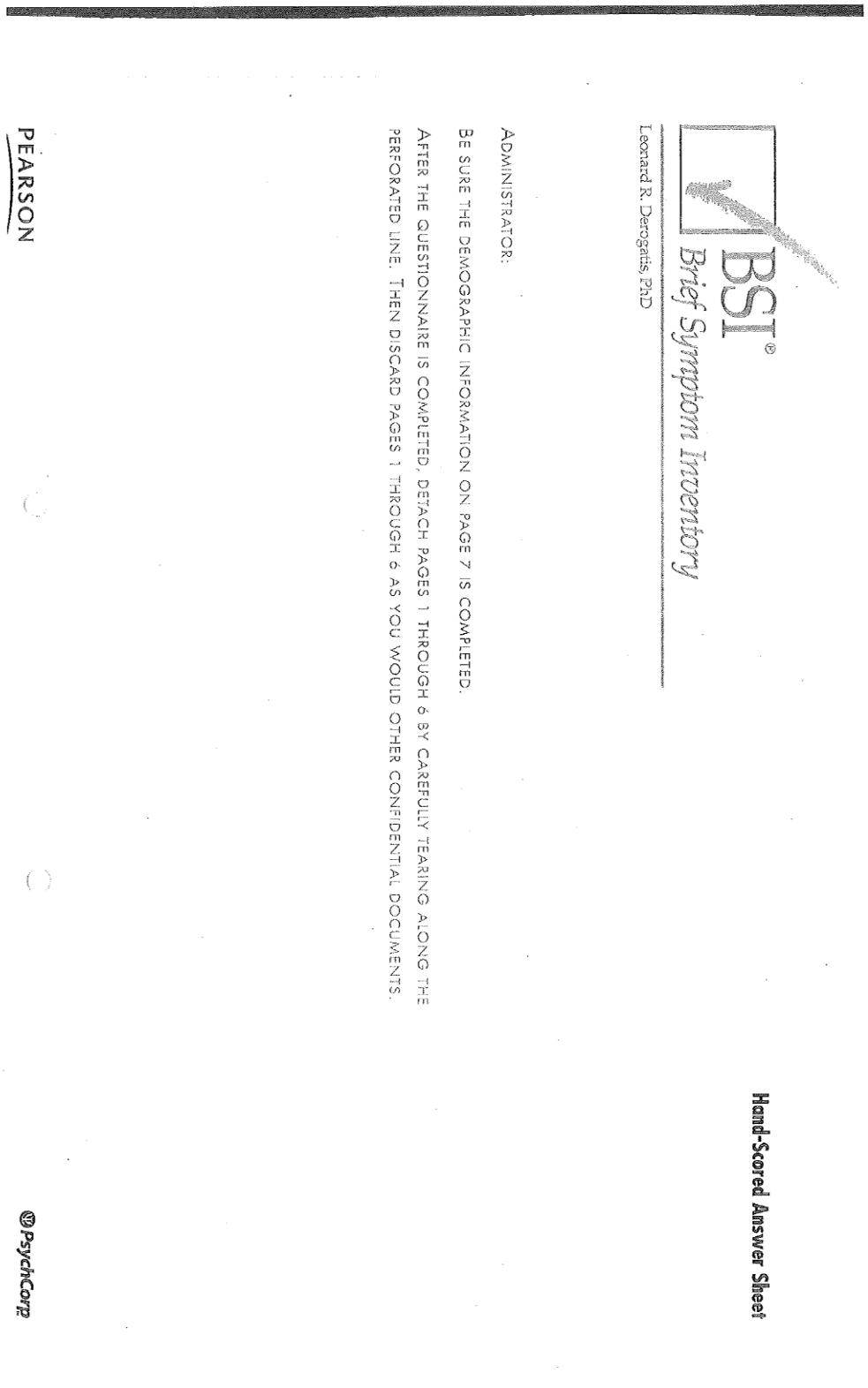
Appendices

Appendix 1: Data Extraction Tool for the Audit of the Clinical Notes

Participant No:	Therapist	Duration of Programme	Number of Meetings	Course Duration	Repeat Years	Outcome of Degree

Appendix 2: Brief Symptom Inventory



BSI®

Brief Symptom Inventory

Leonard R. Derogatis, PhD

Hand-Scored Answer Sheet

ADMINISTRATOR:

BE SURE THE DEMOGRAPHIC INFORMATION ON PAGE 7 IS COMPLETED.

AFTER THE QUESTIONNAIRE IS COMPLETED, DETACH PAGES 1 THROUGH 6 BY CAREFULLY TEARING ALONG THE PERFORATED LINE. THEN DISCARD PAGES 1 THROUGH 6 AS YOU WOULD OTHER CONFIDENTIAL DOCUMENTS.

PEARSON

PsychCorp

PsychCorp

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

HOW MUCH WERE YOU DISTRESSED BY:

1. Nervousness or shakiness inside	0 1 2 3 4
2. Faintness or dizziness	0 1 2 3 4
3. The idea that someone else can control your thoughts	0 1 2 3 4
4. Feeling others are to blame for most of your troubles	0 1 2 3 4
5. Trouble remembering things	0 1 2 3 4
6. Feeling easily annoyed or irritated	0 1 2 3 4
7. Pains in heart or chest	0 1 2 3 4
8. Feeling afraid in open spaces or on the streets	0 1 2 3 4
9. Thoughts of ending your life	0 1 2 3 4
10. Feeling that most people cannot be trusted	0 1 2 3 4
11. Poor appetite	0 1 2 3 4
12. Suddenly scared for no reason	0 1 2 3 4
13. Temper outbursts that you could not control	0 1 2 3 4
14. Feeling lonely even when you are with people	0 1 2 3 4
15. Feeling blocked in getting things done	0 1 2 3 4
16. Feeling lonely	0 1 2 3 4
17. Feeling blue	0 1 2 3 4
18. Feeling no interest in things	0 1 2 3 4
19. Feeling fearful	0 1 2 3 4
20. Your feelings being easily hurt	0 1 2 3 4
21. Feeling that people are unfriendly or dislike you	0 1 2 3 4
22. Feeling inferior to others	0 1 2 3 4
23. Nausea or upset stomach	0 1 2 3 4
24. Feeling that you are watched or talked about by others	0 1 2 3 4
25. Trouble falling asleep	0 1 2 3 4
26. Having to check and double-check what you do	0 1 2 3 4
27. Difficulty making decisions	0 1 2 3 4

Go on to the next page

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

HOW MUCH WERE YOU DISTRESSED BY:

28. Feeling afraid to travel on buses, subways, or trains	0 1 2 3 4	1. 0 1 2 3 4
29. Trouble getting your breath	0 1 2 3 4	2. 0 1 2 3 4
30. Hot or cold spells	0 1 2 3 4	3. 0 1 2 3 4
31. Having to avoid certain things, places, or activities because they frighten you	0 1 2 3 4	4. 0 1 2 3 4
32. Your mind going blank	0 1 2 3 4	5. 0 1 2 3 4
33. Numbness or tingling in parts of your body	0 1 2 3 4	6. 0 1 2 3 4
34. The idea that you should be punished for your sins	0 1 2 3 4	7. 0 1 2 3 4
35. Feeling hopeless about the future	0 1 2 3 4	8. 0 1 2 3 4
36. Trouble concentrating	0 1 2 3 4	9. 0 1 2 3 4
37. Feeling weak in parts of your body	0 1 2 3 4	10. 0 1 2 3 4
38. Feeling tense or keyed up	0 1 2 3 4	11. 0 1 2 3 4
39. Thoughts of death or dying	0 1 2 3 4	12. 0 1 2 3 4
40. Having urges to beat, injure, or harm someone	0 1 2 3 4	13. 0 1 2 3 4
41. Having urges to break or smash things	0 1 2 3 4	14. 0 1 2 3 4
42. Feeling very self-conscious with others	0 1 2 3 4	15. 0 1 2 3 4
43. Feeling uneasy in crowds, such as shopping or at a movie	0 1 2 3 4	16. 0 1 2 3 4
44. Never feeling close to another person	0 1 2 3 4	17. 0 1 2 3 4
45. Spells of terror or panic	0 1 2 3 4	18. 0 1 2 3 4
46. Getting into frequent arguments	0 1 2 3 4	19. 0 1 2 3 4
47. Feeling nervous when you are left alone	0 1 2 3 4	20. 0 1 2 3 4
48. Others not giving you proper credit for your achievements	0 1 2 3 4	21. 0 1 2 3 4
49. Feeling so restless you couldn't sit still	0 1 2 3 4	22. 0 1 2 3 4
50. Feelings of worthlessness	0 1 2 3 4	23. 0 1 2 3 4
51. Feeling that people will take advantage of you if you let them	0 1 2 3 4	24. 0 1 2 3 4
52. Feelings of guilt	0 1 2 3 4	25. 0 1 2 3 4
53. The idea that something is wrong with your mind	0 1 2 3 4	26. 0 1 2 3 4
		27. 0 1 2 3 4

Turn the page and follow the direction[illegible]or completing the additional information.

Appendix 3: SF-36v2 Measure

Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. ***Thank you for completing this survey!***

For each of the following questions, please tick the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐ 1	☐ 2	☐ 3
b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
c Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
d Climbing several flights of stairs	☐ 1	☐ 2	☐ 3
e Climbing one flight of stairs	☐ 1	☐ 2	☐ 3
f Bending, kneeling, or stooping	☐ 1	☐ 2	☐ 3
g Walking more than a mile	☐ 1	☐ 2	☐ 3
h Walking several hundred yards	☐ 1	☐ 2	☐ 3
i Walking one hundred yards	☐ 1	☐ 2	☐ 3
j Bathing or dressing yourself	☐ 1	☐ 2	☐ 3

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Were limited in the kind of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d Had difficulty performing the work or other activities (for example, it took extra effort)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Did work or other activities less carefully than usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. **During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?**

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. **How much bodily pain have you had during the past 4 weeks?**

None	Very mild	Mild	Moderate	Severe	Very severe
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

8. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Did you feel full of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Have you been very nervous?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f Have you felt downhearted and low?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h Have you been happy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

10. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11. How TRUE or FALSE is <u>each</u> of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a I seem to get ill more easily than other people	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b I am as healthy as anybody I know	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c I expect my health to get worse	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d My health is excellent	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Thank you for completing these questions!

Appendix 4: Demographic Details Form

Unilink Self-Management Programme

Question1:

Male ☐

Female ☐

Question 2:

What year are you in?

JF ☐

SF ☐

JS ☐

SS ☐

PG ☐

Diploma ☐

Question 3:

What Faculty are you in?

Faculty of Arts Humanities and Social Sciences ☐

Faculty of Engineering, Maths and Science ☐

Faculty of Health Sciences ☐

Cross-Faculty ☐

Question 4:

Which category applies to you?

Asperger's Syndrome ☐

ADD / ADHD ☐

Blind/Vision Impaired ☐

Deaf/Hard of hearing ☐

Dyspraxia ☐

Mental Health Difficulty ☐

Neurological Conditions ☐

Speech and Language Disabilities ☐

Physical Disability ☐

Significant Ongoing Illness ☐

Specific Learning Difficulty (incl. Dyslexia and Dyscalculia) ☐

Question 5:

How long have you been availing of the Unilink service?

Less than 1 month ☐

Less than 3 months ☐

Less than 6 months ☐

Less than 1 year ☐

Less than 2 years ☐

More than 2 years ☐

Appendix 5: Student Pre-programme Semi-Structured Interview

Interview Schedule – Student

Pre –Programme

1. What activities do you do in your **current** daily life, related to college or otherwise, to maintain your health and well-being?

2. Do you feel that the activities that you **currently** do contribute to your health and well-being?

3. In looking at the activities that you do in your daily life;
    - What activities help you to engage in your student role?
    - What activities can hinder you in completing your student role?

4. Do you feel you are able to recognise the signs that you are not engaging in your student role?

5. If so, what do you do?

6. Do you feel that you have a routine at present?

7. What does the term mental health mean to you?

8. What does the term recovery mean to you?

9. What expectations do you have for your student role?

Appendix 6: Student Post-programme Semi-Structured Interview

1. Programme Duration

How many meetings did you have as part of the Unilink Self-Management Programme? _____

1.1 Did you feel that this number of meetings was;

2. Do you feel that the individual approach was effective?

2.1 Do you feel that a Self-Management Group would have been more effective?

3. Is there anything else that you would like to be included in the programme? Please elaborate.

4. Is there anything that you feel could be left out of the programme? Please elaborate.

5. Did you apply any of the techniques and strategies from the Unilink Self-Management Programme in your daily student life in maintaining your health and wellbeing?

6. Do you think the Unilink Self-Management Programme helped you to meet your academic/ social/ personal goals?

7. Do you think Unilink Self-Management Programme helped you to increase your participation in college?

8. Do you feel that the programme was;

Led by the Occupational Therapist	1
Led by you	2
Led jointly by you and the Occupational Therapist.	3

10. What activities do you do in your **current** daily life, related to college or otherwise, to maintain your health and well-being?

11. Do you feel that the activities that you **currently** do contribute to your health and well-being?

12. In looking at the activities that you do in your daily life;
    - What activities help you to engage in your student role?
    - What activities can hinder you in completing your student role?

13. Do you feel you are able to recognise the signs that you are not engaging in your student role?

14. If so, what do you do?

15. Do you feel that you have a routine at present?

16. What does the term mental health mean to you?

17. What does the term recovery mean to you?

18. What expectations do you have for your student role?

Programme content

	Strongly Disagree	Disagree	Agree	Strongly Agree
The content of the programme was relevant to me.	1	2	3	4
The programme helped me to learn new ways to engage in student role and maintain my health and well-being	1	2	3	4
The programme helped me to recognise signs that I am not engaging in my student role	1	2	3	4
The programme helped me to recognise the things that may contribute to me not engaging in my student role	1	2	3	4
The programme helped me to identify personal and practical strategies can help me to re-engage in my student role	1	2	3	4

Appendix 7: Student Follow-up Semi-Structured Interview

Student 12 month follow-up - Programme Semi-Structured Interview

1. How long has it been since you completed the Unilink Self-Management Programme?

2. Have you attended the Unilink Service since you completed the programme

3. Did you apply any of the techniques and strategies from the Unilink Self-Management Programme in your daily student life in maintaining your health and wellbeing?

   (a) Do you apply these techniques and strategies in your daily life now?
      - Please give examples.

4. Do you think the Unilink Self-Management Programme helped you to meet your academic/ social/ personal goals?

5. Do you think Unilink Self-Management Programme helped you to increase your participation in college?

6. What activities do you do in your **current** daily life, related to college or otherwise, to maintain your health and well-being?

7. Do you feel that the activities that you **currently** do contribute to your health and well-being?

8. In looking at the activities that you do in your daily life;
    - What activities help you to engage in your student role?
    - What activities can hinder you in completing your student role?

9. Do you feel you are able to recognise the signs that you are not engaging in your student role?

10. If so, what do you do?

11. Do you feel that you have a routine at present?

12. What does the term mental health mean to you?

13. What does the term recovery mean to you?

14. What expectations do you have for your student role?

Appendix 8: Occupational Therapist Semi-Structured Interview

Project Title: The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students with Mental Health Difficulties.

Investigator: Kieran Lewis, Occupational Therapist, Unilink.

1. Use of the programme
   a. On average, how many meetings did the programme take to complete? Did you feel that this number of meetings was appropriate?
   b. What criteria informed the decision to use the programme with students?
   c. How prepared did you feel to outline and introduce the programme to students?
   d. Are there any other resources that you would have found useful in introducing the programme?
   e. Do you feel that the Unilink Self-Management Programme was appropriate to use with all of the students attending you?

2. Programme Format / Administration

a. Are there any changes that you would suggest to the format of the programme with regards to the following;

- Printed workbook or online version?
- The 6 sections of the programme
- The format of each sections (Introduction; list of the suggestions; list of priorities; review section)

b. Do you feel that the resources were helpful within the different sections? Were there any other resources that you would include?
c. Did you feel that the assessments (Occupational Questionnaire; interest checklist) were useful in establishing a student's current routine?
d. Did you find the goal and routine sheets useful within each section?
e. Do you feel that the individual approach was effective? Do you feel that a Self-Management Group would have been more effective?

3. Programme Content

a. Do you feel that the content was relevant to the students that you were working with?
b. Is there anything else that you would like to be included in the programme? Please elaborate.
c. Is there anything that you feel could be left out of the programme? Please elaborate.
d. Did you feel that discussing the concepts of occupation, mental health and recovery was useful within the introductory meeting?

4. Student – Occupational Therapist Interaction

a) Were the strategies developed based upon student experience or suggested by you, the therapist?
b) Do you feel that the programme was;
   - Led by you
   - Led by the student
   - Led jointly by you and the student.

c) Did you feel that the structured format of the workbook allowed flexibility for the student-therapist interaction to develop?]

d) Did you feel that the interaction differed from student to student? In what way?

5. Recovery-Orientated Practice

a) Do you feel the Unilink Self-Management Programme approach was more recovery-orientated than your previous approach?
b) Did you feel that you had sufficient knowledge in the area of recovery-orientated practice?
c) How would you define recovery?
d) How would you define mental health?
e) How would you define occupation?
f) Did you feel comfortable and prepared to discuss these concepts with students?

6. Occupation focused

a) Do you feel that the programme was occupation focused?
b) What strategies did you use to facilitate the student's occupational balance and occupational engagement?

Appendix 9: Student Participant Cover Letter

Project Title:

The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students with Mental Health Difficulties.

Principal Investigator: Kieran Lewis, Occupational Therapist in the Unilink Service, is the principal investigator carrying out this research project.

Dear Sir / Madam,

I am inviting you to participate in a research project to study the above mentioned self-management programme for students experiencing mental health difficulties. Along with this letter is a Participant Information Leaflet, which provides an outline of the study and explains your possible participation within it. Please read this Participation Information Leaflet carefully and think about your wish to participate. If you wish to participate, please inform your Occupational Therapist or contact me at klewis@tcd.ie, stating that you would like to participate. I will then arrange to meet you at a location and that time that suits you to answer any questions about the programme and to explain the aims of the study and to ask you to sign an informed consent form. If you volunteer to participate in this study, you may withdraw at any time. You are not obliged to participate, and if you decide not to participate, or if you withdraw, you will not be penalised and you will not give up any benefits that you had before entering the study.

If you would like more information or answers to your questions about the study, your participation in the study, and your rights, please contact the research investigator, Kieran Lewis; 087 2743879, email: klewis@tcd.ie or contact the Director of the Disability Service, Mr Declan Treanor; 01-8963475, email: dtreanor@tcd.ie or contact the Director of the Unilink Service, Dr Clodagh Nolan; 087 2743858, email: nolancl@tcd.ie. If the investigator learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Yours sincerely,

Kieran Lewis, Occupational Therapist, Unilink Service.

Appendix 10: Student Participant Information Letter

Participation Information Leaflet – Student

Title of Study:

The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students with Mental Health Difficulties.

Introduction:

I am Kieran Lewis, Occupational Therapist in (Irish Higher Education Institute) and I am the principal investigator carrying out this research project. In 2010, I developed a workbook-based approach called the Unilink Self-Management Tool, which was designed to help students develop their ability to manage their mental health difficulties in a practical way. I am currently developing an occupation-focused self-management programme based upon this Self-Management Tool. At this stage in the development of the programme, I am seeking participants to take part in the evaluation of this programme within the Unilink Service.

The aim of the research project:

To explore the effectiveness of the Unilink Self-Management (US-M) programme within the (Irish Higher Education Institute)

What is involved in participating in the research project and what you need to do?

The project will involve participating in the programme on six or more occasions with your Unilink Occupational Therapist, as per the format outlined below:

Session Topic
1. Introduction
2. Identifying the things that I need to do to look after my Mental Health
3. Identifying the things that may contribute to me becoming unwell

4. Identifying Early warning signs
5. What I can do to make myself feel better when I am not feeling well.
6. Review of the programme and future use of strategies learned.

Your access to Unilink meetings will not be affected by participation in the study. You will be asked to complete three written assessments prior to starting the programme, after completion of the programme and at twelve month follow-up. Please read this Participation Information Leaflet carefully and think about your desire to participate. If you wish to participate, please inform your Occupational Therapist or contact me at klewis@tcd.ie, stating that you would like to participate. I will then arrange to meet you at a location and that time that suits you to answer any questions about the programme and to explain the aims of the study and to ask you to sign an informed consent form. Once you have signed this form, I will give you the three written assessments to complete. This meeting will take approximately 20-25 minutes. Your Occupational Therapist will keep notes on your meetings within the US-M programme and these notes will be audited by the Investigator, Kieran Lewis, following the completion of the programme. You can have access to these notes at any stage during study as per the Unilink Service code of practice.

What will be done with the information gathered?

Only the investigator and the research supervisor will have access to the information gathered, which will be made confidential through the use of coding (using numbers). All information gathered will be stored securely in a locked cabinet in the (Irish Higher Education Institute). The information will be used to evaluate the US-M Programme and for the writing up of a research project. The findings may be published, but the names of participants, the Occupational Therapy service or the university will not be mentioned thus ensuring your personal details remain confidential.

Risks:

No risks are anticipated by participating in this research. The research does not involve any invasive procedures. However, in engaging in the US-M programme, students will be discussing possible triggers and warnings signs related their mental health. This process of reflection has the possibility of causing distress. If participants become distressed or anxious at any stage during the research study, all meetings will be stopped and participants will be provided with support by their Occupational Therapist. The Unilink protocol for distressed students will be followed and referral to appropriate medical professionals will be made as required.

Exclusion from the Study:

- Students not attending the Unilink Service will be excluded from the study.
- Students who attend the Researcher (or Investigator or Research Investigator) within the Unilink Service will be excluded from the study.
- As students must register with the Disability Service in the (Irish Higher Education Institute), students not registered will be excluded from the study.
- Students without a mental health diagnosis from a qualified psychiatrist will be excluded from the study group.
- Students will be excluded from the study group who are deemed unwell at the time of the study to such a degree that their participation would be detrimental to their well-being in the opinion of their Occupational Therapist.

Voluntary Participation:

If you volunteer to participate in this study, you may withdraw at any time. You are not obliged to participate, and if you decide not to participate, or if you withdraw, you will not be penalised and you will not give up any benefits that you had before entering the study. Regardless of your choice, your access to the Unilink service will not be affected.

Stopping the study:

It is also important to be aware that you understand that the investigator may withdraw your participation in the study at any time without your consent.

What you gain from participating:

It is envisaged that this process will help you to reflect upon your experience and the experience of your Occupational Therapist, and that this, in turn will help you to improve the self-management of your mental health.

Confidentiality:

Your identity will remain confidential throughout the research project. The final report may be published but your name will not be published and will not be disclosed to anyone outside the study group.

Compensation

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Has this study ethical approval?

Yes, this study has ethical approval from the Faculty of Health Sciences, Trinity College Dublin.

Further information:

If you would like more information or answers to your questions about the study, your participation in the study, and your rights, please contact the research investigator, Kieran Lewis; 087 2743879, email: klewis@tcd.ie or contact the Director of the Disability Service, Mr Declan Treanor; 01-8963475, email dtreanor@tcd.ie or contact the Director of the Unilink Service, Dr Clodagh Nolan; 087 2743858, email: nolancl@tcd.ie. If the investigator learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Appendix 11: Informed Consent: Student Participant

INFORMED CONSENT FORM – STUDENT

Project Title: The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students with Mental Health Difficulties.

Principal Investigator: Kieran Lewis, Occupational Therapist in the Unilink Service, is the principal investigator carrying out this research project.

Background:
I understand that by participating in this research project I am agreeing to be involved in the Unilink Self-Management Programme. I understand that the project will involve participating in the programme on six or more occasions with my Unilink Occupational Therapist. I understand that I will not be identified by name and my identity will be coded. I understand that any personal distinguishing characteristics or circumstances will not be disclosed in the research report. The name and the location of the university will not be mentioned in the research report or any subsequent publications.

I acknowledge that the research project may be published as a journal article, presented at conferences or it may be used for other educational purposes. I understand that the data / information will be stored for the duration of the study, i.e. until the work is fully reported and disseminated. It will then be kept in a locked cabinet for five years as per accepted best practice.

DECLARATION: I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may

withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME:……

CONTACT DETAILS:……

PARTICIPANT'S SIGNATURE:……

Date:……

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:……

Date:……

Appendix 12: Staff Participant Information Letter

Participation Information Leaflet – Unilink Staff

Title of Study:

The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students experiencing mental health difficulties.

Introduction:

I am Kieran Lewis, Occupational Therapist in the (Irish Higher Education Institute) and I am the principal investigator carrying out this research project. In 2010, I developed a workbook based approach called the Unilink Self-Management Tool, which was designed to help students develop their ability to manage their mental health difficulties in a practical way. I am currently developing an occupation-focused self-management programme based upon this Self-Management Tool. At this stage in the development of the programme, I am seeking participants to take part in the evaluation of this programme within the Unilink Service.

The aim of the research project:

To explore the effectiveness of the Unilink Self-Management (US-M) programme within the Unilink Service in (Irish Higher Education Institute)

What is involved in participating in the research project and what you need to do?

The project will involve you administering the US-M programme with students attending you within the Unilink Service. This will involve meeting individually with students on six or more occasions, as per the format outlined below:

Programme Overview
Introduction
Section 1: Identifying the things that I need to do to engage in my student role and to look after my Mental Health
Section 2: Identifying the things that may contribute to my **not** engaging in my student role
Section 3: The Signs that I am not engaging in my Student Role and possibly becoming unwell
Section 4: Personal and Practical Strategies for engaging and re-engaging in my student role.
Review of the programme and future use of strategies learned.

A student's access to Unilink meetings will not be affected by participation in the study. The lead investigator will administer three written assessments and carry out a semi-structured interview with your students prior to starting the programme and after the completion of the US-M programme. You will be asked to complete an interview with the Principal Investigator following the pilot phase, prior to starting the programme in data collection phase of the study. You will also be asked to complete an interview at the end of the data collection phase. Transcripts of these interviews will be provided to you, if you so wish. You will be asked to complete a reflective diary during the programme and you will also be asked to keep accurate notes on your meetings within the programme and these notes will be audited by the Investigator, Kieran Lewis, following the completion of the programme.

Please read this Participation Information Leaflet carefully and think about your desire to participate. If you wish to participate, please respond to Mr Declan Treanor at this email address, dtreanor@tcd.ie, stating that you would like to participate. Declan will then inform me that you would like to be part of the study. I will then arrange to meet you at a location and that time that suits you to answer any questions about the programme and to explain the aims of the study and to ask you to sign an informed consent form. Once you have signed this form, I will begin the interview with you. This meeting will take approximately 30-45 minutes.

What will be done with the information gathered?

Only the investigator, the research supervisor will have access to the information gathered, which will be made confidential through the use of coding (using numbers). All information gathered will be stored securely in

a locked cabinet in (Irish Higher Education Institute). The information will be used to evaluate the Unilink Self-Management Programme and for the writing up of a research project. The findings may be published, but the names of participants, the Occupational Therapy service or the university will not be mentioned thus ensuring your personal details remain confidential.

Risks:

- No risks are anticipated by participating in this research. The research does not involve any invasive procedures. However, in engaging in the US-M programme, students will be discussing possible triggers and warnings signs related their mental health. This process of reflection has the possibility of causing distress. If participants become distressed or anxious at any stage during the research study, all meetings will be stopped and participants will be provided with support by their Occupational Therapist. The Unilink protocol for distressed students will be followed and referral to appropriate medical professionals will be made as required.

Exclusion from the Study:

- Occupational Therapists not working with students within the (Irish Higher Education Institute) will be excluded from this study.

Voluntary Participation:

If you volunteer to participate in this study, you may withdraw at any time. You are not obliged to participate, and if you decide not to participate, or if you withdraw, you will not be penalised and you will not give up any benefits that you had before entering the study. Regardless of your choice, your access to the Unilink service will not be affected.

Stopping the study:

It is also important to be aware that you understand that the investigator may withdraw your participation in the study at any time without your consent.

What you gain from participating:

It is envisaged that this process will help develop a practical approach to be employed by Occupational Therapists working within the Unilink

Confidentiality:

Your identity will remain confidential throughout the research project. The final report may be published but your name will not be published and will not be disclosed to anyone outside the study group.

Compensation

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Has this study ethical approval?

Yes, this study has ethical approval from the Faculty of Health Sciences, Trinity College Dublin.

Further information:

If you would like more information or answers to your questions about the study, your participation in the study, and your rights, please contact the research investigator, Kieran Lewis; 087 2743879, email: unilink1@tcd.ie or contact the Director of the Disability Service, Mr Declan Treanor; 01-8963475, email dtreanor@tcd.ie or contact the Director of the Unilink Service, Dr Clodagh Nolan; 087 2743858, email: nolancl@tcd.ie. If the investigator learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Appendix 13: Informed Consent – Staff

INFORMED CONSENT FORM – STAFF

Project Title: The Investigation into the Effectiveness of an Occupation Focused Self-Management Programme for College Students experiencing mental health difficulties.

Principal Investigator: Kieran Lewis, Occupational Therapist in the Unilink Service, is the principal investigator carrying out this research project.

Background: I understand that by participating in this research project I am agreeing to be involved in the Unilink Self-Management Programme. I understand that the project will involve administering the US-M programme with students attending me within the Unilink Service. I understand that I will be asked to keep a reflective diary and accurate notes on my meetings within the programme. I understand that I will be asked to complete an interview with the Principal Investigator following the pilot phase and again following the data collection phase. I am aware that transcripts of these interviews will be provided to me, if I so wish. My identity will remain confidential in the final research report. I understand that I will not be identified by name and my identity will be coded. I understand that any personal distinguishing characteristics or circumstances will not be disclosed in the research report. The name and the location of the university will not be mentioned in the research report or any subsequent publications. I acknowledge that the research project may be published as a journal article, presented at conferences or it may be used for other educational purposes. I understand that the data / information will be stored for the duration of the study, i.e. until the work is fully reported and disseminated. It will then be kept in a locked cabinet for five years as per accepted best practice.

DECLARATION: I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME:……

CONTACT DETAILS:……

PARTICIPANT'S SIGNATURE:……

Date:……

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:……

Date:……

Appendix 14: Occupational Therapist quick guide to Meetings in the Unilink Self-Management Programme; Sections 1-4

At the Beginning of the Meeting

Ask: Would you like to start / continue with the programme today or are there any specific demands that you want to focus upon today?

- If they say that there are other specific demands, agree an amount of time at the end of today's meeting to go through these. If the student wants to focus on these throughout the session, that is fine. Make a note that the student wanted to focus on other demands today.

Check: Last week we went through XXX. Was there anything in particular that we completed/covered last week that stuck with you during this week? And if so, could you tell me more about this?

Check: How did your goals to engage in XXX / find out more about XXXX go this week? **(Review the goal sheet from last week)**

Ask: How was your routine this week? (After section 1 ask this question)
State: Today we are going to go through XXX

Ask: Would you like to start today's section by going through the key points / introduction? We can go through this together so that we can discuss the topics and I can answer any questions you may have.

Current Demands

State: The main aim of the programme is to relate these ideas to your life and to make them personal to you. There are suggestions in the workbook in relation to XXXX, but these are just suggestions; so please add to these ideas. **Prioritise your ideas** on your personal list in the table on the next page. Please ask any questions you have at any time and I can suggest more resources to find out more information. You can take a copy of this list with you if you would like.

State: Now that you have made out your personal list, let's use the goal sheet to establish a plan of how to engage / find out more about it.*

***In Section 1 tell the student that you have information about resources to engage in these activities.**
***In Section 1, suggest using the timetable to plan out engagement in identified occupations.**

Review: Now that we have gone through this section, what were the main points that you took from it?

Ask: Would you like to move on to the next section or review the current section?

More than one section can be completed in a given meeting.

Check: You identified XXXX demands last week and we set some goals to meet these. How did you progress with these goals over the week? Would you like to go through this goal some more today?

Ask: Are there any new / other current demands that you would think we need to focus upon today?

Ask: We can use the goal setting sheet to make out a plan to meet these demands?

Ask:

1. What is the goal that you need to work on?

2. What resources do you have?

3. What steps do you need to take to achieve this goal?

4. When will you complete this goal by?

State: If you would find it useful, we can make out a routine for the coming week using the timetable to help to plan out your time.

Ask:

1. Is there a balance of occupations in this routine?

2. Based upon our meetings so far, is there anything else that you think needs to be included in your routine?

Appendix 15: Ethical Permission from Trinity College Dublin

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH TRINITY COLLEGE DUBLIN
CladdÁthCliath TheUniversityofDublin

Dámh na nEolaíochtaí Slainte,
An Chéad Urlar, Foirgneamh na Ceimice (an sineadh)
Colaiste na Tríonóide,
Baile Átha Cliath 2, Éire.

Faculty of Health Sciences,
1st Floor, Chemistry Building
Extension,
Trinity College,
Dublin 2, Ireland.
T:- +353 (0)1 8964255

Mr. Kieran Lewis
Unilink Service,
Room 2054,
Arts Building,
Trinity College Dublin,
Dublin 2.

22 November 2012

Study: The Development and Investigation of an Occupation Focused Self-Management Programme for College Students with Mental Health Difficulties.

Dear Applicant(s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in February 2012, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely,

Dr. Ruth Pilkington
Chairperson
Faculty Research Ethics Committee

Supervisor:
Dr. Clodagh Nolan

Appendix 16: Self-Management Tool Card

Appendix 17: International prevalence studies and reports of mental health difficulty amongst students in higher education

Table 2. 3: International prevalence studies and reports of mental health difficulty amongst students in higher education

Author and Year	Focus	Student Population	Type of Study / Measures	Prevalence / Findings
Ibrahim, Kelly, Adams, & Glazebrook, (2013)	Explore prevalence of depression in university students	Undergraduate students in higher education 24 Studies (12 medical students only; 11 from different facilities; 1 excluding medical students) (n=48,650 students within the review)	Systematic Review	Prevalence rates for depression across 24 articles ranged from 10% to 85% with a weighted mean prevalence of 30.6%. Weighted mean was higher for the studies from different faculties (35.6%) as compared to medical students alone (25.6%). Higher prevalence rates were reported in earlier years of study in six articles, with equal rates amongst each year reported in 2 articles
Storrie et al. (2010)	To critically appraised the currently available peer-reviewed literature that addresses emotional/mental health problems of university students	11 studies were included from the period 2000–2009 (n=18,600 within the review)	Systematic Review	Anxiety, depression and psychotic disorders the major mental health issues experienced by students. 51% reported the onset of mental illness before they attended college
Mortiers et al (2017)	To obtain pooled prevalence estimates of	36 college student samples,	Meta-Analysis	Lifetime estimates for suicidal ideation was 22.3%, plans was 6.1% and attempts 3.2%.

	Suicidal thoughts and behaviours among college students worldwide	representing a total of 634,662 students		Twelve month estimates were 10.6%, 3% and 1.6% respectively. Pooled estimates were generally higher for females, as compared with males
Auerbach et al, (2018)	Establishing prevalence and basic sociodemographic correlates of common mental disorders among first-year college Students	Incoming first year full-time students from 19 University sites across 8 countries as part of the World Mental Health International College Student project (n=13,984)	Cross-Sectional Web-based self-report questionnaires screening for six common lifetime and 12-month DSM–IV mental disorders (major depression, mania/hypomania, generalized anxiety disorder, panic disorder, alcohol use disorder, and substance use disorder).	35% of respondents reported at least one of the six lifetime mental disorders and 31% reported at least one of 12-month disorder. Major depressive disorder (MDD) was the most common of the disorders examined (21.2% lifetime prevalence; 18.5% 12-month prevalence) followed by generalized anxiety disorder (18.6 lifetime prevalence –16.7% 12-month prevalence)
Bruffaerts R, Mortier P, Kiekens G, et al. (2018)	12-month mental health problems among freshmen Associations of mental health problems with academic functioning	First Year Undergraduates (N= 4921) in Belgium as part of the World Mental Health International College Student project	Cross-Sectional Global Appraisal of Individual Needs Short Screener (GAIN-SS) GAIN-SS consists of four sub-screeners, each indicative for one type of mental health problems, including: internalizing mental health problems, externalizing mental health problems, problems with substance use, and crime/violence-related problems.	34.9% of college freshman reported mental health difficulty in the last year with 36.1 % of these students having cooccurring mental health difficulty. Internalising (23.7%); externalising (18.3%); substance use (5,4%) and antisocial (0.1%)

Jenkins, Ducker, Gooding et al. (2020)	Estimate the prevalence of depression and anxiety in United Kingdom college students and examine associations between mental health symptoms and quality of life (QoL).	Undergraduate and postgraduate students in the School of Psychology and Clinical Language Sciences within one UK HEI (N=236)	Cross-Sectional Self-report measures of depression, anxiety, and Quality of Life were completed online (PHQ-2 – Screening Tool for Depression; GAD-2 – Screening Tool for Anxiety; RAND 36-Item Health Survey)	Any Depression 34.5% (37.2% Female and 16.7% Male) Any Anxiety Disorder 42.1% (45.7% Female and 16.7% Male) Both anxiety and depression (27.8% (29.8% Female and 13.9% Male)
Akram et al. (2020)	The prevalence of suicidal ideation among UK university students and assessed the association with multiple psychiatric risk factors	Students from six UK universities were recruited (N = 1273 students)	Cross-Sectional Four-item self-report Suicidal Behaviours Questionnaire-Revised (SBQ-R; Osman et al., 2001)	37.3% students were classified as high-risk for suicidal behaviour. 20.1% of students had planned their suicide and 10.8% reported making an attempt. 42.2% of students contemplated suicide at least once within the past twelve months.
Mortier et al. (2018)	To establish data on prevalence as well as socio-demographic and college-related correlates for suicide thoughts and behaviours among first-year college students	First year undergraduate students across 19 colleges in 8 countries (n=13,984)	Cross-Sectional Modified version of the Columbia Suicidal Severity Rating Scale	Lifetime prevalence of suicidal ideation was 32.7%, plans 17.5%, and attempts 4.3% Twelve month prevalence was 17.2%, 8.8%, and 1.0%, respectively.
Auerbach et al. (2016)	Examine the associations of mental disorders with college entry and attrition	Comparing college students (18-22 years) in 21 countries	Cross-Sectional	The 12-month prevalence of any DSM-IV/CIDI disorder was 20.3% among college students compared with 25.0% among students who left

		(n=1572) and non-students in the same age range (18-22 years; n=4178), which included 702 students who left college without graduating). This was conducted as part of the World Mental Health International College Student project	Mental health conditions were assessed by face to face interview with version 3.0 of the Composite International Diagnostic Interview (CIDI; Kessler & Ustun, 2004). The CIDI assessed for mood disorders, anxiety disorders, ADHD, oppositional–defiant disorder, conduct disorder, intermittent explosive disorder and substance disorders	college without graduating, and 21.4% among other non-students 83.1% reported onset prior to starting college. Anxiety disorders were the most prevalent class of disorders across all groups in the full sample (11.7–14.7%) followed by mood disorders (6.0–9.9%), substance disorders (4.5–6.7%) and behavioural disorders (2.8–5.3%)
Liu et al. (2018)	Identified prevalence and correlates of Mental Health diagnoses	U.S. undergraduate students (n=67,308) across 108 Higher education institutions.	Cross-Sectional Analysis based upon the dataset from the Spring 2015 American College Health Association-National College Health Assessment (ACHA-NCHA) survey Participants asked if diagnosed or treated by a professional within the past 12 months for 15 MH diagnoses: anorexia, anxiety, attention deficit and hyperactivity disorder, bipolar disorder, bulimia, depression, insomnia, other sleep disorder, obsessive–compulsive disorder, panic attacks, phobia,	24.9% of students being diagnosed with or treated for a MH disorder in the past year. 3.4% Depression; 6.1% Anxiety; 10.0% anxiety and depression; Other MH Disorders 5.4%

			schizophrenia, substance abuse or addiction and other MH condition.	
Kovess-Masfety et al. (2016)	To compare mental health status of college students and their noncollege-attending peers whether working, attending a secondary school, or non-college-attending peers who are neither employed nor students or trainees.	Data were drawn from a large cross-sectional survey conducted in 2005 in four regions of France. Analyses were restricted to the college-age subsample, defined as those aged 18 to 24 (n=1313 college students)	Twelve month DSM-IV axis I mental disorders were assessed with the Composite International Diagnostic Interview Short Form (CIDI-SF) [21, 22]. Conducted by phone interview.	21.56% of college students report one anxiety disorder 8.53% of college students major depressive disorder. Depression, anxiety disorders, 12-month suicide attempts, and elevated psychological distress higher in women than men. The prevalence of anxiety disorders was higher among college-aged individuals in the NENST group
Eisenberg et al (2013)	To estimate the prevalence and correlates of mental health problems among college students in the United States	Random samples of students at 26 campuses in the United States (N=14,175)	Online surveys with brief mental health screens	Prevalence of positive screens was 17.3% for depression, 4.1% for panic disorder, 7.0% for generalized anxiety, 6.3% for suicidal ideation, and 15.3% for non-suicidal self-injury
Eisenberg et al. (2011)	To examine the prevalence, correlates, persistence, and treatment-seeking related to symptoms of eating	Random sample of students at a large university were recruited for an Internet survey in Fall	SCOFF questionnaire (Morgan, Reid, Lacey, 1999)	13.5% of female undergraduates and 3.6% of male undergraduates screened positively on the SCOFF.

	disorders (EDs) in a random sample of college students.	2005 and a follow-up survey in Fall 2007 (n=2,822 students)		Among students with positive screens, 20% had received past-year mental health treatment.
Mahmoud et al. (2012)	To examine the relative importance of coping style, life satisfaction, and selected demographics in predicting undergraduates' depression, anxiety, and stress.	Full-time undergraduate students aged 18–24 years old at a US University (n=508)	Cross Sectional Mailed self-report questionnaire. Depression, anxiety, and stress were measured using the Depression Anxiety and Stress Scale21 (DASS-21)	29% of the students were depressed, 27% were anxious, and 24% were stressed. 67% of students who were anxious were also depressed and 61% of the anxious students were also stressed.
Stallman et al (2010)	To assess the prevalence and severity of mental health problems in university students at two Australian universities and compare to national prevalence studies	Students from two Australian HEIs (n=6479)	Kessler 10 (Kessler, Barker et al., 2003), was used to screen for DSM-IV anxiety-mood disorders	Estimated prevalence for mental health problems was 19.2% Rates were significantly higher than the general population
Blanco et al. (2008)	12-month prevalence of psychiatric disorders, sociodemographic correlates, and rates of treatment among individuals attending college and their non–	Subsample of college-aged individuals, defined as those aged 19 to 25 years who were both attending (n=2188) and not	Face-to-face interviews were conducted in the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions in the US	Almost half of college-aged individuals in college had a psychiatric disorder in the past year (45.79%). Non–college-attending peers reported a higher rate (47.84%).

	college-attending peers in the United States.	attending (n=2904) college in the previous year.		Personality Disorder (17.86%) highest amongst sample of college students; anxiety disorder (11.94%) and mood disorder (10.62%); substance use disorder highest (29.15%)
American College Health Association, (2019 - Spring) US Reference Group	Provides data on the health of college students, providing the college health and higher education fields with a vast spectrum of information on student health	Student from 98 HEIs across the US (N=67,972 respondents)	Data from American College Health Association-National College Health Assessment (ACHA-NCHA) survey Spring 2019	Self-report diagnosed or treated by professional with the last 12 months: Anxiety (13%); Depression (11.7%); ADHD (7%); Panic Attacks (4.7%); OCD (2.1%); Bipolar Disorder (1.7%); Anorexia (0.7%); Bulimia (0.6%); Other (3.1); Depression and Anxiety (8.7%); Two or more other than combination of Depression and Anxiety (6.4%)
American College Health Association, (2019 - Spring) Canadian Reference Group	Provides data on the health of college students, providing the college health and higher education fields with a vast spectrum of information on student health	Student from 58 HEIs across Canada N=55,284 respondents	Data from American College Health Association-National College Health Assessment (ACHA-NCHA) survey Spring 2019	Self-report diagnosed or treated by professional with the last 12 months: Anxiety (12.6%); Depression (11.4%); ADHD (7.1%); Panic Attacks (5.3%); OCD (2.6%); Bipolar Disorder (1.9); Anorexia (1.2%); Bulimia (1.1%); Other (3.9); Depression and Anxiety (8.4%); Two or more other than combination of Depression and Anxiety (7.2%)
Tsai & Muinidi (2016)	The mental health needs of postgraduate students	Graduate and postdoctoral students from four HEIs in the United States (n=5402 students)	Brief Review including seven studies on the mental health of postgraduate and postdoctoral trainees	Range of 43-44.7% for experiencing emotional/ stress-related problems, including symptoms of depression

Puthran et al. (2016)	To evaluate the global prevalence of depression amongst medical students	77 studies were included (n= 62,728 medical students and 1845 non-medical students	Meta-Analysis	Global prevalence of depression amongst medical students of 28.0% Year 1 students had the highest rates of depression at 33.5%, and decreased to reach 20.4% in year 5

Appendix 18: Summary of Recovery-Orientated Mental Health Self-Management Interventions

Table 2.5: Summary of Recovery-Orientated Mental Health Self-Management Interventions

Intervention Name & Description	Format	Facilitator	Content	Dose / duration	Theoretical Frameworks	Evidence of Effectiveness
The Wellness Recovery Action Plan (Copeland, 1997) WRAP (Copeland, 1997) is a peer-led self-management and recovery approach developed by a group of people who were experiencing mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives.	Group but has been delivered individually.	Delivered by trained WRAP facilitators or WRAP practitioners with or without mental health difficulties.	Participants develop individualised plans for promoting and maintaining recovery, by utilising daily wellness strategies, and by managing symptoms and triggers, as well as establishing plans for during and after mental health crises (Cook et al., 2011).	Commonly delivered in 8 weekly 2.5-hour group meetings, but number of group meetings has ranged from 1 or 2 day workshop to 40 hours over 40 weeks.	Recovery	**Systematic Review and Meta-Analysis:** WRAP small but significant self-perceived recovery outcomes but Improvements were not sustained over time. Not significant for reducing clinical symptomatology. (Canacott, Moghadda & Tickle, 2019) **RCT:** Positive outcomes of WRAP in domains of addictive behaviours and identity and self-esteem. No significant effect of WRAP on personal recovery, quality of life or psychiatric symptoms (O'Keefe et al., 2016) **RCT**: Decreased use of individual or group services and perceived need for overall and group services; for both conditions, improved symptom severity and perceived recovery (Cook et al., 2013) **RCT:** Significant improvement in symptoms, hopefulness, and quality of Life

						at immediate postintervention and at 6-month follow-up (Cook et al, 2012) **RCT:** Intervention participants reported significantly greater reduction over time in Brief Symptom Inventory depression and anxiety subscales and significantly greater improvement in total Recovery Assessment Scale scores as well as the subscales measuring personal confidence and goal orientation (Cook et al., 2012) **RCT:** Significantly more likely than controls to report engaging in self-advocacy. Higher self-advocacy also was associated with greater hopefulness, better environmental quality of life and fewer psychiatric symptoms (Jonikas et al, 2011)
Illness Management and Recovery Programme (Mueser et al. 2006) The Illness Management and Recovery (IMR) programme is a curriculum-based approach, with the aim of symptom reduction, improved functioning, and	Individual and Group	It is delivered by mental health agency staff or other clinicians.	Eleven modules which consist of: recovery strategies; practical facts about mental illness; the stress-vulnerability model; building social support; using medication effectively; drug and alcohol use; reducing relapses; healthy lifestyle; coping with stress; coping with problems and	Modified versions of the IMR have ranged from 9 to 52 1-hour sessions in various studies. However, most studies follow a standard curriculum of	Transtheoretical Model (Prochaska and DiClemente, 1984) and the Stress-Vulnerability Model (Liberman et al., 1986)	**RCT:** IMR had no significant effect on functioning, symptoms, substance use or service utilization. (Dallum et al., 2018) **RCT:** Increased use of social support and problem solving and decreased use of avoidance and self-control (Fardig et al., 2011) **RCT:** Significant improvements in self-reported and clinician ratings of illness management, symptoms psychosocial

on-going illness self-management and remission (Mueser et al., 2006).			symptoms; and getting your needs met in the mental health system	between 39 and 43 sessions		functioning, and self-reported symptom distress (Levitt et al., 2009) **RCT:** Significant improvement in knowledge about their illness and progress toward their personal goals compared with those receiving treatment as usual. Clinician ratings also indicated significant improvement in overall outcome for clients in the Illness Management and Recovery program compared with those who received treatment as usual. Significant improvement in coping was found in both groups, and no change in social support was found for either group. (Hasson-Ohayon, Roe & Kravetz, 2007)
The Recovery Workbook (Spaniol, Koehler, and Hutchinson, 1994) The Recovery Workbook (TRW) is aims to increase awareness of recovery, knowledge and control of the illness, awareness of the importance and nature of stress, as well as developing personal meaning, identifying personal support, and	Self-help workbook, but can Group or Individual	Self-help workbook, but can be peer-led group TRW relies Self-directed exploration and reflection—reinforcing consumer competence	TRW focuses on strengths and simultaneously explores the impact of and strategies for improving four areas affecting identity and recovery: impairment, dysfunction, disability, and disadvantage. The program provides structured activities for self-reflection directed at feelings, reactions, and goals in the process of emerging identity development while encouraging unstructured	The original programme recommended a programme of thirty meetings. A modified version of twelve meetings has also been developed	Recovery	**RCT**: Significant positive change in perceived level of hope, empowerment, and recovery but not in quality of life. (Barbic, Krupa, Armstrong, 2009)

developing goals and plans of action (Spaniol, Koehler, and Hutchinson, 1994).		and expertise.	reflection in the form of journaling.			
Pathways to Recovery (Ridgeway, et al, 2002) Pathways to Recovery (PTR) is a self-help workbook based upon the Strengths Model (Rapp and Goscha, 2006).	Self-help workbook but can Group or Individual.	Self-help workbook, but can be peer or clinician led	The content focuses upon nine domains (1) home, (2) learning, (3) assets, (4) meaningful work, (5) leisure and recreation, (6) health and wellness, (7) intimacy and sexuality, (8) spirituality, and (9) social support (Fukui et al., 2010). Sections allow individuals to assess strengths, resources, identify goals, and address obstacles. The programme focuses upon enabling individuals to enact strategies to achieve life goals, and deliberately does not provide content on symptom management.	At individual pace	Strengths Model (Rapp and Goscha, 2006)	**Single-group Pre-post Test Design: S**ignificant improvements for PTR participants in self-esteem, self-efficacy, social support, spiritual well-being, and psychiatric symptoms. (Fukui, Davidson, & Rapp, 2010)
Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) (Diehl and Baxter, 2006)	Group	Peer	Course topics included recovery principles and stages; structured problem-solving and communication skills training; strategies for building interpersonal and community support systems;	8 sessions of 2.5 hours.	Recovery	**RCT:** Significant improvement in Recovery scores, personal confidence and tolerable symptoms hopefulness (Cook et al., 2011). **Pre-post Test Design:** Significantly fewer psychiatric symptoms, decreased use of

Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) is a mental health curriculum designed by individuals experiencing mental health difficulties.			brain biology and psychiatric medications; diagnoses and related symptom complexes; traditional and non-traditional treatments for SMI; and relapse prevention and coping skills.			maladaptive coping behaviours, and increased feelings of hopefulness, self-advocacy, empowerment, and recovery (Pickett et al., 2010)
Medication and Symptom Management Education program (Shon & Park, 2002)	Group	Clinician	Sessions covered the following key areas: six sessions covered introduction of the psychiatric disorders; recognising symptoms and a variety of coping strategies, 3 sessions reinforcing knowledge concerning medication use and side effects, and 3 sessions covering relapse warning symptoms and coping skills and prevention strategies.	12 Sessions of 1 hour each	Bandura's self-efficacy theory	**RCT:** Significant improvement in self-efficacy, medication compliance, and signs of relapse (Shon & Park, 2002).
Recovery Is Up to You (van Gestel-Timmermans H, Brouwers EP, van Assen MA, van Nieuwenhuizen, 2012)	Group	Two Trained peer instructors (at an advanced state of their	Workbook that covered recovery-related themes: the meaning of recovery to participants, personal experiences of recovery, personal desires for the future, making choices, goal	12 sessions of 2 hours each	Recovery	**RCT**: The intervention had a significant and positive effect on empowerment, hope, and self-efficacy beliefs but not on quality of life and loneliness. The effects of the intervention persisted three months after participants completed the course (van

		recovery process) were employed to facilitate this	setting, participation in society, roles in daily life, personal values, how to get social support, abilities and personal resources, and empowerment and assertiveness.			Gestel-Timmermans H, Brouwers EP, van Assen MA, van Nieuwenhuizen, 2012)

Appendix 19: Worksheets from the Unilink Self-Management Programme

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Appendices:

- Goal Sheets
- Timetables
- Notes Page

The Unilink *Self-Management Programme* is based upon the *Wellness Recovery Action Plan* (1995-2009), developed by Mary Ellen Copeland and *Wellness Self-Management* (2008; 2010), developed by New York State Office for Mental Health. Sections of the *Wellness Self-Management+ Personal Workbook* have been used with the permission of the New York State Office of Mental Health.

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Introduction

3

Recovery

The statements on the next page are some examples of how people describe recovery from their own point of view. As you read the statements, please circle any words or phrases that are meaningful to you, or that are similar to how you view recovery. **Then write or draw any words or images that help explain what recovery or being recovered means to you in the box below. There is no right or wrong answer to this, it is what this means to you.**

What Does Recovery mean to me?

4

The recovery process is more complicated than I first thought. I kept thinking "If I just do this, if I can just do that". But it's not like that. It's on-going[2]

In a Recovery focused approach, the experience, knowledge and skills of the service users should be valued even though these may challenge those of some professionals.[3]

Recovery involves a sense of hope and the possibility of a life with meaning and purpose, self-determination, and engagement in valued roles that are important to the individual.[3]

Recovery can occur despite symptoms of illness. It involves reclaiming of personal control and a positive sense of self and can occur through engaging in array of activities.[4]

Recovery is not something that is done to the person by mental health professionals: it is something that individuals do for themselves. [4]

As recovery belongs to each unique individual who may be experiencing mental health difficulties, and as it is up to them to define what it entails, it is key that people in recovery lead the way.[5]

It is important to recognise that everyone has mental health needs whether they have a diagnosis or not.

Medication can play an important role in one's recovery but it is not essential.[4]

Like life, recovery has growth and setbacks; yet, when viewed over time, it has a gradual upward trend.

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Occupation

The statements on the next page are some examples of how people describe occupation. As you read the statements, please circle any words or phrases that help to explain what occupation means to you. **Then write or draw any words or images that help explain what occupation means to you in the box below. There is no right or wrong answer to this, it is what this means to you.**

What Does Occupation mean to me?

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Occupation is more than a job; it has been defined as all of the everyday activities that we engage in.

Occupations are everything that people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure) and contributing to the social and economic fabric of their communities (productivity).[6]

Occupation is an individual's one-time, personal experience within a unique context, while activities are a more general, culturally shared ideas about a category of action. Engaging in cooking or studying has a different purpose and meaning for each unique individual.[7]

It is the engagement in your chosen occupations of meaning that helps you to gain a sense of personal control and a positive sense of self and maintain your wellness.

Occupational Therapy has at its heart a belief that occupation is essential to the health, well-being and recovery of the individual.[9]

Increased participation in meaningful occupations promotes health and well-being, mainly through the development of a personal and social identity.[10]

Occupation is more than what we do; it is who we are.[8]

Only the individual can identify the meaning of an activity or report the experience of engaging in an activity.[8]

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What is Mental Health?

The statements on the next page are some examples of how various people and organisations describe mental health. As you read the statements, please circle any words or phrases that help to explain what mental health means to you. **Then write or draw any words or images that help explain what mental health means to you in the box below. There is no right or wrong answer to this, it is what this means to you.**

What does mental health mean to me?

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Section 1

Identifying the things that I need to do to engage in my student role and to look after my mental health

Current Routine

Based upon the Occupational Questionnaire that you have completed since our last meeting, please answer the questions below. (If you have not completed this, please complete it now.)

1. Do you feel that you have a routine at present?

2. Do you feel that you have a balance of occupations in your routine at present?

3. Do you feel that you engage well in your daily occupations?

4. Are you happy with this routine?

5. What would you like to change about your routine?

Now that we have examined your current routine, we will look at your interests and go through some suggestions of daily things that can help you to engage in your student role and look after your mental health.

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Look at the list of suggestions below and tick any daily activities that can help you to engage in your student role and look after your mental health. Please refer to the interest checklist and include these ideas below.

Personal Skills

- Organise my time / make a timetable ☐
- Keep a balance between my college life and social life ☐
- Don't put things off ☐
- Get enough quality sleep ☐
- Take notice of the world around me ☐
- Leave myself enough time to get where I need to go ☐
- Prioritise what I need to do ☐
- Switch off when I get home ☐
- Keep appointments ☐

Managing my Environment

- Find a good place to work / study ☐
- Join a Study Group ☐
- Go for a coffee with classmates ☐
- Join a society / sports club ☐
- Do something outside in nature ☐
- Spend time with my friends / family / partner / kids. ☐
- Say 'no' to people ☐
- Make a budget - manage my finances ☐
- Eat well ☐
- Do housework, cooking, cleaning, washing clothes ☐
- _____ ☐
- _____ ☐
- _____ ☐

My Occupations

- Attend College. ☐
- Set short term goals ☐
- Keep my notes organised ☐
- Keep on top of my workload ☐
- Plan essays ☐
- Be active / Exercise ☐
- Get an hour's work done – be productive ☐
- Take time to myself ☐
- Take my medication ☐
- Relaxation exercises ☐
- Keep a journal ☐
- Give / Help someone else ☐
- Voluntary Work ☐

Do something I am interested in (Look through the Interest Checklist)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Based upon the ideas and suggestions, make a list of the things that can help to engage in your student role in order of importance with 1 being the most important thing. We will then make out a plan of how to engage in these activities. Your OT can provide links to resources within and outside college to help with this planning.

Priority	The things that can help me to engage in my student role and to look after my mental health are:	I do this now	I want to do more of this
1			
2			
3			
4			
5			
6			
7			
8			
9			
10.			

Use the goal sheets to make a plan of how to engage in the activities that you have prioritised on the previous page. Your OT can give you more information about resources available.

Are there any current demands that you feel we need to focus upon today? Please use the goal sheets to develop a plan with your OT and include this on your timetable.

Please use the timetable to work out how to incorporate these activities into your daily routine.

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Section 2
Identifying the things that may contribute to my not engaging in my student role

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Look at the list of suggestions below and tick any of them that may contribute to your not engaging in your current student role. Please add to the list as necessary.

College

- Deadlines ☐
- Placement ☐
- Relationship with supervisor ☐
- Exam Pressure ☐
- Too much to do ☐
- Dealing with lecturers / people in the department ☐
- Bullying ☐
- Bad results ☐
- Practical Work ☐

Personal

- Bereavement ☐
- Relationship problems ☐
- Lack of support ☐
- Family problems ☐
- Substance Abuse ☐
- Can't say 'no' ☐
- Work Stress ☐
- Lack of sleep ☐
- Isolation ☐
- Financial Problems ☐
- Intimacy ☐
- Physical Illness ☐
- Criticism ☐
- Problems with friends ☐

Other

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

These are the things that can contribute to my not engaging in my student role:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

It may be helpful to continue learning about things that can contribute to your not engaging in your student role. Consider one or more of the following ways to learn about these things.

- Talk to peers who know you well.
- Talk to friends and family who know you well.
- Talk to a mental health professional who knows you well.
- Read material on the things that can contribute to student's not engaging in their student role.

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Section 3
The signs that I am not engaging in my student role and possibly becoming unwell

Tick some of the possible signs that are outlined below that are relevant to you but please add to the list if there are any other signs that you can think of from your own experience.

Thoughts

- Negative thinking yes ☐
- Inability to concentrate yes ☐
- Suicidal Thoughts yes ☐
- Forgetfulness ☐

Feelings

- Low mood ☐
- Anxiety ☐
- Inability to experience pleasure ☐
- Feeling worthless / inadequate ☐
- Not being able to switch off when you go home ☐
- Lack of Motivation ☐
- Irritability ☐
- Impulsivity ☐
- Tearfulness ☐

Physical Signs

- Aches and pains ☐
- Panic Attacks ☐
- Tiredness / Fatigue ☐

Behaviours

- Inability to sleep / early waking ☐
- Increased alcohol / substance abuse ☐
- Compulsive behaviours ☐
- Isolation ☐
- Self-Harm ☐
- Over / under - eating ☐
- Not keeping appointments ☐
- Not attending college ☐
- Procrastination ☐
- Missing deadlines Avoidance ☐
- Not taking medication ☐

Other

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These are the signs that I am not engaging with my student role;

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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Section 4

Personal and Practical Strategies for engaging and re-engaging in my student role

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Support Available Within College	
Friend	☐
Family member	☐
Classmate	☐
Tutor	☐
Unilink Contact	☐
Counsellor	☐
Student to Student	☐
Disability Officer	☐
Doctor / Psychiatrist	☐
Lecturer	☐
Student's Union welfare officer	☐
My Mind Matters	☐
Niteline	☐

Support Available Outside College	
Friend	☐
Family member	☐
Counsellor	☐
Doctor / Psychiatrist	☐
Support group	☐
Online support (Your OT can give you more information)	☐
Helpline	☐

Personal Supports	Professional Supports

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Look at the list of suggestions of personal and practical strategies outlined below and tick any that are strategies that can help you to re-engage in your student role. This is your list so please add to it as necessary.

Thinking

- Keep a journal ☐
- Write down everything that is stressing you. ☐
- Challenge my negative thoughts ☐
- Repeat positive mantra ☐
- Be Mindful / Take notice of world around and what you are feeling ☐

Self-Care

- Take your medication ☐
- Avoid alcohol ☐
- Avoid drugs ☐
- Avoid coffee / junk food. ☐
- Get enough sleep ☐
- Eat well ☐
- Take time to yourself ☐
- Rest ☐

Interpersonal

- Ask for help if needed ☐
- Spend time with friends / family / partner / kids. ☐
- Manage my relationships ☐
- Be more assertive ☐

Do something you enjoy

- Take a bath ☐
- Listen to music ☐
- Play an instrument ☐
- Go out for a meal ☐
- Plan something fun for the evening / weekend ☐

Get Organised

- Prioritise what you need to do ☐
- Get an hour's work done ☐
- Set Goals for meeting academic demands ☐
- Make a plan ☐
- Organise your time / make a timetable ☐
- Keep a balance between my college life and social life ☐
- Break down your daily demands into more manageable steps ☐
- Set short term goals ☐
- Do something from your list of goals ☐

Exercise

- Going for a walk ☐
- Play sports ☐
- Go to the Gym ☐

Relaxation exercises

- Progressive Muscle Relaxation ☐
- Guided Imagery ☐
- Deep Breathing ☐

Other

- _____ ☐
- _____ ☐
- _____ ☐
- _____ ☐
- _____ ☐

These are my Personal and Practical Strategies for engaging and re-engaging in my Student Role

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Choose one of your personal and practical strategies to find out more about.

_____

Action Plan developed between Student and Occupational Therapist:

What resources do I have to help me identify my personal and practical strategies?

- _____
- _____

When will I do this? _____

How will you remind yourself to do this?

- _____

What are the steps that I need to do to learn about my personal and practical strategies?

1. _____
2. _____
3. _____

Unilink Self-Management Programme

Review

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Introduction

Over the course of the Unilink Self-Management Programme, we have gone through the following sections:

1. Identifying the things that I need to do to engage in the student role and to look after my mental health
2. Identifying the things that may contribute to my not engaging in my student role
3. The signs that I am not engaging in my student role and possibly becoming unwell.
4. Personal and Practical Strategies for engaging and re-engaging in my student role.

Key Points

- We have used suggestions made by others and have aimed to improve your self-awareness of how you engage in your student role.
- We have also identified strategies that will help you to engage in the daily occupations that make up college life.
- Over the course of the meetings, you have made out unique definitions of some important ideas around engaging in your student role. Some of these definitions and lists may have changed since you completed them.
- Please look through the booklets for the various sections and change any of them if you would like.

How much time do you want to allocate to addressing your current demands today?_____ minutes.

Review Questions

1. Do you have any questions about any part of the programme that we have been working on?
2. Is there any area that you would like to review at this stage?
3. Is there any particular occupation that you would like to develop a plan to help you engage with?

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Unilink Self-Management Tool Card

Please use the Unilink Self-Management Tool card to keep note of the work that you have done in the programme. Please keep this with you day to day to remind you of the practical strategies that you have developed.

You can either place the card up on your wall or another place that you will regularly see it, or you can keep in with you in your wallet or purse.

Please review your personal lists from the previous sections of the workbook and copy the most important items to your card.

If you would like to change any of the lists, please use the tables over the next few pages.