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"I FELT SOME PREJUDICE IN THE BACK OF MY HEAD": NURSING STUDENTS' PERSPECTIVES ON LEARNING ABOUT MENTAL HEALTH FROM 'EXPERTS BY EXPERIENCE'

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"I FELT SOME PREJUDICE IN THE BACK OF MY HEAD": NURSING STUDENTS' PERSPECTIVES ON LEARNING ABOUT MENTAL HEALTH FROM 'EXPERTS BY EXPERIENCE'

ABSTRACT

Introduction:
Consumer participation is central to mental health policy. Negative attitudes of health professionals are barriers to realising policy goals. Evidence suggests consumers (Experts by Experience) can influence positive attitudes in nursing students. Research in this area to date is limited and primarily from Australia and New Zealand.
Aim:
To enhance understanding of nursing students' perspectives and experiences of being taught mental health by an Expert by Experience.
Method:
A qualitative exploratory approach was used. Focus groups were conducted with nursing students from seven universities in Australia and Europe. Data were analysed thematically.
Results:
Student participants described how exposure to Experts by Experience challenged their views and attitudes and provided a mechanism for

reflection, critique and change. The main theme "changing mindset", includes two sub-themes: *exposing stereotypes* and *reflection*.

Discussion:

This unique international study demonstrates the capacity for Experts by Experience to contribute to positive attitudinal change towards mental illness in nursing students. This changed mindset must occur for policy goals to be realised.

Implications for practice:

Nurses in all areas of practice will work with people labelled with mental illness and experiencing mental distress. Overcoming stereotypes and adopting more positive attitudes is essential to deliver quality mental health care.

Keywords:

Attitudes
Consumer academics or educators
Consumer participation
Education of health professionals
Experts by Experience
Mental health
Mental health nursing
Stereotypes of mental illness

Relevance statement

Consumer participation is now embedded in policy and must be supported and facilitated by nurses and other health professionals. Nurses are also required to provide quality mental health care across all areas of health service delivery. Consumers as Experts by Experience can profoundly and positively influence the attitudes of nursing students, reducing the stereotypes that shape these attitudes. Student perspectives presented here suggest

changed mindset as an outcome of this experience, which enabled them to identify and address stereotypes and become more reflective and critical. This changed mindset could facilitate a leadership role for nurses in facilitating genuine consumer participation.

Accessible summary

What is known on the subject

- Consumer participation in mental health services is embedded in mental health policy in many countries. The negative attitudes of nurses and other health professionals to consumer participation poses a significant obstacle to this policy goal
- Involving mental health 'Experts by Experience' in the education of nursing students demonstrates positive attitudinal change

What the paper adds to existing knowledge

- More detailed understanding of nursing students' experiences and perspectives about being taught mental health nursing by 'Experts by Experience'
- An international focus, extending understandings about how Experts by Experience might be perceived in a broader range of countries

What are the implications for practice

- Positive attitudes towards people labelled with mental illness are essential for quality nursing practice

- Nurses have an important leadership role in facilitating consumer participation within health services. It is critical that their attitudes are professional and optimistic.

INTRODUCTION

National mental health strategies mandate consumer participation in all aspects of mental health services, throughout design, service delivery and evaluation (Commonwealth of Australia, 1992, 1998, 2009, 2017; Health and Consumer Protection Directorate-General, 2005; Health Service Executive, 2018). This policy direction has led to initiatives in facilitating increased systemic participation, such as identified positions for consumers in the mental health workforce (Bennetts, Pinches, Paluch, & Fossey, 2013; Byrne, Stratford, & Davidson, 2018; Vandewalle et al., 2016) and a call for an increasing understanding of consumer leadership (Byrne et al., 2018; Callard & Rose, 2012; Gee, McGarty, & Banfield, 2016; Scholz, Bocking, & Happell, 2017; Scholz, Gordon, & Happell, 2017).

Redressing negative attitudes among mental health professionals has been identified as an important element to ensure the increase in consumer participation is not merely tokenistic and superficial (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015; Bennetts et al., 2013; Scholz, Gordon, et al., 2017). Consumer participation initiatives are most effective when supported by professionals with positive attitudes who value the unique contribution of consumers. Consumer involvement in the education of mental health professionals has been identified consistently as an effective strategy in negating the impact of negative attitudes (Byrne, Happell, Welch, & Moxham, 2013a; Byrne, Happell, Welch, & Moxham, 2013b; Goossen & Austin, 2017; Ridley, Martin, & Mahboub, 2017).

A review of the literature suggests students of nursing and other mental health professions find the experience of consumer-led teaching to be very

positive (Arblaster, Mackenzie, & Willis, 2015; Byrne et al., 2013b; Byrne, Platania-Phung, Happell, Harris, & Bradshaw, 2014). Furthermore, the findings of quantitative studies demonstrate positive attitudinal change including: reducing stigmatised, pessimistic attitudes towards people labelled with mental illness (Happell, Byrne, Platania-Phung, et al., 2014; Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, Lahti, et al., 2019; Stacey & Pearson, 2018), less anxiety about and greater perceived preparedness to work in a mental health setting or to provide mental health care for people accessing services across the health care system (Happell, Platania-Phung, Harris, & Bradshaw, 2014; Unwin, Rooney, & Cole, 2018). This attitudinal shift is a welcomed development given the identified relationship between a diagnosis of mental illness and poorer clinical outcomes in physical health care (Correll et al., 2017; Ventriglio, Gentile, Stella, & Bellomo, 2015; Vigo, Thornicroft, & Atun, 2016) . It is unfortunate that this evidence has not been sufficient to stimulate a large-scale adoption of consumer- led teaching throughout clinical university curricula. The lack of action to date may reflect the need for more rigorous and compelling evidence to persuade the relevant decision makers that such an intervention is imperative.

It is encouraging that consumer involvement in the education of mental health professionals is emerging in the literature, evolving somewhat organically in the absence of a formal framework. The first known academic position for a consumer of mental health services was introduced into a university in Melbourne, Australia in 2001 (Happell & Roper, 2009). In the almost two decades to follow there has been only a marginal increase in these positions. Consumer-led teaching is reported most commonly in nursing (Byrne et al., 2014; Happell, Byrne, McAllister, et al., 2014; Happell, Platania-Phung, et al., 2015; Horgan et al., 2018; O' Donnell & Gormley, 2013; Scammell, Heaslip, & Crowley, 2016; Schneebeli, O'Brien, Lampshire, & Hamer, 2010), and more recently in occupational therapy (Arblaster et al., 2015; Mahboub & Milbourn, 2015), social work (Fox, 2011; Goossen & Austin,

2017; Ridley et al., 2017), and medicine (Gordon, Ellis, Gallagher, & Purdie, 2014). Despite these advances, consumer participation in the education of health professionals remains embryonic and lacks penetration and consistency (Happell, Platania-Phung, et al., 2015; McCann, Moxham, Usher, Crookes, & Farrell, 2009). Making a case for consumer academic roles requires a more robust evidence base. The limited data available suggests the impact of consumer involvement in academia is not yet fully realised.

The existing evidence-base on this topic has limitations, particularly in relation to students' experiences and perspectives. To date in-depth qualitative explorations of undergraduate nursing students' experiences and opinions of consumer led mental health education have primarily been oriented towards students who have chosen to undertake a major in mental health nursing (and therefore completed the consumer-led component as additional to core mental health content), presumably reflecting their interest in this field of practice (Byrne et al., 2013b; Happell, Byrne, McAllister, et al., 2014). It could therefore be argued these experiences may not be typical of all nursing students, many of whom are not considering a career in mental health nursing. Furthermore, most research into student experiences and opinions has been undertaken in Australia and New Zealand and it is difficult to determine the extent to which these findings could be transferable across a broad range of settings, particularly internationally.

The prevalence of diagnosed mental illness and mental distress within the general health care system is significantly higher than the general population. (Bahorik, Satre, Kline-Simon, Weisner, & Campbell, 2017; Garrido et al., 2017; Giandinoto & Edward, 2015; Jayatilleke, Hayes, Chang, & Stewart, 2018). Therefore all nursing graduates must have some confidence and competence for managing acute symptoms for people labelled with mental illness across the health care sector.

In part, to address these limitations, the COMMUNE (Co-production of Mental Health Nursing Education) project was funded to create, implement and evaluate a pre-registration learning module. The module was co-produced by Experts by Experience and Nurse Academics in seven universities across six countries (Iceland, Ireland, Norway, Finland, the Netherlands and Australia).

The members of the COMMUNE team with personal experience of mental distress elected to use the term 'Experts by Experience' (EBE) as a position title to convey their distinct expertise; this term will be used throughout this paper. The term consumer is used to describe people accessing mental health services more broadly. Consumer is the term most commonly used in Australia, leaders of this component of the research. It is equivalent to the term service users, used throughout Europe.

Implementation of the project included a comprehensive mixed methods evaluation of the impact of EBE involvement on nursing students' attitudes to mental illness mental health nursing and consumer participation using self-report surveys (Happell et al., 2018; Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, Lahti, et al., 2019; Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, & Lahti, 2019). Findings suggested positive attitudinal change at completion of the co-produced, EBE- led learning module (Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, Lahti, et al., 2019). Focus groups with nursing students were undertaken to enable a more detailed understanding of students' experiences of this innovative approach. A greater understanding of holistic nursing and recovery-oriented practice were identified as key benefits to EBE-led teaching (Happell et al., in press).

Aim:

The findings presented in this paper constitute a component of the evaluation of the COMMUNE project. The aim of this paper is to present the views and experiences of EBE-led teaching from the perspective of nursing students. The international focus of the project has extended the knowledge base on this topic to include the European perspective.

METHODS

Design

A qualitative exploratory design was employed for this study. Given the limited literature on the topic in question, it was essential that participants played the role of informants and contributed their ideas and experiences without being restricted by a more structured research design (Stebbins, 2001). It was crucial to use a design with sufficient flexibility to enable the broad skills and expertise of the research team due to the co-produced nature of this project.

Setting

This international research project was conducted across seven universities in six countries: Australia, Iceland, Ireland (Cork and Dublin), Finland, the Netherlands and Norway. There were differences in the educational program undertaken by participants, further enhancing the diversity of the sample. In Ireland, students elect a specialist branch of nursing from the outset and undertake a four-year bachelor's degree in their area of speciality (in this case mental health nursing). The other countries undertake a comprehensive generic program of three or four years duration. Although these programs do

not specialise in any one specific area of nursing practice, students undertake one or more subjects on mental health nursing.

Participants

All students who had participated in the co-produced learning module were provided the opportunity to participate in the focus groups. Students were invited during class time and via advertisement displayed in prominent locations or sent via email and message boards. A total of eight focus groups were held, comprising 51 students. The break down for participants in each country/university is included in Table 1.

Insert Table 1 here

Procedure

Focus groups were conducted at each university. Focus groups were conducted by a member of the project team who had not been involved in the teaching program and did not hold a dependant relationship with students. This independence is essential to ensure students feel comfortable to share their views and opinions without fear of reprisal or the potential of causing offence. Interviews were conducted in the native language in countries where English is not the first language. Data were translated in English following analysis.

An interview guide was prepared to assist in framing general questions to facilitate participants describing their experiences and opinions about the EBE led teaching (the interview guide is presented in Table 2). The guide also enabled the interviewers to ensure specific areas of interest to the research team were addressed. It was not intended to be prescriptive. All interviewers used a relaxed conversational approach, so participants would feel comfortable to contribute ideas and experiences beyond these questions.

The focus groups were digitally audio recorded and subsequently transcribed verbatim.

Insert Table 2 about here

Ethics

Ethics approval was provided by the Research and Ethics Committee at each participating University. Potential participants were provided with a detailed explanation of the purpose of the study and reminded of the voluntary nature of their participation. They were assured that no potentially identifying information would be published. In some sites, interested students were given a copy of the Plain Language Statement and asked to read this before agreeing to participate. Students were provided the opportunity to ask questions and seek clarification before continuing. Finally, they were asked to sign the consent form to confirm their willingness to participate. All data including audio recordings and transcripts were securely stored in accordance with Ethics Committee requirements of each jurisdiction.

Data analysis

Data analysis took place in two stages. The initial phase occurred at each university where at least one EBE and one nurse academic independently analysed the data. To ensure consistency, the Braun and Clarke (2006) framework for thematic analysis was adopted at all sites. In summary this involved:

- Reading transcripts several times to gain a deep understanding of the content and its meaning.
- Assigning codes to specific sections of content.

- Scrutinizing codes with regards to the research aims, confirming the relevance of each to the research topic.
- Clustering codes together to form provisional themes based on similarity of content.
- Developing a conceptual map of the identified themes.
- Re-examining themes for accuracy and relevance.
- Reading transcripts a final time to ensure all important data had been included.

Team members involved in the analysis subsequently met and discussed their analysis. These were compared and discussed until consensus could be reached. Data from each university were subsequently combined. The full dataset was then analysed to identify the major themes across all settings. Throughout the data analysis process, detailed discussion was undertaken to ensure differences in perspectives between team members, and, most importantly between nurse academics and EBE, were resolved. This was important to ensure these diverse perspectives were evident in the final work. Including both nurse academics and EBE in data analysis facilitated a more rigorous process and ensured consistency with the principles of co-production (Roper, Grey, & Cadogan, 2018).

Rigour and reflexivity

Establishing confidence in research findings requires close attention to, and articulation of, rigour (Engward & Davis, 2015). A reflexive approach is an essential component of rigour (Walker, Read, & Priest, 2013). To ensure reflexivity in this project, regular team meetings were held throughout. This included meetings at the local level in each university and for the team as a whole. These meetings occurred both face to face and via video-conferencing. One aim of the meetings was to develop the interview guide,

ensure a consistent approach to conducting interviews and to conduct and monitor data analysis. Interview transcripts were analysed independently by at least two researchers, with preliminary findings discussed until consensus was reached, to reduce the likelihood of bias (Walker et al., 2013). Data analysis in each country involved at least one Expert by Experience and Nurse Academic to ensure it reflected all perspectives.

FINDINGS

Student participants described the experience of being taught by EBE as impacting them profoundly and positively. They described how exposure to EBE challenged their views and attitudes and provided a mechanism for reflection, critique and change. The main theme "changing mindset", includes two sub-themes: *exposing stereotypes* and *becoming more reflective*.

Changing mindset

Participants described and provided many examples about the profound personal impact of this teaching approach. In particular, they developed a more positive and less stereotypical view of people who access mental health services. They also found themselves more reflective and with an enhanced capacity to critique many aspects of mental health practice that previously they would likely have taken as acceptable clinical practices.

Exposing stereotypes

Participants frequently described their fears about mental illness and apprehension about working in mental health settings before undertaking this learning module. Their perceptions had been tainted by negative portrayals of people labelled with mental illness as dangerous and unpredictable:

> There are … attitudes that mental health patients are restless and dangerous (Finland).

These views were sometimes reinforced by nursing staff within clinical facilities who appeared to advise students not to divulge anything personal to mental health consumers, lest their safety be negatively impacted:

> We're told not to share anything of ourselves [to consumers] … students have said they've been told don't even tell the patients that you've got a dog, you know, don't even tell the patients what suburb you live in (Australia).

Participants also reported their family and friends commonly expressed negative views about people labelled with mental illness about mental health nursing as a profession more broadly:

> I also found people [friends and family] had a really negative idea of the patients … I remember someone was saying to me … oh you shouldn't be doing that [mental health nursing] you'll get attacked (Cork, Ireland)

Some participants found these adverse comments so pervasive that they still questioned their decision to pursue this field of study, even after confirming mental health nursing as their chosen career:

> It [negative feedback] nearly, nearly made me not want to do it [mental health nursing] ... they [family and friends] have the perception that it was going to be so tough … they just think that if you are working with people who are mentally unwell, … it may not be good for you (Cork, Ireland).

Participants were also aware of the impact of the media in shaping the attitudes of people towards mental illness:

> My impression is … the fields of mental health and psychiatry still are a little unknown, not that many know exactly what they are, and there is still a lot of taboo, and horror stories in the media (Norway).

Some students indicated they too had been influenced by media perspectives of mental illness:

> I feel whether I like it or not my perceptions of mental health have been shaped by television before I came to uni. They've been shaped by the movies I've watched … so this [teaching by EBE) has helped break down some of those (Australia).

> Thinking about psychiatry, I thought about things I had seen in movies. About such an institution with people who are all "crazy" (the Netherlands).

Some participants also questioned the capacity of consumers to overcome the impact of the diagnosed illness. In some instances their previous clinical experience led them to believe most consumers made little progress with their recovery:

> A lot of times they [consumers] would continually come in with the same problem again and like try to start from scratch each time (Cork, Ireland).

Most participants were enthusiastic when told they would be taught by an EBE. However, for some there was concern that the EBE would not be capable of undertaking this role. The pessimistic beliefs about recovery from

'mental illness' extended to doubt of the EBE' capacity to be a professional. Some students expressed concerns that EBE would not be capable of delivering useful content due to drawing on lived experience rather than clinical or academic knowledge:

> I felt some prejudice in the back of my head . . . some kind of academic arrogance because they (EBE) are not especially educated in the field (Iceland).

Students were also concerned that the EBE' vulnerability and lack of capacity might be aggravated through the discussion of sensitive material in the classroom and that such an experience might cause psychological harm:

> You don't know what people can talk about or how far they can go so from that perspective, you'd be scared that you would push them too far (Cork, Ireland).

Contrary to this expectation, the EBE provided students with a different perspective from their personal experience of mental health service use. This impacted significantly on students and shifted the belief systems they held:

> The Expert by Experience taught me … to have less prejudices. Because that person was very different from what I thought (the Netherlands).

> I think I've … completely changed my mindset and how I see and view people, and in all aspects … it's turned it upside down. I think she [EBE] … nailed it, really pressed that in for me… (Australia).

> That guy [EBE] that shared stories of himself, he seems to be really normal again. And he can function normally again. Seeing that has changed something I belief (the Netherlands)

Becoming more reflective

Participants from all countries described how their interactions with EBE was a catalyst for them to reflect on the views and attitudes they held. The students found that the EBE challenged them in a positive way to realise their understanding of the mental health system was either limited or heavily influenced by clinical perspectives or both. Students acknowledged they had tended to accept the system at face value, rather than applying critical thinking to concepts and processes. Their experience of being taught by EBE persuaded them to contemplate alternative, non-biological understandings of mental distress and treatment to what they had been traditionally taught:

> We are trained from the hospital's and the nursing department's point of view. You do not always realize how your own views are limited. You think you are critical and then you realise, when you meet them [EBE], that maybe you are not so critical and broad minded. Why do we do what we do, like using the ICD [International Classification of Diseases] diagnostic system? Sometimes you just do things blindly … I became more critical of the methods used at the hospital . . . It [being taught by the EBE] got you to think more about why things are done as they are done (Iceland).

EBE describing their experiences through storytelling was noted by most participants as a very powerful tool to aid their understanding of first-hand experience of mental health services, as one student articulates:

> There's a few stories that she [EBE] shared that have really stuck with me and how she was locked up as a really young person going through grief. And how she was alone that entire time, that really made me question why … how could this happen? How could they think that this was right? (Australia).

Through this example the student felt able to understand the intentions of the nurses and acknowledged their motivations were probably genuine. However, the firsthand account provided by the EBE highlighted how the same scenario was perceived by the consumer, and how understanding this perspective was enormously valuable for the student:

> You can see where they [nurses] thought they were doing the right thing. You can see how these mistakes happen, but it's so easy to see how hideously wrong it is once you get that other side, which we never would get to see without someone sharing that (Australia).

Participants provided many examples of how the EBE approach to teaching facilitated an environment where students felt free to express themselves, creating an important space for reflection on the EBE led learning:

> There's no wrong responses … she's wanting people to express things that may, outside of the room and in their life, be inappropriate. There was no wrong thing to say in the class (Australia).

The experience also encouraged students to consider the impact of language on consumers, subsequently encouraging them to be more careful and considerate in their use of language:

> She [EBE] gives us insights and even into the language we use and how language used can be quite debilitating to service users because it

alienates them…so it opens up your mind into thinking we should watch the way we speak (Dublin, Ireland).

The impact of EBE on reflective practice by nursing students was also noted. One participant describes how this new way of understanding was useful in encouraging a more open, less reactionary, and more autonomous approach to mental health nursing practice:

> It is about taking my experiences, and … work towards what I believe is for the good, and not forget the things I reacted to, so I don't fall into something, and be aware when you enter a culture … not just be led (Norway).

> I… approach people more open, with less of a judgement. That could definitely influence my nursing practise. (the Netherlands)

Reflection throughout this teaching experience also provided insight into the uniquely taxing nature of listening deeply to another's trauma, which in turn facilitated an awareness of the requirement for self-care for some participants. Engaging with EBE' life stories was an emotional experience for students, and they made the connection between these in-class sessions and the prospect of experiencing similar emotions while on clinical placement:

> "I think it shows as well … that it's important to look after ourselves because … even just listening to the stories you're sometimes emotionally … drained (Cork, Ireland)."

DISCUSSION

The findings presented in this paper support findings of other components of the COMMUNE study derived from self-report surveys (Happell et al., 2018; Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, Lahti, et al., 2019; Happell, Platania-Phung, Scholz,

Bocking, Horgan, Manning, Doody, Hals, Granerud, & Lahti, 2019), and focus groups with nursing students (Happell et al., in press). These findings provide further evidence to the existing literature by demonstrating that nursing students respond positively to being taught by EBE (Arblaster et al., 2015; Byrne et al., 2013b; Byrne et al., 2014). Through this experience, many students became aware of, and questioned, their existing stigmatised attitudes. The literature demonstrates health professionals have negative attitudes towards people labelled with mental illness (Bingham & O'Brien, 2018; Gras et al., 2015; Griffiths, 2011; Morgan, Reavley, Jorm, & Beatson, 2016; Ozer, Varlik, Ceri, Ince, & Delice, 2017; Reavley, Mackinnon, Morgan, & Jorm, 2014), suggesting these are reflective of attitudes of the broader population. It is particularly important to note that participants' awareness of their own stereotypical views resulted from their interactions with EBE during the teaching program, And that these interpersonal interactions encouraged them to challenge their current views and opinions. The impact of EBE to challenge negative attitudes through health professional education is a clear theme to emerge from research in this area (Byrne et al., 2013b; Goossen & Austin, 2017; Happell, Byrne, Platania-Phung, et al., 2014; Happell, Platania-Phung, Scholz, Bocking, Horgan, Manning, Doody, Hals, Granerud, Lahti, et al., 2019; Ridley et al., 2017). The international scope of the current research suggests this experience may be broadly applicable to nursing students, at least within the western world.

One particularly interesting finding was that students of the universities in Ireland (who had chosen a mental health speciality) also reported having negative views about the consumers they supported. It might be expected that students who have chosen this career path hold more positive attitudes. Yet this finding extends current understandings, suggesting such attitudes are not significantly different to those of students undertaking a generic nursing program. It seems reasonable to conclude that involving EBE in mental health nursing education should not be restricted to undergraduate programs and

could be included in both specialist undergraduate and postgraduate mental health nursing programs. Only one published research article has examined how the attitudes of postgraduate mental health nursing students have been influenced by EBE education and this study indicated attitudinal improvement occurring as a result of this approach (Happell, Pinikahana, & Roper, 2003).

Students described themselves as more reflective as a result of EBE teaching. The ability to engage in reflective practice is identified as central to most contemporary nursing curricula (Asselin, 2011; Parrish & Crookes, 2014). The capacity for reflection is considered essential for nursing graduates, given the dynamic nature of health care delivery (Kim Yen Nguyen-Truong, Davis, Spencer, Rasmor, & Dekker, 2018), and its contribution to the development, improvement and articulation of nursing knowledge (dos Santos Martins Peixoto & dos Santos Martins Peixoto, 2016). Reflection is therefore an important skill to facilitate lifelong learning, continuous improvement discipline knowledge creation. Evidence suggests students do not necessarily understand the relevance of reflection to their clinical practice, and therefore it may be a difficult concept to teach (Edwards, 2014). The current findings suggest EBE-led teaching significantly assisted students to become more reflective and critical of current clinical practices. EBE inclusion in nursing curricula could have an additional benefit of organically facilitating reflection, without it having to be specifically 'taught' to students and therefore a task to be completed rather than a change in conceptual thinking.

Some participants acknowledged that when they learned they would be taught by EBE, they felt some uncertainty. This was due in part to concerns that their educational preparation would not hold the same credibility as the knowledge held by nurse academics. An even greater issue was that EBE were thought to be potentially too vulnerable as a result of their

mental state to contribute, and some worried that words or actions from students might contribute to a deterioration in their mental health. The issue of perceived vulnerability of EBE was identified in a qualitative study of nurses and EBE's attitudes to consumer involvement in nursing education (Happell, Bennetts, et al., 2015).

A strength of the current research is the co-produced approach taken to developing and delivering the curriculum content. Co-production identifies and values the experiential knowledge EBE bring (Durose, Beebeejaun, Rees, Richardson, & Richardson, 2014; Johnstone et al., 2018; Roper et al., 2018; Slay & Stephens, 2013); through this process they are active and ideally equal partners in developing, implementing and delivering curriculum. A co-produced approach contributes to addressing power differentials that pose a major limitation to genuine consumer involvement in mental health services, education and research (Johnstone et al., 2018; Roper et al., 2018).

Contemporary mental health policy requires consumers to be involved more closely in all aspects of mental health service delivery. It is essential that the negative attitudes of emerging health professionals are addressed prior to embarking on their professional careers. The demonstrated impact of EBE teaching suggests that their systematic inclusion in the education of health professionals may be an effective strategy to start this process (Horgan et al., 2018). Furthermore, interacting with EBE in this way provides students the opportunity to develop a greater understanding of firsthand experience and, more importantly, to value and respect that perspective, rather than dismissing it as being less rigorous than clinical and academic knowledge. The recognition of consumer leadership in the academic arena is also facilitated. Strong leadership is essential to ensure sustainable and genuine consumer participation in mental health services (Byrne et al., 2018; Callard & Rose, 2012; Gee et al., 2016; Scholz, Bocking, et al., 2017; Scholz, Gordon, et al., 2017).

Limitations

The use of a qualitative exploratory approach does not allow the findings to be generalised to broader settings. This limitation is minimised due to the international focus of the project. Regardless of the more diverse sample, the relatively small sample size means generalising findings to other contexts is not recommended.

CONCLUSIONS

Positioning people labelled with mental illness as active participants in all aspects of mental health services is a laudable goal and an essential characteristic of quality service delivery. Involving EBE in teaching nursing students has proven effective in influencing positive attitudinal change. The current study adds further strength to existing evidence, particularly given the international nature of the research. Student participants described their experiences of being taught by EBE as 'changing their mindset'. It had two key impacts: it changed their initial stereotypical views of people who use mental health services and facilitated them to become more critical and reflective in their approach to this field of nursing practice. EBE involvement in the education of mental health professionals could therefore be an important initiative to ensure enhanced participation and recovery-orientated policy moves beyond rhetoric and becomes a reality.

Co-production of mental health nursing curricula is crucial for moving beyond the limited, ad hoc and often tokenistic involvement of consumers in tertiary education. Co-production clearly positions EBE as experts and leaders; and facilitates the authenticity of curriculum content and delivery. COMMUNE is the first international, multi-site, co-produced project on consumer

involvement in mental health nursing education. These findings are therefore particularly imperative and will ideally stimulus for similar projects in the future.

IMPLICATIONS OF FINDINGS

Contemporary mental health policy acknowledges consumer participation as essential for quality service delivery. Nurses have an important role to play in the implementation of policy and the quality of mental health services. The findings presented in this manuscript support the available literature in suggesting EBE in nurse education can influence positive attitudes in nurses towards consumer participation. A robust evidence base is required to assist in advocating for increased EBE involvement in the education of nurses and other health professionals.

	Male	**Female**	**Total**
Finland	2	8	10
Australia	1	5	6
Netherlands	1	4	5
Norway	0	2	2
Ireland (Dublin)	0	3	3
Ireland (Cork)	3	19	22
Iceland	1	2	3
Total	8	43	51

Table 1: Student focus group participants

1. Please describe your thoughts and feelings when you first learned you would be taught by a person with experience of mental health service use?
2. What do you see as the positives (if any) of being taught by a mental

health service user? Please explain.

3. What do you see as the negatives (if any) of being taught by a mental health service user? Please explain.
4. In what ways (if any) do you feel your nursing practice will be influenced by this experience?
5. If you have had a mental health placement since being taught by a person with experience of mental health services, did it influence your placement or practice?
6. Did the consumer content of the unit influence your values or beliefs about working with consumers?
7. What were your thoughts and feelings about mental health nursing as a career when you first commenced your nursing program? Has this view changed since completing this course?
8. In what way do you consider mental health skills are important for nursing more broadly?

Table 2 - Interview Guide

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