‘THEY ARE A DIFFERENT BREED AREN’T THEY? EXPLORING HOW EXPERTS BY EXPERIENCE INFLUENCE STUDENTS THROUGH MENTAL HEALTH EDUCATION.

ABSTRACT

Experts by Experience (EBE) in mental health are increasingly becoming involved in the education of health professionals. In response, research findings suggest positive attitudinal change toward people who experience mental distress, and enhanced appreciation of recovery and person-centred approaches to practice. However, this growing body of evidence has not resulted in the broad adoption of these roles in academia. The perspectives of academics instrumental in implementing academic positions for EBE (referred to as allies) have not yet been articulated. Acknowledging this gap, the aim of this research is to explore experiences of allies involved in implementing EBE positions in academia regarding the impact of EBE led education on students. Qualitative exploratory methods were used involving in-depth interviews with allies. Data were analysed thematically. Participants observed significant positive impacts on students, as evidenced through four themes: *contextualised learning, enhancing reflection, feedback from the clinical field,* and *students’ own lived experience*. The fifth sub-theme, *Challenging experiences* were observed to potentially detract from the student experience in some instances. Overall, participants were very supportive of EBE involvement, and were confident this approach produced more person centred and recovery-oriented clinicians, with the skills,

knowledge and attitudes needed to work as practitioners. These findings support previous research, and suggest positive implications for clinical practice and for students with their own mental health challenges.

KEYWORDS

Allies

Clinical practice

Consumers

Education

Experts by experiences

Health Professionals

Mental Health

Recovery

Reflective practice

Service users

INTRODUCTION

Internationally the expectation that consumers of mental health services (hereafter referred to as consumers) are active participants in all aspects of mental health services from design to delivery is increasingly reflected in policy (Commonwealth of Australia, 2017; Health Services Executive, 2018; McKeown, Malihi-Shoja, & Downe, 2010; Mental Health Commission, 2012; Mental Health Commission of Canada, 2016). The realisation of this policy goal requires an attitudinal shift in health professionals by valuing the contribution consumers can make at a broader systemic level. The positive impact consumers can make through the unique knowledge and expertise they bring must be recognised as equally valuable to that of health professionals (Gee, McGarty, & Banfield, 2016; Scholz, Bocking, & Happell, 2018; Veseth, Binder, Borg, & Davidson, 2017). In contrast the attitudes of health professionals have been identified as a significant barrier to genuine consumer leadership (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015; Bennetts, Pinches, Paluch, & Fossey, 2013; Edwards, 2014; Scholz, Gordon, & Happell, 2017).

Involving consumers as experts by experience (EBE) in the education of health professionals has gained considerable momentum as a strategy to enhance students' attitudes, knowledge and skills through the different perspectives that EBE bring to mental health education (Byrne, Happell, Welch, & Moxham, 2013b; Goossen & Austin, 2017; Ridley, Martin, &

Mahboub, 2017; Tanner, Littlechild, Duffy, & Hayes, 2015). While the initial momentum came predominantly from mental health nursing (Happell et al., 2014; Happell, Pinikahana, & Roper, 2002; Happell, Platania-Phung, et al., 2019; Horgan et al., 2018; O' Donnell & Gormley, 2013; Schneebeli, O'Brien, Lampshire, & Hamer, 2010), activity is increasing in other disciplines including: general nursing (Scammell, Heaslip, & Crowley, 2016), occupational therapy (Arblaster, Mackenzie, & Willis, 2015; Mahboub & Milbourn, 2015; Scanlan et al., 2020), social work (Goossen & Austin, 2017; Ridley et al., 2017), radiology (Flood, Wilson, & Cathcart, 2018; Keenan & Hodgson, 2014), physiotherapy (Thomson & Hilton, 2012), and medicine (Gordon et al., 2020; Gordon, Ellis, Gallagher, & Purdie, 2014; Newton-Howes, Gordon, & Fedchuk, 2020). Involvement is a mechanism for addressing the expectation that through insights into the service user perspective, the knowledge, attitudes and skills that students of health professions gain promote person-centeredness (Happell, Platania-Phung, et al., 2019; Horgan et al., 2018; Terry, 2013) and recognition of the importance and value of collaborative partnership (Skilton, 2011).

Research into the impact of EBE led teaching has demonstrated the development of more positive attitudes towards people experiencing mental distress (Arblaster et al., 2015; Byrne, Platania-Phung, Happell, Harris, & Bradshaw, 2014; Goossen & Austin, 2017; Gordon et al., 2014; Happell et al., 2014; Happell, Platania-Phung, et al., 2015; Happell, Platania-Phung, et al., 2019; Horgan et al., 2018; Mahboub & Milbourn, 2015; O' Donnell & Gormley,

2013; Perry, Watkins, Gilbert, & Rawlinson, 2013; Ridley et al., 2017; Scammell et al., 2016; Schneebeli et al., 2010). Students have exhibited a greater understanding of and appreciation for recovery and recovery-oriented practice as a consumer focused alternative to the medical model (Arblaster et al., 2015; Byrne, Happell, & Reid-Searl, 2016; Byrne, Happell, Welch, & Moxham, 2013a; Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Maher, Bell, Rivers-Downing, & Jenkins, 2017). Despite the identified benefits and some notable increase in EBE inclusion in the education of health professionals (Scanlan et al., 2020), involvement remains primarily focused on classroom teaching with lesser input into curriculum design, implementation and evaluation (Happell, Platania-Phung, et al., 2015; McCann, Moxham, Usher, Crookes, & Farrell, 2009; Scanlan et al., 2020). Genuine Involvement of service users in the design and development of mental health education is imperative to strengthen their contribution to student learning.

Research evidence suggests the impact of EBE in mental health education contributes to the reduction of stigmatising attitudes (Happell, Platania-Phung, et al., 2019; Happell, Waks, Bocking, Horgan, Greaney, et al., 2019; Stacey & Pearson, 2018; Unwin, Rooney, & Cole, 2018), and a greater appreciation of the fundamental humanity of people accessing mental health services (Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Stacey, Oxley, & Aubeeluck, 2015; Stacey & Pearson, 2018).

To date the research into the impact of EBE generally has primarily explored the perspectives of students (Arblaster et al., 2015; Kang & Joung, 2020; Ridley et al., 2017), and to a lesser degree EBE (Bocking et al., 2019; McKeown et al., 2012; Prytherch, Lea, & Richardson, 2018; Speers & Lathlean, 2015). Research has also examined the perspectives of nurse academics regarding EBE involvement in mental health nursing education (Happell, Bocking, Scholz, & Platania - Phung, 2019; Happell, Wynaden, et al., 2015) however the majority of nurse participants had not worked closely with EBE in substantial academic roles. The findings revealed that amid predominantly positive opinions, some strong negative attitudes were evident.

Inadequate funding and negative attitudes have been identified as two major barriers to active involvement of EBE in the education of health professionals (Happell, Bennetts, Platania Phung, & Tohotoa, 2015; Happell, Bocking, Scholz, & Platania-Phung, 2020; Scanlan et al., 2020) and probably explains, at least partially, the lack of proliferation of consumer academic roles. Allyship has been identified as an important strategy in supporting and facilitating the implementation for consumer leadership roles in mental health services and academia (Happell & Scholz, 2018; Lambert, Egan, & Thomas, 2021; Lambley, 2020).

Allies generally do not identify as consumers and actively advocate for and promote increased consumer involvement (Happell & Scholz, 2018; Slay

& Stephens, 2013). Allies utilise their privileged positions, often involving seniority and influence, to advance consumer involvement in research (Happell et al., 2018; Lambley, 2020; Scholz et al., 2019), mental health education (Byrne, Happell, & Reid-Searl, 2017; Happell, Bocking, et al., 2019), and mental health services (Byrne, Roennfeldt, Wang, & O'Shea, 2019; Juntanamalaga, Roper, Happell, & Scholz, 2019; Moss, Warner, Happell, & Scholz, 2020). It would therefore appear likely that allies will play a crucial role in the sustainability and growth of future consumer academic positions. As such the perspective of allies who have been instrumental and had significant involvement in implementing consumer academic positions would make an essential contribution to understanding the impact of consumer academic positions.

Aim

The aim of this research was to explore the perspectives of academics, who had facilitated the establishment of substantial positions for EBE in mental health education regarding the perceived impacts of these positions on students of the health professions.

METHODS

Design

A qualitative exploratory design guided the conduct of 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).

Setting and Participants

This international study was undertaken with allies, experienced in facilitating the establishment of academic roles for EBE. Recruitment was initiated through the professional networks of the research team. The team members have been actively researching in this area for several years and are well connected with academics involved in the establishment of these roles. An invitation to participate in the research was sent by email to appropriate people known to members of the team. All participants recruited into the study were asked if they knew of other academics with this experience, a common recruitment processes known as snowballing. An email invitation was then also sent to people identified through this process. Seventeen potential participants were identified in total and sent email invitations. Sixteen people from three countries (Australia, New Zealand and Ireland)

participated in an interview. Further information about the participants is presented in Table 1.

Insert Table I about here

Procedure

The email invitation sent to the 17 people identified provided a brief explanation of the study and a copy of the Plain Language Statement. They were asked to respond if they were interested in participating. Sixteen participants indicated their willingness to participate and one declined. Those who did agree to participate were sent the consent form and returned it signed prior to the interview.

Individual interviews were conducted with 14 participants. The other two participants were interviewed together at their suggestion. Interviews were conducted via video conferencing or telephone due to vast distances between participants. Interviews were of approximately 60 minutes duration. An interview guide was prepared by the research team based on an extensive review of the literature and the team's prior experience with research of this kind. The guide was used to provide some focus for the interview and ensure essential information was discussed. At the same time, questions were intentionally broad and a conversational feel was brought to the interview to allow participants to raise other pertinent issues previously not

considered by the research team. Questions to participants included the following:

- What do you see as the positives (if any) for students of being taught by a mental health consumer? Please explain.
- What do you see as the negatives (if any) for students of being taught by a mental health consumer? Please explain.
- Having been involved in this teaching are there ways it could be improved? Please elaborate
- Based on your experiences, do you feel service user involvement should be integral to teaching mental health? Please elaborate

Ethics

Ethics approval was granted by the University of Newcastle Human Research Ethics Committee (approval number H-2020-0007). Participants were advised that their involvement or otherwise in the project was purely voluntary and they were free not to participate or to withdraw their participation at any time. Assurance was provided that all information would be treated confidentially and only aggregate data would be included in publications.

Data analysis

Data were analysed using the framework developed by Braun and Clarke (2006). Transcripts were read several times for the researchers to gain a deep understanding of the content and its meaning. During this process specific sections of content were identified and assigned a code. The codes were scrutinized with regards to the research aims, confirming the relevance of each to the research topic. Codes were subsequently clustered together to form provisional themes based on similarity of content. A conceptual map of the identified themes was developed. Each theme was re-examined for accuracy and relevance. Transcripts were read a final time to ensure all important data had been included.

Data analysis was undertaken independently by at least two members of the research team. On completion the researchers met to discuss their analysis framework, with discussion occurring until consensus was reached.

FINDINGS

The data were rich with examples of the impact that EBE had on students. The participants observed changes in the students resulting in them being "critical of their own practice", "not being afraid of the service users" [13] and that students were more open and accepting. This was observed through the students' use of language and their "accelerated" development

of good interpersonal skills and ability to engage with consumers [11]. The lessening of an *us and them* attitude was noted by many participants [11, 13]. There was an observed reduction in stigma and an increased understanding that mental distress "could happen to anyone at any stage in their life" [11]. The students were observed as being more able to "talk openly and normalise mental illness" [7]. The participants noted that they were receiving "extremely good feedback, from the clinical field, taking a different philosophical perspective on what constitutes quality care" [14]. This data revealed the following themes: *contextualised learning, enhancing reflection, feedback from the clinical field, students' own lived experience* and *challenging experiences.*

Contextualised learning

EBE engaged students and enabled them to contextualise their learning by linking theory and practice [12] as well as translating concepts such as recovery into real life and embedding recovery into the curriculum [5]. EBE played an important role in assisting students to:

> …transfer the recovery principles into their assignments on a very practical level … I knew [recovery] was quite a slippery concept as it is for a lot of clinicians…That's the value she [EBE] had; that they would go to her and talk about these things because it was easier

> to talk to her. They felt a lot more comfortable because she was living it every day [7].

Having exposure to people with lived experience in a range of normal settings helped students see that recovery was possible [4]:

> They could see that recovery was possible from [the EBE] sharing their stories and their experiences…they could see that it wasn't all doom and gloom, that people can recover…that simple, ordinary things mattered…the value in having the ordinary chat and doing ordinary things for people…that was just as important as learning about medication…When first years go out after having done the module that [the EBE run], the language is different, and the perspective is different [13].

The result is a shift in the "mindset" of the students which can be seen in the "the kind of literacy they have around lived experience and their openness to it" [2]. This enhanced their capacity to see service users as individuals with the ability to make their own decisions:

> …the best person to make decisions about themselves. I can say that until the cows come home and I do. But when people are able to talk about being given autonomy, being given respect, being

> put in charge, that I think is so much more powerful than me saying 'It's really important to put the person in charge' [10]

Students "valued engagement" with EBE [10] and through these interactions they came to develop a greater understanding of EBE as people and in the classroom as teachers:

> Except for the odd exception, it was a no-brainer. It is always inspiring, it's always motivating, and it's always, 'Oh, my God, I never saw our service users as people, I always saw them as patients, and not only people but people who are teaching me how to be a better nurse' [9].

These benefits were described by one participant as unique to EBE:

> People like you and I, I am sure are both excellent educators and we have a lot to offer and I am not suggesting in any way that lived experience replaces that, but it brings something that just can't be brought in any other way. It is just that experience of seeing the world from a different perspective. Seeing that person as a person. … We did some interviews with students who did that course [EBE led] and they said that this is the best thing we have ever done and all nurses should do it. It shouldn't be just be for mental health, it should be in all programs.

The impact of EBE on the education of students was so profound, the academic qualifications of the EBE was not an issue of concern:

> The students didn't give a damn what qualification the EBE had. They just got what they needed... It didn't matter what the qualification was [4].

Enhancing reflection

Participants observed that EBE brought unique knowledge and skills to the classroom that enhanced students' to be more reflective:

> the way in which information is understood and communicated to a student audience [by an EBE] that I think creates a possibility in the mind of the learner [and] probably not as easily made by others in a traditional academic role. The possibility…of personal reflection, the possibility of deeper meaning and thinking about concepts and how they may play [out] [8].

Participants presented many examples [5, 11, 14] where significant changes and difference in students had been observed, for example:

> Their ability to self-reflect and change because they were exposed to a very different style of teaching from the very, very outset. First year often it can be quite didactic…from even their writing for assignments, their ability to self-reflect at an earlier stage in the program was evident. Given the age of most of them, it was quite interesting [11].

The increased capacity for self-reflection increased their respect for one another and understanding of their own needs, both considered important characteristics of a good clinician:

> I noticed a huge difference in the way they communicated with their colleagues online. They were more respectful…You could hear them listening to other people who seemed to be struggling…It was quite amazing…It was their self-reflection and being more sensitive to themselves…sensitivity to their colleagues…how they were advocating for each other to make sure that they had support, and…their relationship with the people that they were entrusted to care for. And that makes a better nurse, from my point of view [14].

Contact with EBE could be transformative [4, 14] for the students. One participant described how these interactions encouraged students to question the values they brought with them into education and practice. One participant described students' making comments like:

> I am in a new position and I am in a new space and I see the world in a different way. I am seeing it in a much more respectful way in terms of the things that I used to take for granted and assume and make value judgments about, whether that was conscious or unconscious, that informed my practice. Now I am far more sensitive to the nuances of people with whom I am responsible…They were able to go away and just really feel comfortable in exploring self about how they can improve their practice [14].

Feedback from the clinical field

The impact of EBE involvement in teaching was also reported by staff in clinical areas where students undertook their clinical placements. Feedback from clinicians included improved communication skills and a different use of language being observed:

> The language that they were using was quite different to previous first years, and their attitude and their ability to communicate more effectively with people in distress was quite different and they were using the recovery language a lot more than previous years [11].

Positive feedback also came from clinical educators who noticed a difference in the students who had been taught by EBE in terms of their confidence and enthusiasm:

> They [students] felt confident to speak up. They were the first out of the [office] on the first day in clinical…and away they went. And they [clinical educators] were like, 'Whoa, this is new, what's going on here?'...they thought they were new grads not second year students because of their preparation [7].

Similarly:

> Our students, when they did go out into the mental health team, lots of the clinicians would say, 'Gee, they are a different breed aren't they? They look at things in a different way. The level of sensitivity about what they're doing in their everyday practice is obvious.' So they came across as being far more discerning about the way that they were going to interact, the quality of their interactions, the importance of eliciting feedback from the ones that they're caring for about how am I being perceived? [14].

The differences noted on clinical placements, were described as being in clear contrast with students from other universities who did not receive EBE led teaching:

> The kind of literacy they have around lived experience and their openness to it, versus students from other universities. Most students

> are open to it and the students generally are more open to it than…supervisors. [2].

Students' own lived experience

There were powerful examples given of how students with their own lived experience of using mental health services were validated and found a space to share their own experiences. One participant described how students preferred to approach the EBE academic with concerns, particularly issues related to their own lived experience:

> Mostly the students just gravitated towards her. We could then plan ahead for their clinical so that they could feel safe. Some of them would wind up [on placement] in the units they'd been in as patients. All very fearful that they wouldn't get their nursing registration because they had disclosed a mental illness. That was what was driving a massive anxiety and concern and we were able to minimalise that for them. And [the EBE] had this wonderful saying, 'You know, telling me that you have this problem is not that you're going to be worried you won't be a nurse, but you'll be a much better nurse' [7].

One participant described transformative changes in students taught by the EBE, especially the impact on those with their own lived experience:

> It had a lot of depth, it was quite transformative for most social work students, particularly those with their own lived experience…Students with their own lived experience have a place and a space to kind of hang their hat and say, 'Oh okay, so I don't have to be totally closed about this, I can be a bit open'. I mean, I remember one qualitative comment, so 'I'm not a freak?' It's like, 'No you're not' [2].

Challenging experiences:

Not all experiences were positive and it is important to note the challenges. Some students struggled with conflicting stories and narratives [9]. One participant described a situation where an EBE was quite aggressive in their approach and said to the students:

> 'Why are you training to be a nurse? Nurses are awful. This is my experience of nurses.' When that approach is taken with very junior students there has been occasions where we have lost students and they have dropped out of the program as a result [10].

Another participant described wrong messages being given that was sometimes associated with the EBE being unwell or lacking control:

> [The EBE went into] the classroom swearing on occasion and talking horribly to…her colleagues. And so that was quite distressing...having to just stop the class for a minute and have those conversations and ask if everything was OK [4].

The challenging nature of some EBE sessions suggested students needed support and possibly greater preparation before being exposed to the experience:

> They were hearing uncomfortable truths, really, I suppose, for some. Sometimes, they would've been somewhat distressed…I'm just thinking of one particular session, one service user did with them and it really challenged their views and they weren't ready for it, maybe [13].

DISCUSSION

The current study is significant in the context of pressing issues currently facing the health professions both in Australia and globally, in areas where health professionals have the potential to not only contribute to positive change, but take on leadership roles in driving that change. A recent integrative

review on person-centred practice in nursing, identified a misalignment between the concept of person-centred practice and how it is operationalised (Byrne, Baldwin, & Harvey, 2020), this can be addressed by the inclusion of EBE lectures in nursing education A prominent gap between theory and practice is evident, where the reality of busy practice environments, detract from the desired person-centred approach.

The findings support previous research in demonstrating that EBE involvement in health and social care education promotes person-centredness (Happell, Platania-Phung, et al., 2019; Terry, 2013), highlights to students the importance of partnership (Skilton, 2011), and can build the capacity of the health workforce to deliver improved and more relevant outcomes for consumers (Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Schneebeli et al., 2010). Importantly, the current study provides further evidence that EBE involvement leads students to an understanding of how theory relates to policy and practice (Felton, Cook, & Anthony, 2018; Happell, Waks, et al., 2020; Tanner et al., 2015; Thomson & Hilton, 2012) and promotes awareness of the theory/practice gap (Thomson & Hilton, 2012). This suggests that EBE involvement contributes to the development of a health workforce that can conceptualise and actualise person centred practice.

Contemporary mental health practice has seen increasing calls for, and policy in support, of a paradigm shift from biomedical approaches to practice to an emphasis on recovery, wellbeing and community solutions

(Commonwealth of Australia, 2017; Health Services Executive, 2018; New Zealand Government, 2018; Scanlan et al., 2020). Recovery-focused practice requires person centred clinicians with the skills and motivation to understand consumers as people rather than diagnoses (Bocking et al., 2019). These findings support earlier research in suggesting that involving EBE in the education of health professionals results in an enhanced understanding of recovery principles (Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Maher et al., 2017; Wilson, 2019) and respect for the origins of recovery within the consumer movement (Byrne, Happell, & Reid-Searl, 2015). Allies observed students becoming more reflective due to EBE involvement in teaching. Reflective and critical approaches are essential for recovery-oriented practice (Happell, Waks, Bocking, Horgan, Greaney, et al., 2019), and have been identified in previous research as a significant benefit of EBE teaching (Happell, Waks, Bocking, Horgan, Greaney, et al., 2019; Norwood, Tickle, De Boos, & Dewa, 2019; Wilson, 2019).

Researching the impact of EBE in mental health education has primarily been investigated at the theoretical level. The effects on clinical practice for students and practitioners is rarely measured (Hughes, 2017; Speed, Griffiths, Horne, & Keeley, 2012; Unwin, Rooney, & Cole, 2017). One Australian study utilised in-depth interviews with social work students to explore their perceptions of the impact of EBE delivered curricula on their clinical experience (Ridley et al., 2017). Student participants described positive changes to their attitudes and values, enhanced understanding of

consumers' experiences, and an overall change in their approach to practice (Ridley et al., 2017). The current study further advances this observation by reporting practice change noticed by clinical staff working with students on clinical placements. Participants noted the positive feedback from clinicians and clinical educators, that students taught by EBE were more confident, and demonstrating enhanced communication, clinical skills, understanding of recovery, and positive attitudes towards consumers, compared to students in previous years, and from universities where EBE were not involved in teaching. While these observed differences do not necessarily constitute evidence that these differences will remain after graduation, it does suggest practice could be positively influenced by EBE involvement in the education of health professionals.

The finding that students who received EBE led teaching felt validated and safe to share their experiences is particularly significant. Mental distress has been identified as particularly high in students of the health professions (Bacchi & Licinio, 2017; Fischbein & Bonfine, 2019; Mitchell, 2018). Students experiencing significant mental distress do not commonly seek assistance due to the associated stigma (Fischbein & Bonfine, 2019; Mitchell, 2018; Wynaden et al., 2014). These findings suggest EBE involvement may promote openness in sharing students' lived experience, and challenge negative perceptions of people who experience mental health conditions. Ultimately, this may encourage students to seek support and practitioners to be open about their experiences, positively influencing the culture of the health

professions. This may be particularly relevant in the context of COVID-19, where the pressures on both students and health professionals are considerably greater and may create and exacerbate mental distress (Florence et al., 2020).

It is important to acknowledge the challenging aspects students encountered in working with EBE, some with quite negative impacts. EBE being too focused on their own negative experiences was noted in focus groups with students of EBE-led education (Happell, Waks, Horgan, et al., 2019). The present research also identified approaches to teaching by EBE that were not consistent with good educational practice. These practices caused concern for colleagues, and were distressing to students. The need for, and inadequate support available to EBE has been noted (Happell, Bennetts, et al., 2015). It would appear that support should also be available to students. Co-produced guidelines were designed to produce a positive environment for EBE positions to reach their full potential and provide the support they require in these pioneering roles (Horgan et al., 2020). These guidelines may address these challenges to some extent. It is important to acknowledge that students experience many different teaching styles at university and this is therefore not likely to be a specific EBE issue.

Limitations

Developing substantive positions for EBE within academia is relatively new and remains the exception rather than the rule. The perspectives presented here are therefore limited by virtue of the small number of academics with the expertise and experience sought. As allies for EBE, the participant responses may have been influenced by their generally positive view of this initiative. Furthermore, the impact on students presented in this paper reflects the perceptions of allies, and while they align with the literature presenting student perspectives, they may not fully reflect how students see EBE lecturers contributing to their knowledge and skills

CONCLUSIONS

Policy shifts towards increased consumer leadership in all aspects of mental health services and recovery oriented practice, requires a future workforce with the skills and knowledge to lead mental health services of the future. The positive outcomes demonstrated from EBE involvement in the education of future health professionals has not resulted in the widespread implementation of these positions. Given the implementation of most positions to date were led by motivated and committed allies, garnering their perspectives may have a persuasive role in supporting interested colleagues and influencing decision makers within academic departments. The perceived positive impact of EBE teaching on students' approach to practice during their

clinical placements, and the validation and support for students to explicitly and openly consider their own mental health experiences and needs in the context of pursuing a role of health professional, are findings from this research that may be particularly persuasive.

IMPLICATIONS FOR CLINICAL PRACTICE

Recovery orientated practice and increased consumer leadership as policy goals have created considerable challenges for the health professional workforce. The educational preparation of health professionals must also change to promote the skills and expertise required for the workforce of the future. Understanding and believing in recovery and the capacity to reflect on their experiences are essential to achieving these goals, and have been identified as outcomes of EBE involvement in mental health education. These findings have been reinforced from the perspective of allies who have supported the implementation of academic roles. The differences in students taught by EBE suggests that the impact that this education has on supporting both enhanced theoretical and applied knowledge may positively influence clinical practice and outcomes. It is hoped this will translate into their practice as qualified health professionals.

TABLE 1 – DEMOGRAPHICAL CHARACTERISTICS OF PARTICIPANTS

Participant Number	Discipline	Gender	Country of employment
1	Mental Health Nursing	Male	New Zealand
2	Social work	Female	Australia
3	Mental Health Nursing	Female	Australia
4	Mental Health Nursing	Female	Australia
5	Psychiatry	Male	New Zealand
6	Mental Health Nursing	Female	Australia
7	Mental Health Nursing	Female	New Zealand
8	Mental Health Nursing	Male	Australia
9	Mental Health Nursing	Male	Ireland
10	Occupational therapy	Male	Australia
11	Mental Health Nursing	Female	Ireland

12	**Psychiatry** **Executive** **Director**	**Male** **Female**	**Australia**
13	**Mental Health** **Nursing**	**Female**	**Ireland**
14	**Mental Health** **Nursing**	**Male**	**Australia**
15	**Mental Health** **Nursing**	**Female**	**Australia**

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