Title:

Expert by Experience involvement in Mental Health Nursing Education: the co-production of standards between Experts by Experience and Academics in Mental Health Nursing

Running title:

Experts by Experience in Mental Health Education

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Expert by Experience involvement in Mental Health Nursing Education: the co-production of standards between Experts by Experience and Academics in Mental Health Nursing

Abstract

Introduction:
Involving people with lived experience of mental distress in mental health nursing education has gained considerable traction yet broader implementation remains ad-hoc and tokenistic. Effective involvement requires curricula be informed by lived experience of service use.
Aim:
To develop standards to underpin expert by experience involvement in mental health nursing education based on lived experience of service use.
Methods:
Phase one used qualitative descriptive methods, involving focus groups with service users (n=50) from six countries to explore perceptions of service user involvement in mental health nursing education. Phase two utilised these findings through consensus building to co-produce standards to support Experts by Experience involvement in mental health nursing education.
Results:

Three themes emerged in Phase one: enablers and barriers, practical and informational support, and emotional and appraisal support. These themes underpinned development of the standards, which reflect nine processes: induction and orientation, external supervision, supportive teamwork, preparation for teaching and assessing, 'intervision', mutual mentorship, pre and post debriefing, role clarity and equitable payment.

Conclusions:

These standards form the framework entitled; Standards for Co-production of Education (Mental Health Nursing) (SCo-PE [MHN]).

Implications for Practice:

The standards aim to support implementation of Expert by Experience roles in mental health nursing education.

Keywords:

Co-production,
COMMUNE,
Expert by experience
Education
Mental health nursing
SCo-PE (MHN)
Standards

Relevance statement

Recovery-oriented and holistic practice are essential for nursing in contemporary mental health services. Experts by Experience (EBE) involvement in mental health nursing education has demonstrated positive outcomes for students. However, lack of structure and support mechanisms are two significant barriers to maximising the role of EBEs in nursing education. The standards presented in this paper were co-produced by EBEs and nurse academics to progress EBE involvement in education. The standards may potentially contribute to high quality EBE involvement in nursing and other health disciplines; and towards a more compassionate mental health workforce.

Accessible summary

What is known on the subject:

- Expert by Experience (EBE) involvement in mental health nursing education has demonstrated benefits, including enhancing understanding of holistic and recovery-focused practice and enhanced application of interpersonal skills
- Structure and support for EBE involvement is lacking; often resulting in inadequate preparation and debriefing and tokenistic involvement
- Service user involvement in mental health nursing education should be underpinned by lived experience perspectives

What the paper adds to existing knowledge:

- An exploration of EBE involvement in nursing education from the perspective of those with lived experience
- The development of standards designed to provide structure to better support future EBEs involved in higher education
- An exemplar for co-production of standards between EBE and nurse academics which has applicability for other contexts

What are the implications for practice?

- The standards could potentially strengthen EBE involvement in mental health nursing education, enhance their confidence and increase the retention of EBEs by creating an inclusive working culture
- By increasing support for EBEs, the benefits to mental health nursing practice are likely to be maximised.

Introduction

The delivery of mental health nursing education by people with lived experience of mental distress is essential, and can improve the effectiveness and skills of the mental health workforce (Happell et al., 2019). This involvement, however, often occurs on an ad hoc basis with little consideration given to the infrastructure supporting Experts by Experience (EBE) within the academic environment (Happell, Byrne, McAllister, et al., 2014; Happell, Platania-Phung, et al., 2015; McCann, Moxham, Usher, Crookes, & Farrell, 2009).

This paper presents findings from a qualitative research project which were utilised to develop a framework entitled: Standards for Co-production of Education (Mental Health Nursing) (SCo-PE [MHN]). SCo-PE (MHN) includes nine standards that were co-produced between nursing academics (NA) and EBEs to support and assist in the design, delivery and evaluation of nursing curricula. It is part of a larger project, COMMUNE (Co-production of mental health nursing education), which is an international multisite project which aims to advance the involvement of EBEs in mental health nursing education. Specifically, the project aimed to co-produce, co-design, co-deliver and co-evaluate an educational module entitled 'exploring human distress with EBEs'. The COMMUNE project consisted of four stages:

1. Interviews with service users to elicit their perceptions of mental health nursing education
2. The development of the mental health learning module and standards to guide its implementation
3. Implementation of the learning module
4. Qualitative and quantitative evaluation of the module and its impact on attitudes and experiences.

The standards presented in this paper were developed prior to the implementation of teaching and learning module to reflect the principles of co-production.

Background

There is a need for students and EBEs to engage in meaningful dialogue in the classroom (Felton, Cook, & Anthony, 2018; Horgan et al., 2018), and there is emerging evidence that this approach can positively influence students' attitudes towards mental illness and mental health nursing as a career (Happell, Byrne, Platania-Phung, et al., 2014; Happell et al., 2019). The co-production and delivery of mental health nursing education by EBEs is recommended in many countries and gaining recognition with formal bodies. In the United Kingdom such involvement has been mandated as a requirement by the Nursing and Midwifery Council (Nursing and Midwifery Council, 2018).

While increased evidence of the involvement of EBEs in nursing education has been noted (Felton et al., 2018; Happell, Bennetts, Platania Phung, & Tohotoa, 2015), there remains stark differences in how this approach is adopted internationally (Byrne, Stratford, & Davidson, 2018). Evidence suggests the approach remains ad hoc, tokenistic and poorly understood (Happell, Bennetts, Platania Phung, et al., 2015; McCann et al., 2009; Paul & Holt, 2017). Strengthening EBE involvement requires a more integrated, systematic approach, moving beyond one-off lectures and "storytelling" (Happell & Bennetts, 2016; Horgan et al., 2018; Meehan & Glover, 2007).

Several barriers to involving EBEs in nursing education have been identified in the literature. Nursing academics reported concerns about the qualifications/suitability of service users to work as educators, about accessing funding to pay them and about an overall lack of guidance on

how to develop effective partnerships (Happell, Wynaden, et al., 2015). Concern about the EBEs mental state deteriorating as a direct result of involvement has been expressed by both NAs and EBEs (Happell & Bennetts, 2016).

EBEs have reported experiencing anxiety before delivering education (Fraser, Grundy, Meade, Callaghan, & Lovell, 2017). It has also been reported (Rani & Byrne, 2014) that those with lived experience can find it daunting to be involved in education, and are challenged with preparing to teach, engaging in public speaking and addressing candid student questions. Adequate induction and ongoing support is therefore crucial (Happell, Bennetts, Platania Phung, et al., 2015). Despite these barriers, EBEs have identified that they are motivated by "giving back" and feeling valued (Fraser et al., 2017; Neech, Scott, Priest, Bradley, & Tweed, 2018) and believe their contributions create opportunities for their own skill development (Fraser et al., 2017).

Attempts have been made to address training deficits through the development of training programmes for EBEs, such as the EQUIP (Evaluating and quantifying service and carer involvement in mental health care planning) programme (Fraser et al., 2017). It is evident that support for EBEs, similar to other academic roles, can be and should be pre-empted and consistently offered (Fadden, Shooter, & Holsgrove, 2005; Fraser et al., 2017; Neech et al., 2018).

EBEs need to be well prepared, offered training, given the opportunity to reflect and debrief, and provided with any assistance required as to how to present their material within education fora (Gordon, Wilson, Hunt, Marshall, & Walsh, 2004). However, the literature offers little explicit guidance on how NAs and EBEs can work in partnership to co-produce mental health nursing education and what support mechanisms are needed so mutual support can

be offered in developing this partnership. Without this guidance, it is argued that the co-production of nursing education will remain ad hoc (Happell & Bennetts, 2016; Happell, Bennetts, Harris, et al., 2015; Happell, Bennetts, Platania Phung, et al., 2015).

Aim:

In light of the identified barriers, the aim of this study was to co-produce standards to facilitate the genuine and meaningful involvement of EBEs in mental health nursing education.

Methods

A phased approach to the development of standards was adopted, with co-production in research a central facet. Co-production involved those with lived experience of mental distress and service use working in partnership with NAs throughout all stages of the research (research design, data collection, data analysis). The collaborative approach allowed for collective learning, mutual reflexivity, and shared decision-making. Furthermore, analysing data from various perspectives added to the rigor of the research. The process was divided into two phases.

Phase One

Aim:

The overall aim of phase one was to ascertain the views of those who had used mental health services on the contribution people with lived experience of service use could potentially make to nursing education. More specifically, the aim was to elicit perceptions derived from service use itself from a theoretical perspective, rather than based on direct experience of involvement in mental health nursing education. This approach enables the teaching to be developed directly from service users and therefore reflect the expertise gained from their own lived experience.

Design:

A qualitative descriptive approach was selected as the most appropriate for this study (Stebbins, 2001). As this research was co-produced, EBEs and NAs worked in partnership to design the study and collect and analyse the data.

Setting:

This international research was undertaken in six countries: Iceland, Ireland (2 sites), Norway, Finland, the Netherlands and Australia.

Recruitment and participants:

Participants were recruited at each geographical location. Local service user groups supported recruitment by distributing information to members via email, newsletters and notice boards. In total 50 participants agreed to participate and attend the focus groups (n= 28 male, n= 22 female). All participants were over 18 years of age and had lived experience of mental distress and service use. Given the aim of this phase of the project was to elicit perspectives of mental health nursing education based on their own personal service use, it was not a requirement that the participants had previous experience of teaching mental health nurses.

Procedure:

A total of eight focus groups were conducted, which were audio recorded and transcribed verbatim in each country. Focus groups were co-facilitated by an EBE and a NA. An interview guide was developed by the team to guide questioning, while allowing sufficient flexibility to create an inclusive environment where service users felt free to contribute their ideas, opinions and experiences. Participants were asked to broadly describe the contribution service users could make to nursing education. Barriers and enablers to involvement and supports required were themes to emerge from the ensuing discussion.

Ethics:

Ethical approval to conduct the research was granted at each respective University ethics committee as required. Participants were provided study information both verbally and in-writing and all provided informed written consent. Participants were advised of their right to withdraw from the study at any time without adverse consequence. Privacy and confidentiality was assured. No names or other potentially identifiable information was recorded.

Data analysis

Data were analysed using Braun & Clarke's (2006) multi-phasic process of thematic analysis. Following initial analysis in each country, findings were translated into English, where necessary, and then synthesised into a coherent cross-country thematic analysis. Data analysis at each site was undertaken independently by an EBE and NA. The detailed analysis process is presented in Table 1.

Insert Table 1 about here.

The rigor of data analysis was strengthened by two analysts (i.e. one NA and one EBE) within each country identifying and comparing emergent themes, thus extending the co-production ethos. Data from each country were subsequently combined and analysed in totality to complete an international thematic analysis. Team meetings were held regularly during the process to engage and discuss different opinions and to ensure different perspectives were clearly reflected in the analysis.

Phase Two

The aim of the second phase was to address the question "How can we best support EBEs in the design, delivery and evaluation of nursing education?" The findings from the focus groups in conjunction with the international literature, were discussed face-to-face amongst EBEs (n=12) and NAs (n=10) (n=9 male, n=13 female), from each country (Iceland, Ireland, Australia, the Netherlands, Finland, Norway) over five days. These discussions enabled the group to collectively identify the pertinent findings and develop standards to underpin the future involvement of EBEs in university settings.

Consensus building was used to facilitate discussion. Consensus building, originally developed by Susskind, McKearnen and Thomas-Lamar (1999), focuses on reaching agreement for a plan. Such an approach can be useful for improving services, finding new and innovative solutions to problems and developing a better understanding of situations. It is a dialogic process, where equal opportunities to participate are created. All stakeholders need to 'live with' what is proposed to increase the likelihood of sustainability.

Innes (2004) describes consensus building as an empowering process, where power differentials within the room are articulated and addressed; while acknowledging that power differentials outside the room continue to exist. These reflexive components are essential to the success of co-production (Roper, Grey, & Cadogan, 2018), therefore making this a highly suitable approach for this work.

The interactive part of the process was carefully sequenced to allow full contribution from each team member. First, NAs and EBEs worked in small groups to prioritise the key items, which were then written on large sheets of paper. The full group reformed and the sheets were displayed on a wall. Through critical dialogue and negotiation, a consensus was reached and a final list of standards were established with the support of all 22 participants. The process for developing the standards is presented in Figure 1.

Insert Figure 1 about here.

Findings

Phase one – Focus group interviews

Three main themes emerged from the findings. The first theme focused on the enablers and barriers regarding EBE involvement in nursing education. The second theme concerned the practical and informational support required. The third theme focussed on emotional and appraisal support.

Enablers and barriers to EBE involvement in nursing education

The participants in the focus groups across all countries agreed on the importance of having EBEs involved in nursing education and identified a number of enablers to their participation. It was acknowledged that students

and NAs need to value the potential contribution, knowledge base, expertise and motivating factors for EBEs to contribute to nursing education. EBEs welcomed the opportunity to influence the future generation of nurses to be more recovery-orientated through the sharing their personal experiences. In this way, EBEs need to be respected for their contribution and be provided with all opportunities to feel both at ease and valued:

> *"First, the users must be made aware that they have something to contribute, that their user knowledge is highly valued" (Norway)*

> *"It is in our nature to want to give back when you have been on the receiving services for a long time" (Iceland)*

It was identified that EBEs need to have confidence and feel empowered to contribute in order to become involved in higher education. NAs have a role in working in partnership with EBEs to develop this confidence. Participants suggested that consideration needs to be given to the stage of the EBEs' recovery journey.

> *"There's a lot of steps before someone would be able to even engage, … like I know even from myself, I feel quite empowered [Laugh] today… I know a few people, and like and I would be quite, let's say on the other scale of people who have, yeah know, have confidence to come, but how do you get to that point, like, I don't. I'm, I'm not sure" (Dublin, Ireland)*

> *"I think, a person has to be in a particular place within themselves before they can get engaged and for me I would love to be engaged within the service and talk to nurses, yes, but we can't" (Cork, Ireland)*

Conversely, lack of confidence was identified as a barrier in many focus group interviews; this included confidence in their ability to navigate the university system, confidence to share their personal stories without fear of judgement and confidence in their own ability regardless of their level of education:

> *"You know that's quite hard, if you're one service user in a room full of nurses or people in academia or make sure that that person hasn't or isn't alone in that "(Dublin, Ireland)*

> *"Empowerment, yes I would do it but what would put me off, in, in getting involved in the nursing or training of the nursing would be the academic side, because a lot of people might have been diagnosed very early or wouldn't have had the full education, wouldn't have the same concentration as what a person of eighteen, nineteen coming straight out of school" (Cork, Ireland)*

> *"Nurses in audience have been afraid that service user gets "mad" while giving the presentation" (Finland)*

> *"[it] can be draining to stand up and talk about your personal story" (Iceland)*

Informational and Practical support

Participants highlighted the importance of receiving both informational and practical support when contributing to nursing education. In terms of information, EBEs identified that training on how to deliver a lecture and communicate their content in an accessible way for students was essential.

"To have education and training to speak in public… the opportunity to influence things… in co-operation with other service users "(Finland)

"They must receive training in how to communicate that knowledge, and support to find the strength they need to do it" (Norway)

Participants in all focus groups identified the importance of being paid for their time and expertise. This practice sends a clear message as to the value of their contribution:

"Obviously, then being paid, respected and for your contribution. That's empowering" (Cork, Ireland)

"They must be paid for their work" (Norway)

Emotional and appraisal support

The need for emotional and appraisal support was identified as important for EBE involved in mental health nursing education. NAs need to recognise how challenging it can be to share personal information and ensure that EBEs have access to general academic and discipline-specific support structures, where possible. This could be done by debriefing following each lecture with a NA, as well as availability of EBE specific support from peers. EBE lecturers need to be supported in developing the skills to answer 'difficult' questions from students and be offered the flexibility to share only what they choose to share, this is most appropriately gained from supervision by EBE who through previous experience have had to confront and address these issues.

"There is a lot of preparation that goes into it and a lot of self-care because you know you're going to dig up stuff and it is going to be painful". (Australia)

"without that flexibility [to decide what you are comfortable to share] you simply aren't going to have people be able to stay in the job" (Australia)

"We have to be able to answer difficult questions, or be at that place that you can just say no …There have been times when I have said too much and regretted it afterwards" (Iceland)

Debriefing with peers was identified as essential, requiring Universities to have more than one EBE educator involved in the education of nurses

"I think it is important to have some time after a session where we can talk about it and support each other". (Iceland)

"I mean … you need peer support groups" (Dublin, Ireland)

"I don't think I could do it by myself. But that's me being aware of my capabilities and stuff like that. But if you had a partner – and I'm looking at [name deleted], because I can really see us doing it. I think just having the two people there. It's just back up support, I suppose" (Australia)

In summary, findings from the focus group interviews indicated that EBE educators need to be valued by students and NAs for their potential contribution to nursing education. EBEs need to be supported to develop the skills and confidence to deliver nursing education, be paid for their time, be provided with necessary information and need to be offered debriefing and peer support.

Findings: Phase two - consensus building and standard development

Developing standards for effective education delivery was a dynamic co-produced process as described in the methods section. Following negotiation and consensus building, nine standards were articulated. Figure 2 presents the standards and how they fit within a model of co-production of mental health nursing curricula, demonstrating what needs to be adopted in the design, delivery and evaluation of nursing education.

Insert figure 2 about here

1. Induction and Orientation – This standard focuses on a general orientation and induction to the university and to the department/school of nursing. It involves receiving practical support from academic and administrative staff, providing an introduction to the library and an orientation to the overall educational context of the nursing programme. The opportunity to "shadow" experienced lecturers could should be offered provided, where EBEs get an opportunity to view how NAs approach their teaching practice.

2. External supervision – This standard focuses on the EBE receiving supervision from an experienced academic who has lived experience of mental distress, preferably outside of the department. If someone with lived experience is not available then external supervision could be provided by an ethnic minority academic, who similar to an EBE, has experience of social, cultural and organisational issues arising from being from a marginalised group.

3. Supportive Teamwork – This standard focuses on preparing the team to include the EBE as well as supporting the EBE to be part of a team. In doing this, NAs need to be prepared and open to working with EBEs and view their expertise as valuable. EBEs must be allowed flexibility and full creative control in how and what they teach, and be provided with constructive and supportive feedback as needed. Teaching may involve the EBE and NA co-delivering sessions, depending on the local context. In addition, having EBEs

as an identified programme team member ensures that they are invited to attend programme team meetings throughout the academic year. This offers EBEs with a communicative space as part of the faculty; to better negotiate their role and influence the broader team culture.

4. Emotional and practical preparation for teaching – This standard focuses on supporting the EBE in relation to self-disclosure, issues around choosing to share their story, boundary setting, self-care and managing student responses. It involves opportunities to practice individual and team teaching, build stronger group facilitation skills, and practice using recovery-focussed language. The EBE may need to participate in other courses to support their teaching as required; such as an introduction to Virtual Learning Environments (VLE), library skills training, IT skills, and relevant teaching and learning strategies and peer-led programs or workshops on teaching and learning strategies if available.

5. Intervision – This standard focuses on peer learning, that is, between two or more EBEs. It is described as 'intervision' as it is within the discipline of lived experience work. Intervision sessions may involve using a number of platforms such as a dedicated EBE online interaction page or EBE face to face peer group. It is up to the respective group to choose the most suitable format which is exclusively comprised of peers.

6. Mutual Mentorship – This standard focuses on mutual mentorship between the EBE and NA. It is an on-going two-way process, where the EBE and NA should share knowledge and expertise from their respective frames of reference. It is important that the NA be in the right mind-set to respectfully learn from the EBE; and vice versa.

7. Pre and post session support – This standard focuses on supporting the EBE to prepare for the actual teaching sessions and involves offering, pre and post session debriefing with either peers or NAs.

8. Role clarity – This standard focusses on ensuring the EBE role is defined, workload negotiated and responsibilities agreed.

9. Equitable payment – This standard focuses on equitable payment for the EBE: EBEs should be paid at the same rate as any other academic in the institution.

Discussion

The importance and value of EBE involvement in preparatory education of nurses and other health professionals is clearly articulated in the literature (Arblaster, Mackenzie, & Willis, 2015; Byrne, Platania-Phung, Happell, Harris, & Bradshaw, 2014; Goossen & Austin, 2017; Gordon, Ellis, Gallagher, & Purdie, 2014; Happell, Byrne, McAllister, et al., 2014; Happell, Platania-Phung, et al., 2015; Happell et al., 2019; Horgan et al., 2018; Mahboub & Milbourn, 2015; O' Donnell & Gormley, 2013; Ridley, Martin, & Mahboub, 2017; Scammell, Heaslip, & Crowley, 2016; Schneebeli, O'Brien, Lampshire, & Hamer, 2010). Potential benefits are impeded by structural barriers (Happell, Byrne, McAllister, et al., 2014; McCutcheon & Gormley, 2014; Towle et al., 2016) such as, a lack of institutional support, an overly rigid and cautious approach to positions (Happell, Wynaden, et al., 2015; Towle et al., 2016) and inadequate resources to assist EBEs undertaking educative roles (Happell, Bennetts, Platania Phung, et al., 2015; McCutcheon & Gormley, 2014).

Contemporary mental health service delivery espouses recovery-oriented practice and humanistic principles (Boumans, van Hoof, Knispel, Michon, & van Rooijen, 2016; Byrne, Happell, & Reid-Searl, 2015; Commonwealth of

Australia, 2013; Health Services Executive, 2018; Santangelo, Procter, & Fassett, 2018). Teaching these core concepts requires a more transformative and flexible model of teaching to ensure students achieve the depth of learning required to internalise these values and concepts (McAllister, Happell, & Flynn, 2014; Rickwood & Thomas, 2017). The concept of recovery initially emerged from the mental health service user movement (Byrne et al., 2015). It stands to reason that articulating this distinct process and viewpoint is best done by people qualified to do so; EBEs. Lived experience involvement in the education of mental health professionals, including nurses, needs advancing (Byrne et al., 2015; Byrne, Happell, Welch, & Moxham, 2013; Edgley, Stickley, Wright, & Repper, 2012; Happell et al., in press; Horgan et al., 2018).

EBE involvement in academic settings is unlikely to develop organically. EBEs come from diverse backgrounds and report that they are sometimes ill equipped with the necessary skills to fulfil their role as educators. This barrier has been identified in the literature (Fraser et al., 2017; Gordon et al., 2014), and requires that EBEs are offered the opportunity to develop these skills as part of their overall involvement in nursing education. Other barriers and enablers to the involvement of EBEs identified in this research are similar to those identified in other studies (Fraser et al., 2017; Happell, Bennetts, Harris, et al., 2015; Happell, Bennetts, Platania Phung, et al., 2015; Rani & Byrne, 2014). In particular, the focus group findings clearly identify support mechanisms for the EBE as being crucial to the overall success of the initiative. The co-production of these standards offer some practical means to circumvent the structural barriers to EBE involvement in nursing education.

Identifying the need for a more structured approach, Standards for Co-production of Education (Mental Health Nursing) (SCo-PE [MHN]) are presented in this paper. These standards are evidence-based, developed directly from interviews with service users and by a co-produced consensus

exercise. Co-produced mental health nursing education is essential to ensuring service user involvement is genuine (Manning et al., 2017) and tokenism is avoided (Paul & Holt, 2017).

To the best of our knowledge this is the first time international standards to support EBE educators in the design, delivery and evaluation of nursing curricula have been co-produced and reported in the literature. This study is unique, in that the research involved a phased approach, with co-production between EBEs and NAs a central facet. It also offers an international perspective (Europe and Australia), increasing its potential applicability in different contexts and countries.

For standards such as these to be implemented, it is essential that NAs engage in open dialogue on issues of power. Without power differentials at organisational and individual level being explored and addressed, co-production cannot be achieved (Gordon & O'Brien, 2018). Due to the likely power differential between NAs and EBEs, there is a need to acknowledge, reflect on and explore power when using standards such as those presented in this paper. It is argued that in this situation, NAs need to see themselves as learners, and recognise the EBEs as legitimate leaders (Roper et al., 2018). Without these open discussions, the standards as described in this paper are unlikely to be actualised.

Limitations

The standards were developed prior to teaching the learning module developed as part of the COMMUNE project. Further analysis is needed to determine if they were fit for purpose and addressed all emerging issues. Finally, further research involving additional sites (multiple universities and countries) is essential to further refine these standards.

Conclusions

Repositioning EBE involvement as central to mental health nursing education will not occur while an ad hoc approach to involvement remains. The standards reported in this research offer a more systematic and consistent approach. Mental health nursing needs a workforce that is willing and able to work in partnership with those accessing services, and an integrated co-produced approach to nursing education has the potential to deliver on this.

The present research goes beyond identifying the barriers and enablers to EBE involvement and the co-production of nursing education, to offering a practical, consolidated solution to the actualisation of this approach in mental health nursing education. A co-produced evaluation, reflecting the perspectives of EBEs and NAs on this framework could determine its fit for purpose and provide valuable information for its improvement.

Phase one	Researchers independently read and re-read transcripts to become familiar with the data. All researchers from each country coded the transcripts and drafted a preliminary coding framework.
Phase two	Researchers endeavoured to identify meaning in the data by recognising patters and major themes and patterns from the coding framework.
Phase three	Meetings were conducted in each country between the researchers involved in the analysis. The codes and emerging themes were discussed, with modifications made as required to achieve consensus.
Phase four	Themes and subthemes were closely reviewed through the use of conceptual maps. Data were worked and reworked several times until themes were clearly identified and reflected the essence of the data in each country.
Phase five	Analysis of data from all countries was combined and reanalysed. Three researchers (one expert by experience, one nurse academic, one student) from the lead institution for this section undertook this work. The draft analysis was provided to all partners during a face to face meeting. The key findings and themes from the aggregate data were further redefined to ensure all partners believed the data was adequately presented and reflected the views of participants from their country. Adhering to principles of co-production, perspectives of both experts by experience and nurse academics, were facilitated and reflected in the final analysis. Most notably, changes were made to wording and phrasing of some themes to more accurately reflect the language of service users and

	ensure relevance to an international audience.

Table one: Data analysis framework

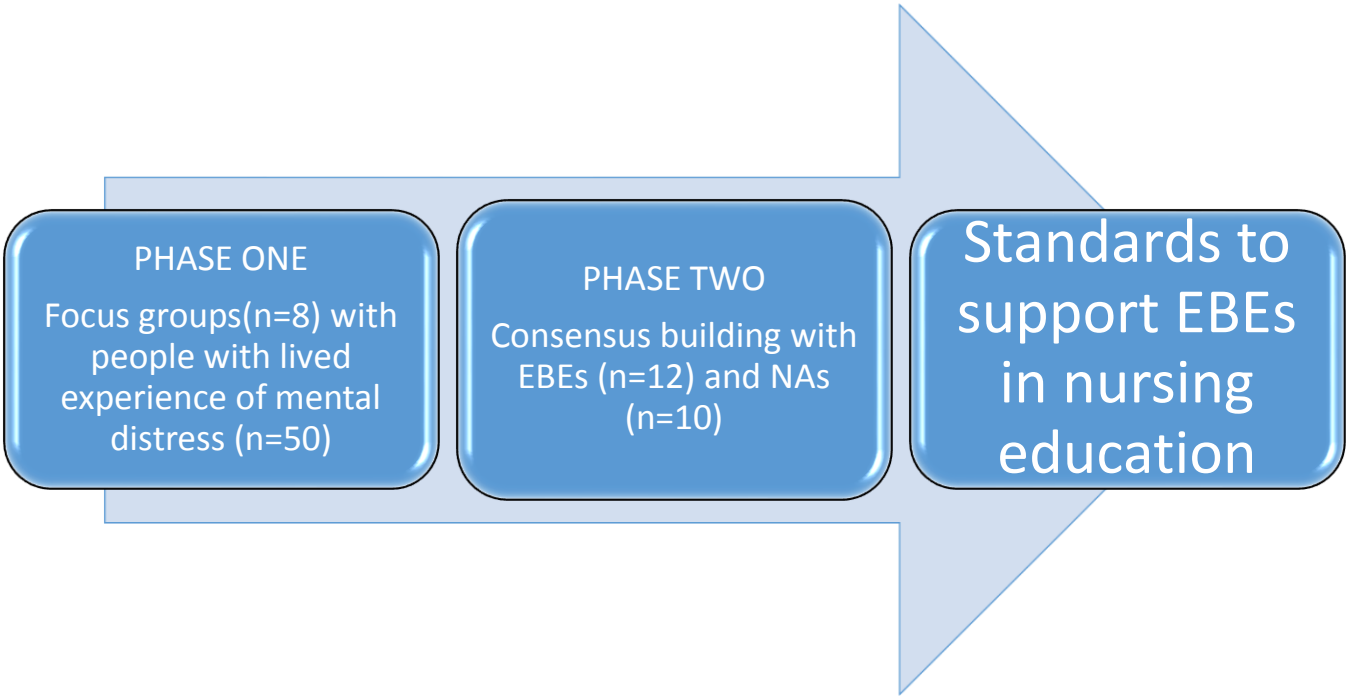

Figure 1: Process for development of Standards

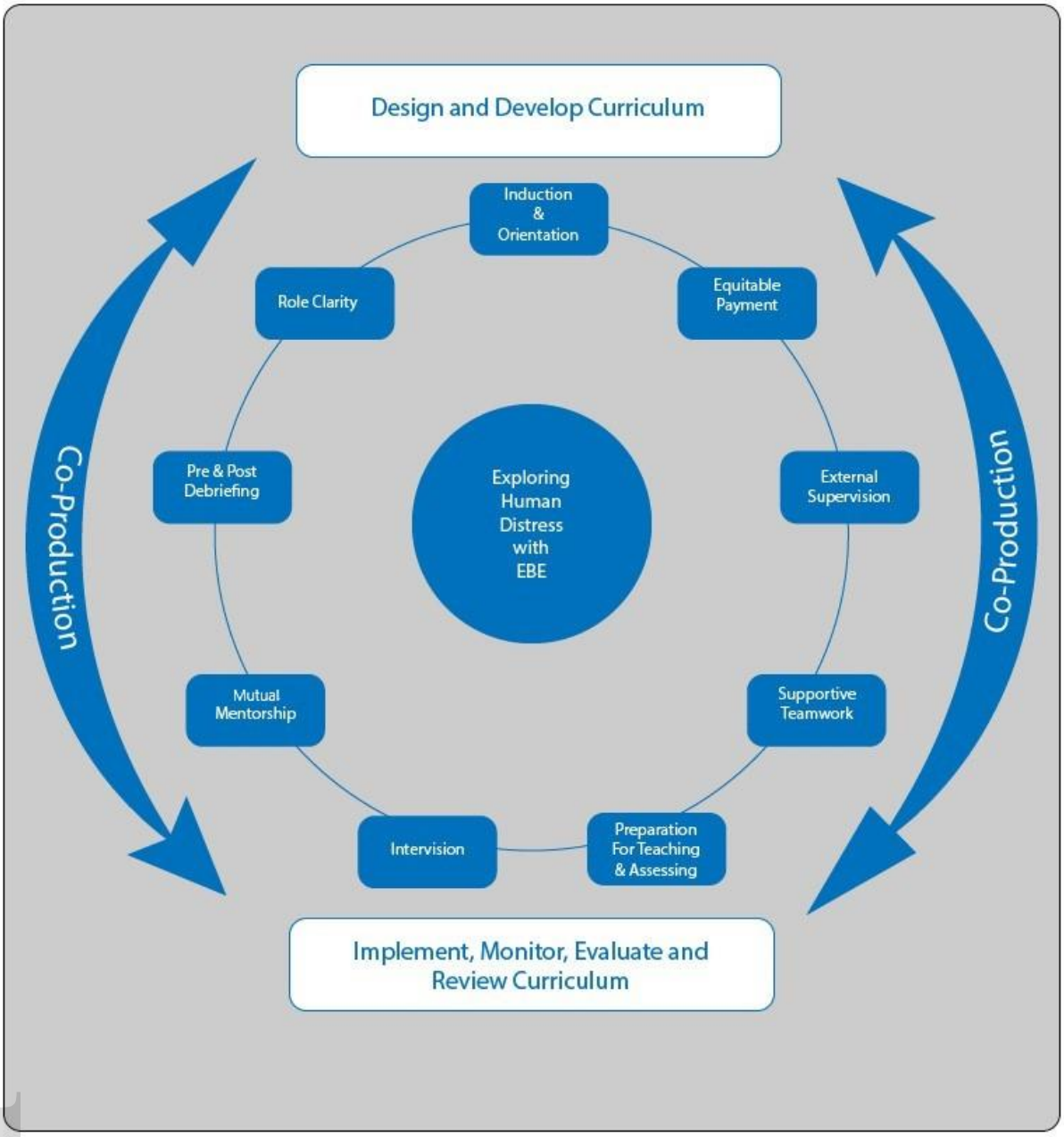

Figure 2: Standards for Co-production of Education (Mental Health Nursing) (SCo-PE [MHN]) in the design, delivery and evaluation of nursing curricula

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