ABSTRACT

Background:

Consumer participation in mental health service delivery is now a policy expectation. Negative attitudes of health professionals towards collaboration with consumers has been identified as a major barrier to policy implementation. Consumers contributing to the education of nurses and other health positions has been identified as an effective strategy, particularly when consumers occupy academic positions. Attitudes of nurse and consumer academics to the consumer academic role remains under-researched.

Aims:

To explore the implementation of a consumer academic position from the perspectives of the broader academic team.

Methods:

Qualitative exploratory research was undertaken to give voice to different perspectives of the implementation of a consumer academic position. Indepth interviews were conducted with nurse academics, the consumer academic and the research team.

Results:

Thematic data analysis revealed five main themes: seeking a united perspective; Who can provide a consumer perspective?; How accurate is

consumer perspective?; One consumer, one opinion, one way, one delivery; Bias and poor portrayal of nurses.

Conclusions;

Marked divergence in views and opinions was evident in terms of support for the role and its perceived value. Further investigation of factors facilitating successful implementation is required and strategies identified to facilitate mutual understandings and goal setting.

KEYWORDS:

Consumer academic

Consumer participation

Education of health professionals

Mental health

Mental health nursing

Professional defensiveness

Stigma

INTRODUCTION

Consumer participation has been articulated in policy since the introduction of Australia's first National Mental Health Policy (Commonwealth of Australia, 1992). Successive Plans (Commonwealth of Australia, 1998, 2009, 2017) reinforced the importance of consumer participation, with an increasing focus on participation extending beyond individual care to influencing the design, development, implementation, delivery and evaluation of mental health services.

Translating policy into practice is rarely uneventful. Attitudes of health professionals to consumer participation has been identified as a major barrier to achieving desired outcomes (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015; Bennetts, Pinches, Paluch, & Fossey, 2013; Scholz, Gordon, & Happell, 2017). Consumer participation relies on health professionals embracing consumers as colleagues and valuing consumer knowledge equally to professional knowledge. In reality professional knowledge is highly privileged and considered scientific and objective compared to consumer knowledge as individual and subjective (Gee, McGarty, & Banfield, 2016; Scholz, Bocking, & Happell, 2018; Veseth, Binder, Borg, & Davidson, 2017).

Mental health nurses have been identified as actual and potential allies of consumer involvement in education (Byrne, Happell, & Reid-Searl, 2016; Happell & Scholz, 2018). However, research examining their attitudes to

consumer participation in educative roles is limited (Happell, Byrne, McAllister, et al., 2014). Nurses appear supportive, particularly those who have worked with consumers in this capacity (Happell, Bennetts, Platania Phung, & Tohotoa, 2016; Happell, Wynaden, et al., 2015). Advantages of consumer involvement in education include learning from lived experience perspective, opportunities to address stigma and myths about mental illness, and overcoming associated fears and anxieties (Happell, Bennetts, Harris, et al., 2015; Happell, Bennetts, Tohotoa, Platania-Phung, & Wynaden, 2016; Happell, Wynaden, et al., 2015).

Systemic barriers to consumer participation in education include inadequate resources (Happell, Wynaden, et al., 2015). At the individual level some nurses believe consumer educators may be unreliable and vulnerable because of mental health challenges (Happell, Bennetts, Platania Phung, & Tohotoa, 2015). Concerns consumer academics might be removed from the experience of service use and therefore not representative of broader range of consumers have been expressed (Happell, Bennetts, Platania Phung, et al., 2016).

Consumer involvement in mental health nursing education has been described as ad hoc and limited in scope and influence (Happell, Bennetts, Platania Phung, et al., 2015, 2016; McCann, Moxham, Usher, Crookes, & Farrell, 2009). The need for capacity building within the consumer education workforce was seen as an essential step towards more meaningful

involvement. Stronger collaborative relationships between nurses and consumers were identified as important to achieve this aim (Happell, Bennetts, Tohotoa, et al., 2016).

Introducing academic roles for consumers within nursing programs has been one strategy to expand consumer involvement beyond teaching and into curriculum development, assessment and evaluation (Happell & Roper, 2009). These positions have been evaluated positively in Australia (Byrne, Happell, Welch, & Moxham, 2013b; Byrne, Platania-Phung, Happell, Harris, & Bradshaw, 2014) and internationally (Schneebeli, O'Brien, Lampshire, & Hamer, 2010; Simons et al., 2007). The most recent survey of consumer participation in nursing programs in Australia identified three consumer academic positions at that time (Happell, Platania-Phung, et al., 2015), suggesting these positions have not been widely adopted.

Research into consumer academic positions has focused primarily on nursing students. Implementing academic positions requires organisational support. It is necessary to understand how views and experiences might differ between consumer academics, nurse academics, and other stakeholders. Learnings from these experiences may prove invaluable to people considering implementing similar positions in the future.

Aim

The aim of this research was to explore the implementation of a consumer academic position from the perspectives of academic stakeholders: the consumer academic, the nurse academics teaching mental health nursing; and the researchers overseeing the project, to consider how implementation might be perceived and influenced by different perspectives.

METHODS

Design

Qualitative exploratory research design was utilised (Stebbins, 2001). This approach is preferred when researching topics without a strong research base and further information is required to more thorough understanding the topic of interest. Qualitative exploratory research facilitates participants' ability to contribute their knowledge, expertise and experiences to further this understanding.

Participants and settings

This study was undertaken as part of a large international research project [Name withheld for anonymous review] designed to evaluate the

introduction of content coproduced by consumers (defined in the project as Experts by Experience) and nurses into mental health nursing modules. This component was undertaken in an Australian University offering a three-year Bachelor of Nursing program. The participant group included academics involved in either the teaching or research component including the Expert by Experience, engaged to teach from a consumer perspective; the two nurse academics who coordinated and taught the mental health nursing component; and the two mental health researchers associated with the implementation of the project and its evaluation.

Procedure

The research was endorsed and supported by the Head of School and Unit Coordinator for mental health nursing. The team provided information about the project and the proposed content with the teaching academics. The research component was presented and discussed, including a request to interview.

Interviews were conducted by a mental health researcher independent of the project. An interview guide was utilised to frame broad questions designed to elicit participants' views and experiences of this approach to teaching and provide some focus for interviews. Participants were encouraged to share additional thoughts and experiences considered

relevant. Interviews were audio recorded to enable a complete and accurate record transcribed by a transcription service.

Ethics

Ethics approval was obtained prior to study commencement by the University of Canberra Human Research and Ethics Committee (project number: 17-106). Each participant was provided a full explanation of the project and an opportunity to ask questions or seek clarification. The Plain Language Statement and consent form were given and participants were asked to complete and sign the form prior to interview commencement. Participants were advised in the Plain Language Statement that the research outcomes will be submitted for publication and presented at conferences. Due to the small number of participants in this research (five), and the potential for identification, participant numbers or pseudonyms are not assigned to quotes.

Data analysis

Thematic analysis was undertaken based on the framework developed by Braun and Clark (2006). This five-step framework begins with the transcripts being read numerous times to ensure researchers develop strong familiarity with content and meaning. In the second stage, specific areas of content are assigned a code. Each code is individually considered in relation to the

aims of the research to determine relevance or otherwise and codes with similar content are grouped together. The third stage, the grouped content areas are assigned provisional themes and a descriptive title. Stage four involves the development of a conceptual map inclusive of provisional themes. During the final stage, each theme is revised for accuracy and relevance. Transcripts are re-read to check that all relevant data has been considered. Data analysis was conducted separately by two researchers. The findings were discussed and adjusted until consensus was reached. A final revision was undertaken by the full team.

FINDINGS

Seeking a united perspective

An emergent issue from the interviews concerned whether consumer perspective should be or whether there should be an attempt to produce a more unified approach to the curriculum content between consumer and nursing perspectives. One participant describes the perception that this changed from an initial understanding of difference to a stronger quest for unity:

> ... we'd sat with the whole team and said that it would be great if there's differences in perspectives.... we ...wanted to challenge students ... as the semester went on, some conversations were about

> aligning the consumer perspective with the nursing perspective ... the whole point was that it doesn't matter if they're not aligned ... we want those different perspectives to be heard.

Similarly another participant described a perceived fundamental misunderstanding or concern that differences might not be in the best interests of the students:

> she [nurse academic] wanted [us] "singing from the same song sheet." …to be cohesive in saying the same thing... she didn't understand... we are not going to agree on things and the students actually can handle that. She thought that would be…confusing for the students

The response from one participant suggests that being able to bring the two perspectives together in some way would have been desirable as a means to enhance consistency in the teaching program:

> I'm expecting` [consumer academic] to... tell stories. Then [consumer academic] comes up with an activity, let's talk about how many people you would have contact with, before you actually get into bed in a service. I didn't know that was coming... there would have been scope… talk to me about what the students are getting out of this. How can I complement that? ...That team approach is really, really important, so that we're consistent.

Another participant challenged the concept of consistency as desirable, suggesting that this approach does not reflect broader reality and is therefore not necessarily a desired outcome of a nursing program:

> ...we [academics] try to present everything all nicely homogenised and the world doesn't work that way. So... having this is a nursing perspective that might be informed by a medical model or whatever perspective that person comes from and here's a consumer perspective... is really useful... because that's the world we live in... the system doesn't work the same way for everybody.

Who can provide a consumer perspective?

A challenge was made to the concept that a consumer academic was necessary to provide a consumer perspective. One participant describes the experience nurse academics can bring based on their clinical expertise and close relationship with consumers:

> ...there was no understanding of the level of contemporaneous practice ... I work two days a week in clinical... I am constantly with people, living their stories with them. I'm often using those stories – "Here's an experience, what do you think about that? How would you feel in this situation?" There's no acknowledgement that we would be able to

> provide those stories... I worked alongside of two other people who practice in a consultation liaison team. So, they're constantly hearing peoples' stories... To retell a story of what it's like to see the young person who's gained 23 kilos and is now drooling... I bring that to the table... A little bit offensive to not be asked and to also not have that expectation that we are contemporaneous and really in touch with the people that we work with.

This suggests the engagement of the consumer academic was interpreted as an apparent deficit in the knowledge and skills of nurse academics. By contrast, the following quote suggests the expertise of nurse academics is not in question and that the consumer academic brings a unique expertise to the learning experience:

> there is something about having a service user involved that is irreplaceable by any means. Even the very best nurse academic… can't do it... The ability for somebody to get up and talk about something that happened to them… constructing curriculum in a way that brings students right into what it's like to experience mental illness... to be given treatment against their will, to be secluded.... It can't be done in any other way and all… I've seen in my time as an academic it is the most revolutionary in terms of influencing attitudes.

How accurate is consumer perspective?

On several occasions throughout interviews, accuracy of the consumer academic's perspective was questioned, with an apparent assumption that nurse academics were able to provide a more reliable picture of reality:

> any person's interpretation of what happens becomes their reality... if it's not right ...it's not anybody's place to say well, that might be what you thought but it isn't what had happened

A participant described an example of firmly believing the consumer's recollection of an experience was inaccurate:

> Whilst I wasn't specifically there at that moment of time…, I worked in area about six months later, so I can say categorically, the conditions that were being described, didn't exist in that unit at that time. They never have and they never did...

The participant described this experience as challenging, forcing reflection to feel assured that the consumer's recollection was inaccurate. The participant felt compelled to discuss recollections with colleagues for further reassurance:

> I had to question my own knowledge... Am I wrong? ...Which makes it difficult for me, when I've got to do recall professionally... I found that personally quite challenging ... I had to go back to some colleagues and say, "Hey, look, we were all here 20 years ago. Did we do this? Would we have done this? What does this say about us practitioners, if we did?" And knowing that… my recall was correct.

One consumer, one opinion, one way, one delivery

Having only one consumer academic involved in the teaching was considered a limitation by some, for example: "one-sided opinion... it was one way – one delivery" with a limited range of experiences one consumer could bring:

> ...There was only one consumer and there were degrees of limitations to their experience. They'd not had access to private mental health services. They'd not had access to lots of community... treatment

Concern was also expressed about obtaining consumer perspective from a consumer at a particular point in the health/illness continuum:

> We need to have people that are both unwell and well and people who are articulate and not articulate... We're going to have folks that can't necessarily explain what this experience has been like.

Bias and poor portrayal of nurses

Some participants expressed concerns the consumer academic portrayed nursing practice negatively. These views were described as biased, and not the way they envisaged the consumer academic would contribute:

> Some stories that were recounted were from a biased opinion that nursing was almost the significant other that was doing harm… we didn't want it about that.

similarly:

> The level of shame that was being given to us as the carer... It was confronting, we wouldn't do that. I wouldn't do that.

Another participant observed the nurse academics may have needed to defend themselves and the profession more broadly:

> ...there's a lot of... professional defensiveness around. if [consumer academic] talks about an experience... the nurses may feel the need

> to explain that and justify that. I think that's unfortunate but that does happen… and I think it did happen in this particular case.

The consumer academic was aware of some discomfort from members of the teaching team, particularly relating to specific areas of knowledge that may have been viewed as beyond scope:

> The nursing academics were comfortable with me talking about the service user perspective of the mental health system... they were uncomfortable with me talking about non-medical ways of describing distress or dealing with distress... if I got too critical about current practice, that seemed to make people uncomfortable.

In some instances, the apparent defensiveness extended beyond nursing practice to aspects of the broader system:

> there was [an occasion] where she [nurse academic] seemed quite defensive from some of the things I was saying a... story I shared about being on 15-minute observations and this trap door... this nurse looks through every 15 minutes. I find it's quite powerful to give students these snapshots that are quite heavy in detail... The size of the room and how it smelt and how there was nothing in it... white walls... that helps students really imagine it... When I finished that story, the nursing academic said to the students that they're not going to have any influence in the way

> that buildings are designed... Perhaps she felt I was being too critical, and she ...needed to balance that somehow.

One participant described the importance in being secure in one's own knowledge and skill and taking challenges to professional knowledge as equally legitimate:

> I have been doing this work for a long time... you must be very comfortable in yourself as an academic, a professional. If a consumer does say something that you go, geez, that challenges the core of everything I believe in, you just have to sit with that and think… well I might have a different view but that doesn't mean that that [consumer's] view's not legitimate.

DISCUSSION

The findings demonstrate stark contrasts between participants about the scope, content and legitimacy of consumer perspective in mental health nursing education. Research addressing this topic has generally emphasised the positive aspects of consumer academic roles, particularly in influencing positive attitudes from students. The current research suggests the possibility of negative attitudes and resistance that should be considered and addressed.

In the current study, consumer perspectives and knowledge were considered on one hand as unique and essential, and on the other as content that should be blended into the curriculum to achieve a consistent approach. Indeed, one participant questioned whether consumers were necessary to provide consumer perspective, suggesting experienced nurse academics could draw on their professional experience to provide this. Consumer perspective is acknowledged in policy and broader literature as knowledge based on the experience of diagnosis of mental illness and of mental health service use (Commonwealth of Australia, 2017; Davies & Gray, 2017; Walker, Perkins, & Repper, 2014). For example, mental health policy over five mental health plans clearly expects consumers to be active contributors to mental health services (Commonwealth of Australia, 1992, 1998, 2003, 2009, 2017), contrary to the idea experienced health professionals can act on their behalf. The idea that an experienced clinician would be appropriate to provide a consumer perspective is a unique finding in this study.

Considering policy directives, consumer perspective must be provided by people with lived experience. Arguing otherwise suggests positioning professional knowledge as superior to consumer knowledge (Boaz, Biri, & McKevitt, 2016; Gee et al., 2016; Scholz et al., 2018; Veseth et al., 2017). It is unlikely that an argument for psychiatrists providing a nursing perspective based on having worked closely with nurses over a broad range of settings would be accepted as legitimate (Byrne & Happell, 2012). Nurses are identified as a profession with potential to be allies in support of consumer

leadership roles, including academic positions (Byrne, Happell, et al., 2016; Happell & Scholz, 2018). A recent article draws clear boundaries around consumer knowledge as the domain of consumers and not to be influenced by allies (Happell & Scholz, 2018). Clarifying this position would appear crucial for the successful introduction of consumer academic positions.

The desire for consistency in teaching nursing while understandable within curriculum based accreditation standards (Brown, Crookes, & Iverson, 2015), potentially diminishes the power of consumer perspectives. As previously argued consumer perspectives should not be dictated or influenced by professional knowledge (Happell & Scholz, 2018; Roper, Grey, & Cadogan, 2018). Just as the experience of mental health services will be fundamentally different for consumers and nurses, the knowledge each bring to the classroom will be different and at times opposed. While different perspectives are described in the literature, the current findings present an in-vivo example, and therefore provides a basis to address these issues.

Educating nurses to be holistic practitioners has been enhanced by consumer participation in education (Byrne, Happell, Welch, & Moxham, 2013a). Maintaining its integrity and authenticity is crucial. Ultimately successful collaborations between nurses and consumers requires mutual recognition of and respect for each other's knowledge and expertise (McCloughen, Gillies, & O'Brien, 2011).

Respecting consumer knowledge also requires accepting their experiences as legitimate. Stigma and discrimination experienced by people diagnosed with mental illness is widely acknowledged in the literature (Ezell, Choi, Wall, & Link, 2018; Oexle & Corrigan, 2018; Pescosolido, Medina, Martin, & Long, 2013) The statement of one participant "that might be what you thought but it isn't what had happened", calls the consumer's experience into doubt. People working in lived experience roles continue to experience this stigma even when employed specially for their lived experience and its contribution to service delivery (Bennetts et al., 2013; Byrne, Roper, Happell, & Reid-Searl, 2016; Scholz, Bocking, & Happell, 2017). The current findings are the first to highlight stigma within the educational setting. Given the education of health professionals has been identified as an important strategy for addressing negative attitudes (Happell, Byrne, McAllister, et al., 2014; Happell, Byrne, Platania-Phung, et al., 2014; Schneebeli et al., 2010; Simons et al., 2007), particular attention to addressing stigma within academia is essential.

Some participants described the consumer academic's experience with mental health services as being limited to only one perspective and therefore a limitation. Previous literature exploring the representation of consumers working in mental health has argued expecting individual consumers to be representative disempowers them by dismissing their views as self-serving and not necessarily the views of a broader constituency

(Happell, 2010; Happell & Roper, 2006; Scholz, Stewart, Bocking, & Happell, 2017).

The current study extends this finding through the theme 'one consumer, one opinion, one way, one delivery', and suggests the same rhetoric may be used to silence consumers within academia. Indeed, participants referred to having only one consumer as a serious limitation and believed the initiative would be improved with the inclusion of many consumers from a variety of settings and in a range of states of health. Such rhetoric places impossible demands on an individual consumer. Also telling is participants' failure to acknowledge that there was only one nurse academic in each tutorial and only two in the team.

Two particular implications of this finding are that a) allies to the consumer movement do what they can (Happell & Scholz, 2018) to encourage other non-consumer mental health professionals to value consumer perspectives and to point out when common discourses of representation serve to silence consumers, and b) instead of demanding individual consumers represent consumers more broadly, mental health educators should seek opportunities to collaborate with more consumers (where consumers are appropriately paid and valued for their expertise) to increase capacity.

Critique of nursing practice was of concern to some participants. This phenomena was termed 'professional defensiveness' in relation to a consumer academic position (Roper & Happell, 2007). This reflective paper described the responses of nurses to consumer critique of mental health services, including nursing practice. The tendency was for nurses to feel attacked either individually or as part of the broader profession even though the critique was not directed at them personally. The findings of the current study extend this to demonstrate that in the context of co-created teaching environments, non-consumer mental health professionals' professional defensiveness is a barrier not only to greater consumer participation, but also to student learning. For instance, the consumer academic reported feeling very aware that teaching students about perspectives "critical about current practice" made the nursing academics "a little bit uncomfortable". The nursing academics suggested that they "didn't want [course content] about" how "nursing…was doing harm".

Critical thinking is considered an ultimate goal of nursing education (Morrall & Goodman, 2013; Theisen & Sandau, 2013). Alternative views and attitudes towards the nursing profession should therefore be considered invaluable for students, rather than something to be silenced. Professional defensiveness may be preventing students as the next generation of mental health professionals from developing better understandings of consumer perspectives, potentially perpetuating stigma and negative attitudes towards

consumers. This is clearly expressed by Cath Roper, an international leader of consumer academia:

> On the one hand, mental health nursing is about wanting to help some of the most marginalized people in our community. On the other hand, interventions are sometimes experienced as unwelcome even damaging. One truth does not cancel out the other – things can be both contradictory and true at the same time - it's about accepting both truths rather than brushing away the more unpleasant (Roper, 2000*)*.

Limitations

The setting for this research was one Australian university, with only a small number of participants able to inform the study topic. It would therefore be inappropriate to consider the findings as representative of actual or potential experiences elsewhere. Rather than attempting to discover something generalisable, the aim of this research was to highlight divergent experiences with the view to identifying specific issues that could therefore be addressed for replications of this process in the future. This work is only one small component of a broader arena, the perspectives of and implications for, nursing students and consumers of mental health services must also be considered in additional research. A broader scope for the research agenda inclusive of all major stakeholders would assist research to consider how the

introduction of more consumer academics and consumer content into the education of health professionals impacts on relationships between consumers and health professionals and ultimately influences a change in power dynamics in these therapeutic relationships.

CONCLUSIONS

Policy provides direction for required change. Despite the growing evidence in support of consumer academic positions, successful implementation of these positions requires support from multiple stakeholders. The findings from the current research highlight the divergent and suggest the negative views of health professionals evident within mental health services may also be present within universities. To date nurses have provided leadership in facilitating consumer involvement in professional education and been identified as potential allies in facilitating consumer leadership. Positive attitudes among all or most of the profession cannot be assumed, and the introduction of new initiatives to promote consumer involvement need to provide time and space for the exploration of discomfort, concern and other experiences and attitudes that might otherwise impose a major barrier to success.

References

Ahmed, A. O., Hunter, K. M., Mabe, A. P., Tucker, S. J., & Buckley, P. F. (2015). The professional experiences of peer specialists in the Georgia Mental Health Consumer Network. *Community Mental Health Journal, 51*(4), 424-436.

Bennetts, W., Pinches, A., Paluch, T., & Fossey, E. (2013). Real lives, real jobs: sustaining consumer perspective work in the mental health sector. *Advances in Mental Health, 11*(3), 313-326.

Boaz, A., Biri, D., & McKevitt, C. (2016). Rethinking the relationship between science and society: Has there been a shift in attitudes to Patient and Public Involvement and Public Engagement in Science in the United Kingdom? *Health Expectations, 19*(3), 592-601. doi: 10.1111/hex.12295

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brown, R. A., Crookes, P. A., & Iverson, D. (2015). An audit of skills taught in registered nursing preparation programmes in Australia. *BMC Nursing, 14*, 1-8. doi: 10.1186/s12912-015-0113-7

Byrne, L., & Happell, B. (2012). Psychiatrists teaching mental health nursing: What's the problem? *International Journal of Mental Health Nursing, 21*(4), 299-300. doi: 10.1111/j.1447-0349.2012.00849.x

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Risky Business: Lived experience mental health practice, nurses as potential allies. *International Journal of Mental Health Nursing, 25*(3), 217-223.

Byrne, L., Happell, B., Welch, A., & Moxham, L. (2013a). Reflecting on holistic nursing: the contribution of an academic with lived experience of mental health service use. *Issues in Mental Health Nursing, 34*(4), 265-272. doi: 10.3109/01612840.2012.745038

Byrne, L., Happell, B., Welch, T., & Moxham, L. J. (2013b). 'Things you can't learn from books': Teaching recovery from a lived experience perspective. *International Journal of Mental Health Nursing, 22*(3), 195-204. doi: 10.1111/j.1447-0349.2012.00875.x

Byrne, L., Platania-Phung, C., Happell, B., Harris, S., & Bradshaw, J. (2014). Changing Nursing Student Attitudes to Consumer Participation in Mental Health Services: A Survey Study of Traditional and Lived Experience-led Education. *Issues in Mental Health Nursing, 35*(9), 704-712. doi: 10.3109/01612840.2014.888604

Byrne, L., Roper, C., Happell, B., & Reid-Searl, K. (2016). The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles. *Journal of Mental Health*, 1-7. doi: 10.1080/09638237.2016.1244715

Commonwealth of Australia. (1992). *National Mental Health Plan*. Canberra: Australian Government Printer.

Commonwealth of Australia. (1998). *Second National Mental Health Plan: 1998-2003.* Canberra: Australian Government Printer.

Commonwealth of Australia. (2003). *Third National Mental Health Plan: 2003-2008.* Canberra: Australian Government Printer.

Commonwealth of Australia. (2009). *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014*. Barton, Australia: Commonwealth of Australia Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09.

Commonwealth of Australia. (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. Canberra: Australian Government.

Davies, K., & Gray, M. (2017). The place of service-user expertise in evidence-based practice. *Journal of Social Work, 17*(1), 3-20. doi: 10.1177/1468017316637222

Ezell, J. M., Choi, C.-W. J., Wall, M. M., & Link, B. G. (2018). Measuring recurring stigma in the lives of individuals with mental illness. *Community mental health journal, 54*(1), 27-32.

Gee, A., McGarty, C., & Banfield, M. (2016). Barriers to genuine consumer and carer participation from the perspectives of Australian systemic mental health advocates. *Journal of Mental Health, 25*(3), 231-237. doi: 10.3109/09638237.2015.1124383

Happell, B. (2010). Facilitating consumer participation: an approach to finding the 'right' consumer. *Collegian, 17*(3), 125-130. doi: 10.1016/j.colegn.2010.03.001

Happell, B., Bennetts, W., Harris, S., Platania-Phung, C., Tohotoa, J., Byrne, L., & Wynaden, D. (2015). Lived experience in teaching mental health nursing: Issues of fear and power. *International Journal of Mental Health Nursing, 24*(1), 19-27. doi: 10.1111/inm.12091

Happell, B., Bennetts, W., Platania Phung, C., & Tohotoa, J. (2015). Consumer involvement in mental health education for health professionals:

feasibility and support for the role. *Journal of Clinical Nursing, 24*(23-24), 3584–3593.

Happell, B., Bennetts, W., Platania Phung, C., & Tohotoa, J. (2016). Exploring the scope of consumer participation in mental health nursing education: perspectives from nurses and consumers *Perspectives in Psychiatric Care, 52*(3), 169-177.

Happell, B., Bennetts, W., Tohotoa, J., Platania-Phung, C., & Wynaden, D. (2016). Nothing without vision! the views of consumers and mental health nurses about consumer involvement in mental health nursing education. . *Collegian: Journal of the Royal College of Nursing Australia, 23*, 241-248 doi: 10.1016/j.colegn.2015.04.004

Happell, B., Byrne, L., McAllister, M., Lampshire, D., Roper, C., Gaskin, C. J., . . . Hamer, H. (2014). Consumer involvement in the tertiary-level education of mental health professionals: a systematic review. *International Journal of Mental Health Nursing, 23*(1), 3-16. doi: 10.1111/inm.12021

Happell, B., Byrne, L., Platania-Phung, C., Harris, S., Bradshaw, J., & Davies, J. (2014). Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International journal of mental health nursing, 23*(5), 427-434.

Happell, B., Platania-Phung, C., Byrne, L., Wynaden, D., Martin, G., & Harris, S. (2015). Consumer participation in nurse education: A national survey of Australian universities. *International Journal of Mental Health Nursing, 24*(2), 95-103. doi: 10.1111/inm.12111

Happell, B., & Roper, C. (2006). The myth of representation: the case for consumer leadership. *Australian e-Journal for the Advancement of Mental Health, 5*(3), 1-8.

Happell, B., & Roper, C. (2009). Promoting genuine consumer participation in mental health education: a consumer academic role. *Nurse Education Today, 29*(6), 575-579. doi: 10.1016/j.nedt.2008.01.004

Happell, B., & Scholz, B. (2018). Doing what we can, but knowing our place: Being an ally to promote consumer leadership in mental health. *International Journal of Mental Health Nursing, 27*(1), 440-447. doi: 10.1111/inm.12404

Happell, B., Wynaden, D., Tohotoa, J., Platania-Phung, C., Byrne, L., Martin, G., & Harris, S. (2015). Mental health lived experience academics in tertiary education: The views of nurse academics. *Nurse Education Today, 35*(1), 113-117. doi: 10.1016/j.nedt.2014.07.006

McCann, T. V., Moxham, L., Usher, K., Crookes, P. A., & Farrell, G. (2009). Mental health content of comprehensive pre-registration nursing curricula in Australia. *Journal of Research in Nursing, 14*, 519-530. doi: 10.1177/1744987109347041

McCloughen, A., Gillies, D., & O'Brien, L. (2011). Collaboration between mental health consumers and nurses: shared understandings, dissimilar experiences. *International Journal of Mental Health Nursing, 20*(1), 47-55. doi: 10.1111/j.1447-0349.2010.00708.x

Morrall, P., & Goodman, B. (2013). Critical thinking, nurse education and universities: Some thoughts on current issues and implications for nursing practice. *Nurse Education Today, 33*(9), 935-937. doi: 10.1016/j.nedt.2012.11.011

Oexle, N., & Corrigan, P. W. (2018). Understanding Mental Illness Stigma Toward Persons With Multiple Stigmatized Conditions: Implications of Intersectionality Theory. *Psychiatric Services*, appi. ps. 201700312.

Pescosolido, B. A., Medina, T. R., Martin, J. K., & Long, J. S. (2013). The 'Backbone' of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness. *American Journal of Public Health, 103*(5), 853-860. doi: 10.2105/AJPH.2012.301147

Roper, C. (2000). Pers Comm

Roper, C., Grey, F., & Cadogan, E. (2018). Co-production: Putting principles into practice in mental health contexts. Melbourne.

Roper, C., & Happell, B. (2007). Reflection without shame -- reflection without blame: towards a more collaborative understanding between mental health consumers and nurses. *Journal of Psychiatric & Mental Health Nursing, 14*(1), 85-91.

Schneebeli, C., O'Brien, A., Lampshire, D., & Hamer, H. P. (2010). Service user involvement in undergraduate mental health nursing in New Zealand. *International Journal of Mental Health Nursing, 19*(1), 30-35. doi: 10.1111/j.1447-0349.2009.00642.x

Scholz, B., Bocking, J., & Happell, B. (2017). Breaking through the glass ceiling: Consumers in mental health organisations' hierarchies. *Issues in mental health nursing, 38*(5), 374-380.

Scholz, B., Bocking, J., & Happell, B. (2018). Improving exchange with consumers within mental health organizations: Recognizing mental ill health experience as a 'sneaky, special degree'. *International Journal of Mental Health Nursing, 27*(1), 227-235. doi: 10.1111/inm.12312

Scholz, B., Gordon, S., & Happell, B. (2017). Consumers in Mental Health Service Leadership: A Systematic Review. *International Journal of Mental Health Nursing, 26*(1), 20-31.

Scholz, B., Stewart, S. J., Bocking, J., & Happell, B. (2017). Rhetoric of representation: The disempowerment and empowerment of consumer leaders. *Health Promotion International*. doi: 10.1093/heapro/dax070

Simons, L., Tee, S., Lathlean, J., Burgess, A., Herbert, L., & Gibson, C. (2007). A socially inclusive approach to user participation in higher education. *Journal of Advanced Nursing, 58*, 246-255. doi: 10.1111/j.1365-2648.2007.04216.x

Stebbins, R. (2001). *Exploratory research in the social sciences: Qualitative research methods: Volume 48*. London, England: Sage.

Theisen, J. L., & Sandau, K. E. (2013). Competency of New Graduate Nurses: A Review of Their Weaknesses and Strategies for Success. *Journal of Continuing Education in Nursing, 44*(9), 406-414. doi: 10.3928/00220124-20130617-38

Veseth, M., Binder, P. E., Borg, M., & Davidson, L. (2017). Collaborating to stay open and aware: service user involvement in mental health research as an aid in reflexivity. *Nordic Psychology*.

Walker, L., Perkins, R., & Repper, J. (2014). Creating a recovery focused workforce: supporting staff well-being and valuing the expertise of lived experience. *Mental Health & Social Inclusion, 18*(3), 133-141. doi: 10.1108/MHSI-07-2014-0022