SOMETHING SPECIAL, SOMETHING UNIQUE: PERSPECTIVES OF EXPERTS BY EXPERIENCE IN MENTAL HEALTH NURSING EDUCATION ON THEIR CONTRIBUTION

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SOMETHING SPECIAL, SOMETHING UNIQUE: PERSPECTIVES OF EXPERTS BY EXPERIENCE IN MENTAL HEALTH NURSING EDUCATION ON THEIR CONTRIBUTION

ABSTRACT

Introduction:
Embedding lived experience in mental health nursing education is increasing, with research findings suggesting the impact is positive. To date research has primarily targeted the perspectives of nursing students and academics from the health professions.
Aim:
To enhance understanding of the unique knowledge and expertise experts by experience contribute to mental health nursing education.
Methods:
Qualitative exploratory research methods were employed. In-depth individual interviews were conducted with experts by experience who delivered a coproduced learning module to nursing students in Europe and Australia.
Results:
Participants described their unique and essential contribution to mental health nursing education under four main themes: critical thinking, beyond textbooks;

interactive and open communication; understanding personal recovery; and mental health is health.

Conclusions:

These findings present an understanding of the unique knowledge and expertise Experts by Experience contribute to mental health education not previously addressed in the literature. Appreciating and respecting this unique contribute is necessary as Expert by Experience contributions continue to develop.

Implications for Practice:

Mental health services purport to value service user involvement. Identifying and respecting and valuing the unique contribution they bring to services is essential. Without this understanding, tokenistic involvement may become a major barrier.

Keywords:

Co-production,
COMMUNE,
Expert by experience
Expertise
Education
Knowledge
Mental health
Mental health nursing

Relevance statement

Mental health services are aspiring to become recovery oriented. The expert by experience workforce is crucial for the successful adoption of recovery principles and nursing graduates will increasingly work with experts by experience as colleagues. The current research articulates the unique and expertise experts by experience contribute to mental health services. Effective collegial relationships require that nurses identify and respect the unique experiential knowledge and expertise of experts by experience and this understanding must come from experts by experience themselves.

Accessible summary

What is known on the subject

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

What the paper adds to existing knowledge

- The paper presents perspectives from Experts by Experience about the unique knowledge and expertise they derive from their lived experience of mental distress and mental health service use. As a result, they can make a unique and essential contribution to mental health nursing education. They utilise this knowledge to create an interactive learning environment and encourage critical thinking.
- The international focus of this research enriches understandings about how Experts by Experience might be perceived in a broader range of countries.

What are the implications for practice

- Mental health policy articulates the importance of service user involvement in all aspects of mental health service delivery. This goal will not be fully achieved without nurses having positive attitudes towards experts by experience as colleagues.

- Positive attitudes are more likely to develop when nurses understand and value the contribution experts by experience bring by virtue of their unique knowledge and expertise. This paper provides some important insights to achieving this end.

INTRODUCTION

Expert by Experience (EBE) involvement in health and social care education is becoming more common internationally. This is driven in part by the increased involvement of service users in their own care and in planning, delivery, evaluation and governance of services (Australian Commission on Safety and Quality in Health Care, 2017; Commonwealth of Australia, 2017; Health Services Executive, 2018; McKeown, Malihi-Shoja, & Downe, 2010; Mental Health Commission, 2012; Mental Health Commission of Canada, 2016). EBE involvement is a mechanism for addressing the expectation that students of health professions gain insight into the service user perspective, develop skills that promote person-centeredness (Happell, Platania-Phung, et al., 2019; Horgan et al., 2018; Terry, 2013) and recognise the importance and value of collaborative partnership (Skilton, 2011).

Research in this area largely occurs in a nursing context (Scammell, Heaslip, & Crowley, 2016), particularly mental health nursing (Happell, Byrne, et al., 2014; Happell, Platania-Phung, et al., 2019). More recently the trend is emerging in medicine (Gordon et al., 2020; Newton-Howes, Gordon, & Fedchuk, 2020), occupational therapy (Arblaster et al., 2018; Mahboub & Milbourn, 2015; Scanlan et al., 2020), physiotherapy (Thomson & Hilton, 2012), midwifery (Davis & McIntosh, 2005) and social work (Basset, Campbell, & Anderson, 2006; Geregová & Frišaufová, 2019; Hughes, 2017; Ridley, Martin, & Mahboub, 2017; Skilton, 2011; Tanner, Littlechild, Duffy, & Hayes, 2015).

Proponents argue EBE involvement enhances student experiences (McKeown et al., 2010), assists them to meet learning outcomes (Felton, Cook, & Anthony, 2018), is professionally enriching (O' Donnell & Gormley, 2013) and transformative (Rush, 2009; Scammell et al., 2016), and will help to shape health

professionals capable of delivering improved and more relevant outcomes for service users (Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Schneebeli, O'Brien, Lampshire, & Hamer, 2010). Research across the disciplines indicates that EBE involvement has a positive influence on stigma, attitudes, prejudices and stereotypes (Geregová & Frišaufová, 2019; Sandhu, 2017; Unwin, Rooney, & Cole, 2017), develops students' interpersonal and communication skills (Felton et al., 2018; Gordon et al., 2020; Horgan et al., 2018), enables them to relate theory to policy and practice (Felton et al., 2018; Tanner et al., 2015; Thomson & Hilton, 2012), promotes critical thinking, reinforces person-centredness (Felton et al., 2018; O' Donnell & Gormley, 2013), and increases empathy (Happell, Wynaden, et al., 2015; Perry, Watkins, Gilbert, & Rawlinson, 2013; Rees, Knight, & Wilkinson, 2007).

Evidence is emerging that the learning students derive from EBE teaching and the knowledge that EBE impart is unique, distinct both from the content of textbooks (Byrne, Happell, Welch, & Moxham, 2013; Felton et al., 2018; Sandhu, 2017) and the professional lecturer (Rush, 2009). EBE teaching is described as at least as effective as teaching by clinicians (Gordon et al., 2020). EBE involvement enables a different sort of learning (Prytherch, Lea, & Richardson, 2018), and provides an essential source of new knowledge (Prytherch et al., 2018). This reflects experiential authority of EBE (Jones & Pietilä, 2020), which brings a unique authenticity to teaching (Winn & Lindqvist, 2019).

EBE have firsthand experience and knowledge of diagnosis and management of illness processes that differs from professional knowledge (Jordan & Court, 2010; Speers & Lathlean, 2015). Respecting the value of this expertise challenges the hegemony of official knowledge (Townend, Tew, Grant, & Repper, 2009), it also acts as bridge or translator (Byrne & Wykes, 2020), enabling understanding about the embodied experience of treatments and

approaches (Townend et al., 2009). This extends to an applied and internalised understanding of recovery (Byrne & Wykes, 2020).

In a mental health context, EBE involvement is particularly important because mental health professionals need to develop recovery capabilities and competencies (Arblaster et al., 2018; Happell, Bennetts, Tohotoa, Wynaden, & Platania-Phung, 2019). Recovery orientation requires that health professionals recognise that lived experience expertise is equally valuable to their knowledge. They consider EBE involvement in learning and teaching to be critical for developing graduates with recovery-oriented capabilities (Happell, Waks, Bocking, Horgan, Greaney, et al., 2019).

To date, evaluations of EBE involvement in teaching have primarily reflected the perspectives of students and academics from the health disciplines, and most research has been conducted in Australia, New Zealand and the United Kingdom. Published research from the perspective of EBE is extremely limited. Interviews were conducted with service users who had acted as educators or mentors for students on clinical placement in psychology (Prytherch et al., 2018) and nursing (Speers & Lathlean, 2015). In both studies, service users found the experience extremely positive. The need for greater support from academic staff was identified in one study (Prytherch et al., 2018). From the authorship list it appears this work was designed, conducted and disseminated by academics with no visible input from EBE which could considerably impact the relevance and fidelity of the process and findings.

In terms of classroom teaching, two studies have examined the experiences of EBE in teaching mental health nursing within a university setting (Happell, Bennetts, et al., 2019; McKeown et al., 2012). Findings demonstrate the experience was viewed positively by service user participants, enabling them to

demonstrate recovery in action, enhanced sense of self, social benefits and the opportunity for altruism (Happell, Bennetts, et al., 2019; McKeown et al., 2012). The team included EBE authors, however there is no clear evidence of EBE involvement in all aspects of curriculum design and delivery. In one international study (Bocking et al., 2019), interviews were conducted with EBE team members of a coproduced project involving the design, development and delivery of a mental health learning module to nursing students. Findings suggest this approach to teaching enhanced students' understanding about the humanity that lay beneath psychiatric diagnoses assigned to people in mental health services. While the existing research does assist in articulating aspects of the EBE experience, the unique knowledge and expertise EBEs contribute has not been discussed and articulated. As EBE involvement in educating health professionals develops, an understanding of this unique contribution is required. Understanding and appreciating the unique contribution of EBE with credibility and authenticity is not possible without the perspectives of EBE themselves and their active involvement in the design, development and implementation of the evaluation framework. This gap in the literature must therefore be addressed.

Aim

The aim of this study was to enhance understanding of the unique contribution EBE have made based on their experiences of teaching nursing students as part of a broader research project.

METHODS

Design

A qualitative exploratory approach was undertaken to address the identified gap in the literature (Stebbins, 2001). This method is considered highly suitable in areas of limited research activity. Qualitative exploratory research places the people with the knowledge and expertise relevant to the question as informants (Stebbins, 2001). Co-production was a crucial component of the study design. The goal was to position EBE and mental health nurse academics as collaborative partners in all components of the research including conception, research methods, securing ethics approval, data collection, data analysis and dissemination. Co-production principles facilitated embedding perspectives of EBE within the research, avoiding their contribution becoming little more than tokenism (Gillard, Simons, Turner, Lucock, & Edwards, 2012; Roper, Grey, & Cadogan, 2018).

Setting and Sample

The EBE interviewed for this study had taught into the mental health nursing subject as part of the research project COMMUNE (Co-production of Mental Health Nursing Education). This international study was designed to develop, implement and evaluate a learning unit, coproduced by EBE and mental health nurse academics. The study sites were Australia, Finland, Iceland, Ireland, the

Netherlands and Norway. Fourteen EBE participated in the study and agreed to be interviewed. The distribution by country and gender is presented in Table 1.

Insert Table 1 here

Procedure

EBEs who had been involved in the COMMUNE project were informed about the study and invited to participate in an individual interview in person at team meetings and via email. Following an explanation of the project, and obtaining informed consent, individual Interviews were conducted by a researcher external to the research team to facilitate candid responses. Interviews were conducted at a time and place of convenience for the EBE. The interviews were based on an interview guide developed by the team, to provide a general direction for the research and ensure some fundamental questions were addressed. In countries with English as a second language, the interview guide was translated into the local language. Extensive discussion occurred within the teams of each country and the research team as a whole to ensure the translations recognised the intended meaning of the questions. At the same time a conversational approach was adopted to allow participants to contribute based on their own perspectives and experiences.

Ethics

Ethics approval was granted by the University of Canberra (HREC 17-106). Participants were advised about the study and the voluntary nature of their participation, including their right not to participate or to withdraw their participation at any stage. They were assured of the confidentiality of the data.

Data analysis

Reflecting the principles of coproduction, data were analysed independently by a mental health nurse academic and an EBE at each research site, based on the thematic analysis framework developed by Braun and Clarke (2006). This six step process guided data analysis through the following phases:

Phase 1

Transcripts were read and re-read several times to assist the researchers in gaining familiarity with the data and achieve an understanding of content and meaning.

Phase 2

This phase involved the beginning of the organised process where specific sections of content with common content and meaning were assigned provisional codes, using an open-coding method.

Phase 3

The codes were initially scrutinised in relation to their relevance to the research aims. Codes were then carefully examined for areas of commonality that may be clustered together to form provision themes.

Phase 4

Each provision theme was reviewed to ensure the themes were supported by data and whether the data related closely to that theme. At this stage sub-themes were also identified.

Phase 5

A thematic map was created to demonstrate the relationship between themes and sub-themes. Themes and sub-themes were re-examined for relevance and accuracy. Transcripts were read again to be sure all relevant data had been included.

Step 6

The themes and sub-themes were written up as a findings section for the research paper.

The two researchers at each site met to discuss and refine their analysis. Data from individual sites were collated and analysed in totality following the same process. This resulted in the development of the main themes from all countries. The analysis was subsequently reviewed by the full research team (comprising 12 EBE and 10 nurse academics) before finalising.

FINDINGS

Analysis of EBE responses led to the development of the theme: *Something unique, something special.* The theme describes EBE as teachers with a source of different learning and knowledge for nursing students. The different perspective EBE brought to nursing practice, provided students a broader context for their clinical knowledge. Four distinct sub-themes were identified that indicate the knowledge and learning imparted by EBE was different, both in method and in content, to the clinical components of the course:

- Critical thinking, beyond text books
- Interactive and open communication
- Understanding personal recovery
- Mental health is health

Critical thinking – beyond textbooks

EBE viewed the material they delivered as promoting critical thinking over mastering procedural tasks, and challenging students' preconceived ideas

about people who experience mental health challenges and mental distress. This provided students with both a new way of thinking about the clinical skills and concepts they were learning, and with practical and effective approaches to patient care students could apply during clinical placements. One EBE reflected that this appeared to change students' attitudes towards the theory and practice of mental health nursing, as well as towards people who access mental health services:

> *"I think in mental health the biological medical model is generally not subject to much critique, and I think it's important for students to really engage in critical thinking, and it's an opportunity to balance out the other clinical material that they learn. I think it – I really noticed a change in people's stigmatised attitudes..." (Australia)*

Another EBE reported their explicit intention to extend students' learning beyond the skills and competencies required by the program, to encourage curiosity and person-centredness:

> *"My sole purpose was to make them more interested in what's happening with the person that they are working with ... that they would have more questioning and inquiring mind when they would receive teaching through their degree" (Ireland, Cork)*

Some students were able to test the credibility and effectiveness of the EBE lesson content while on practical placement and relayed these experiences back to the EBE:

> *"It was a second year and third year unit, so some [students] went out on their placements in the semester. So, it was really … great, where they*

were able to tell me some of the things that we worked on in class, how they'd had a go at them in the field and how effective they were" (Australia).

This suggests not only is EBE knowledge distinct from clinical knowledge, the skills and concepts taught by EBE in the classroom environment can be successfully applied in clinical settings and provide a perspective they may not otherwise be experienced within nursing education. Content delivered by EBE was perceived as both unique and practical.

Beyond personal narratives about their experiences of mental health challenges and distress, EBE provided examples of experiences of care that enabled students to critically examine nursing practice. One EBE felt that sharing the EBE perspective was instrumental in this:

"That [nursing action] is something that's clinically correct, that is a nursing policy that is in every hospital. But hearing my perception of that as a 17-year-old, It made them more willing to critique some of these practices. … Without hearing the personal experience of that, they would have not engaged in that critique." (Australia).

Responses indicated that EBE believed their perspective also makes a unique and necessary contribution to mental health sector reform:

"until we take on board the views and the experiences of the people who have received the service how can we ever learn how those services are working, how can we ever learn what to improve, what to change we need, we need that voice throughout the health sector." (Ireland, Cork).

Interactive and open Communication

The EBE described bringing novel communication and teaching styles to the learning program, giving students the opportunity to learn new things in ways the learning module didn't otherwise employ. In delivering content, EBE were upfront about sharing experiential knowledge, and favoured direct communication and dialogue over more structured ways of disseminating information:

> *"I put it out to them [students] at the start that I wanted them to ask questions … if they had them … take the risk. If I wasn't comfortable answering it then I wouldn't and I felt they really did that … they asked." (Ireland, Cork).*

> *"Students dared to be honest with us" (Finland).*

EBE developed sessions that were interactive but not "overly formative", designed to encourage discussion. They would tailor content to students' learning needs and their emotional and psychological needs:

> *"I would always ask them [students] to, if they need to leave or if they need to say 'can you stop right now' I would always lead with them" (Ireland, Cork)*

> *"I had a plan [for] how I interacted with students. Do introductions and do an icebreaker and set out the lecture with the students very, very deliberately and specifically. Sitting in that circle, creating that interactive that critical questioning, without being overly formative about it. Creating an environment of curiosity and … wonder" (Australia).*

One EBE reflected that their approach seemed to be a novel one, based on students' reactions:

> *"The students thought it was really different. They generally … use their laptops. … So when it was my turn to teach, I would have this row of … people behind laptops and I immediately say, "everyone's got to pack up all the stuff, put it in the bag, we're not using that – I don't use PowerPoint slides. I don't use laptops and I don't use notebooks at all for this, this is different. I don't think they'd ever been taught like that before." (Australia).*

Material delivered by EBE was seen as engaging, able to capture and hold students' interest and facilitate the development of more enquiring approach to mental health knowledge:

> *"Students took me so well and they were so interested, they have so many questions and I got the feeling that there is some meaning in what we are doing." (Finland)*

> *"Very curious, absolutely. Also very curious about the stories of the other EBE." (the Netherlands).*

> "*Those students who were not interested in the study period they were still listening EBE´s talk." (Finland)*

Understanding personal recovery

EBE endeavored to provide a learning experience that was holistic and interactive and subtly modeled good practice in working with people who

experience mental health challenges by incorporating elements of recovery oriented and trauma informed practice to their sessions. EBE focused on promoting key elements of personal recovery such as connectedness, focusing on the person rather than their diagnosis and seeing experiences of distress as moments in time rather than enduring and immutable characteristics. This approach had the dual purpose of assisting students to understand personal recovery and challenge their negative perceptions of mental health service users.

> *"My concern was that they do see people at their most unwell … they would say god maybe hope isn't possible so what I was trying to get across to them is hope is always possible" (Ireland, Cork).*

> *"They [students] realize that the individuals they see in great suffering . . . that they have a possibility for a better life. I think that it is the most important message that a mental health nurse can bring to an individual . . . that there is a hope." [Iceland].*

> *"Sometimes they see people at their very very worst and they don't see when they have recovered so it is nice to see someone who has that diagnosis doing well, or not depending on the day when you come into class, laughing … It is good if they could keep people in their mind, I have seen somebody and they have recovered" (Ireland, Dublin).*

> *Everything human is actually fluid ... that is what people with lived experience illustrate when they are teaching … To make them understand that it's really no us and them, we are all us … Suddenly one day, it is your life coming apart, and it's not necessarily because of you or your mental health, it can actually be your surroundings that break you." (Norway).*

Mental health is health

As a specialised area of nursing, the transferability of mental health nursing skills to other areas can be difficult to demonstrate, and students can question the relevance of learning these skills when they don't intend to practice in this area. EBE felt they were able to articulate the ways in which mental health crosses over into other areas of health service use and thus demonstrate the relevance of mental health nursing skills to nursing more broadly. One EBE helped bring the importance of mental health skills broadly by providing examples where a nurse might encounter a patient experiencing distress outside of a mental health service:

> *"students were generally not that interested [in] mental health nursing as a career … they were more interested in having interpersonal skills to support a patient who maybe had just had a stillborn birth, or someone … very nervous about going in to have an operation … Those two particular scenarios … seemed to get the students' attention." (Australia).*

Another EBE shared with students how having experienced mental health challenges can impact the experience of accessing other health services:

> *"I was explaining to the students that a lot of the time for me even things like going for a routine appendectomy … I can come up with difficulties … Nurses and doctors who were … doing a routine procedure in a general setting were very unequipped to deal with the, the mental health side of things." (Ireland, Cork).*

Another EBE found that discussing with students the value of listening and

providing support over taking an exclusively biomedical approach to distress was valuable to students who went on placements in areas outside of specific mental health services:

> *"One was at...the hospice … and the other was in our prison… [the students] were just sort of full of enthusiasm about how these skills carried through into these other settings that aren't strictly mental health settings." (Australia).*

One EBE commented that their material and style of delivery seemed to increase students' interest in mental health nursing:

> *"I felt like the students were getting a bit excited about mental health nursing. At the beginning, I said, I know that you probably don't want to do this. … Towards the end of the semester, I found people were more interested in it … when I talked about how you would be presented with, all these complicated, ethical dilemmas and there's no right or wrong answer … every day is every different ... I felt like they were getting enthused about mental health nursing. And I'm not sure where they would get that without a service user." (Australia).*

DISCUSSION

The findings from the current study suggest the unique knowledge and expertise EBE bring to mental health education can positively impact student learning. EBE bring an in depth understanding of the influence of particular nursing practices on them in areas where evidence is lacking. EBE participants described how they used their expertise to facilitate a learning environment that

challenged students to critique their clinical understanding of mental health and mental health service delivery. EBE stressed the importance of exposing students to service user perspectives, and demonstrating that experiences of care are often different from the patients' view to how they are perceived through a clinical lens. The literature suggests the expertise of EBE is unique as it is grounded in firsthand experience of mental health service use from diagnosis to treatment that professional knowledge does not include (Jordan & Court, 2010; Speers & Lathlean, 2015). Furthermore, this direct experience is regarded as material that cannot be adequately gained from text books (Byrne et al., 2013; Felton et al., 2018; Sandhu, 2017). This unique experiential contribution is increasing regarded as essential component of health professional education (Happell, Waks, Bocking, Horgan, Manning, et al., 2019; Jones & Pietilä, 2020; Winn & Lindqvist, 2019). For EBE to become a critical component of health professional education, the specific expertise must be recognised as distinctly different and equally valuable to clinical knowledge, and by definition as challenging the status quo (Byrne & Wykes, 2020; Happell, Gordon, et al., 2019).

Equally important to knowledge was the educational environment itself. EBE described creating and utilising an interactive environment to encourage active learning. This approach has been identified as an important strategy in reducing the theory-practice gap (Felton et al., 2018; Happell et al., 2020; Tanner et al., 2015; Thomson & Hilton, 2012). Difficulties relating theoretical learning to the practice environment is consistently identified as a significant impediment to the development of competent nursing graduates (Huston et al., 2018; Needham, McMurray, & Shaban, 2016; Saifan, AbuRuz, & Masa'deh, 2015). By bringing direct experience into the classroom, EBE could contribute to enhanced knowledge translation and ultimately to better performing graduates.

Enhancing students' understanding of personal recovery was considered central to EBE teaching. Participants described the importance of students seeing and interacting with EBE who have recovered, to counterbalance their experiences of seeing service users who are often very unwell. As mental health services purport to be moving towards recovery oriented services (Commonwealth of Australia, 2013; Santangelo, Procter, & Fassett, 2018), the underlying premise, that recovery is possible, needs to be established for nursing students to embed the principles of recovery-oriented practice into their interactions with people experiencing mental health challenges (Byrne & Wykes, 2020; Happell, Waks, Bocking, Horgan, Manning, et al., 2019). Despite the development of recovery from the lived experience movement, concerns have been raised that health professionals have co-opted this approach to mental health services (Edgley, Stickley, Wright, & Repper, 2012; Slade, Adams, & O'Hagan, 2012). The absence of an EBE perspective complicates the translation of recovery principles into practice, and it is argued that recovery is a lived experience discipline (Byrne, Happell, & Reid-Searl, 2015). Consequently to ensure recovery is adequately understood and translated into practice it must by definition be taught by EBE (Happell, Waks, Bocking, Horgan, Manning, et al., 2019).

While there is still some debate over whether experiential knowledge is important or real (McIntosh & Wright, 2018), and whether EBE involvement leads to long term practice change or improved outcomes (Hughes, 2017; Speed, Griffiths, Horne, & Keeley, 2012; Unwin et al., 2017), there is one area where experiential knowledge is self-evidently crucial in health and social education – teaching students how to engage with the lived experience workforce. Implicit within recovery based principles is the development and expansion of the lived experience workforce (Byrne, Schoeppe, & Bradshaw, 2018). Mental health professionals increasingly are working alongside people in lived experience roles

in both clinical and academic settings. This further reinforces the requirement for EBE to be identified as the teachers of recovery (Byrne et al., 2015). Their identity as service users informs their professional values, ideas, research and practice (Fox, 2011). Lived experience workers face inadequate training, lack of role clarity and stigma, much of which may stem from health professionals' lack of education (Asad & Chreim, 2016). By teaching through and not about lived experience involvement, EBE will have a role in improving the acceptance and integration of lived experience roles into inter-professional teams.

An important component of EBE teaching was informing students that mental health issues are not confined to mental health services and these skills are relevant in all areas of the health care sector. Given the prevalence of mental illness and mental distress is higher in health services than the general population, (Bahorik, Satre, Kline-Simon, Weisner, & Campbell, 2017; Garrido et al., 2017; Giandinoto & Edward, 2015; Jayatilleke, Hayes, Chang, & Stewart, 2018) this is salient. People diagnosed with mental illness are more likely to access services for physical health problems, therefore skills in managing mental distress are crucially important for ultimate health and wellbeing (Graham et al., 2017; Happell, Galletly, et al., 2015; Lee, Black, & Held, 2016; Wolff, Heister, Normann, & Kaier, 2018).

An outcome of emphasising the importance of mental health in all health care settings was encouraging an interest in mental health nursing as a potential career path. This extends the findings of previous research showing that few nurses enter nursing programs with a desire to pursue this field after graduation (Bingham & O'Brien, 2018; Happell, Platania-Phung, Harris, & Bradshaw, 2014; Ong et al., 2017; Stevens, Browne, & Graham, 2013; Thongpriwan et al., 2015). Positively influencing these attitudes is crucial to attract sufficient numbers into mental health and secure an adequately motivated and skilled workforce

(Butryn, Bryant, Marchionni, & Sholevar, 2017; Lahti et al., 2018; Office of the Nursing and Midwifery Services Director, 2012; World Health Organisation, 2013).

While the research evidence for the impact of EBE in mental health education is promising and developing, most research to date has examined the subject from the perspectives of students and academics from the health professions. Fewer than half of the studies cited in this paper indicated identifiable EBE involvement in designing, conducting or disseminating the research. Acknowledging the unique knowledge and expertise EBE bring to mental health education requires including them as partners in the coproduction of EBE roles and their evaluation, and logically extends to their active involvement in academic research in this area. Future research agendas must also focus on the experiences, perspectives and opinions of EBE gained through their pioneering involvement in the implementation and development of these important roles.

What the study adds to existing knowledge

EBE involvement in mental health education has demonstrated positive outcomes across a broad range of disciplines (Geregová & Frišaufová, 2019; Gordon et al., 2020; Happell, Platania-Phung, et al., 2019). To date most research has explored the perspectives of students and academics from the health professions (Horgan et al., 2020; Stacey & Pearson, 2018). The limited research utilising EBE as participants has primarily focused on the experience of the role which has generally been rated positively (Happell, Bocking, Scholz, & Platania - Phung, 2019; McKeown et al., 2012; Prytherch et al., 2018; Speers & Lathlean, 2015). This process was considered as effective in reducing stigma and encouraging students to see service users as people rather than diagnoses (Bocking et al., 2019). The need for greater support in the role was specifically

mentioned in one study (Prytherch et al., 2018). While this literature describes creating change, it does not address the specific contribution of EBEs that create this change. For EBE to be recognised as valuable and credible members of mental health academic teams the ability to understand and articulate this uniqueness is crucial (Jones & Pietilä, 2020; Winn & Lindqvist, 2019). A strength of the current study is co-production. Given other research has no apparent (Prytherch et al., 2018; Speers & Lathlean, 2015) or limited service user involvement (Happell, Bennetts, et al., 2019; McKeown et al., 2012), the conduct and focus of the research may not adequately reflect what service users consider important and may have failed to capture vital information. The collaboration between nurse academics and EBE is likely to have strengthened the relevance and authenticity of these findings.

Implications for mental health nursing education

EBE make a significant contribution to mental health nursing education. EBE convey to students their perspectives on the valued elements of practice (Horgan et al., 2021; Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2013), promote awareness of the gap between theory and real world practice (Happell et al., 2020; Thomson & Hilton, 2012), and help clarify how services can be improved (Khoo, McVicar, & Brandon, 2009). These learnings arguably contribute to students' developing a critical understanding of mental health nursing education (Hughes, 2017; Tanner et al., 2015) and increase their confidence in promoting service user rights (Felton et al., 2018; McCusker, MacIntyre, Stewart, & Jackson, 2012). As a result they are likely to adopt more positive attitudes to working with people diagnosed with mental illness (Geregová & Frišaufová, 2019; Sandhu, 2017; Unwin et al., 2017). By understanding the unique knowledge and expertise EBE bring to nursing education, students may be

influenced to recognise them as legitimate members of the teaching and broader mental health service teams.

Strengths and limitations

A strength of this study reflects its international focus. This is the first known study to conduct a multi-site evaluation across six countries which contributes to the international relevance of the findings. The greatest strength is derived from the co-production philosophy underpinning the project. This approach enabled EBE to take a partnership role in the evaluation process. Their voices and perspectives were reflected in the design of the evaluation, including, importantly, the data analysis process. It is also important to acknowledge the limitations. Due to the size and scope of the project, only 14 participants were involved in this project, meaning it is difficult to determine the extent to which their experiences and perspectives would reflect those of other EBE in the same or different settings.

CONCLUSIONS

As mental health services adopt the stronger recover-oriented focus they strive for, there will be an increased reliance and likely expansion of the lived experience workforce. The success or otherwise of this fundamental shift will depend at least in part on the attitudes of nurses and other health professionals, and their willingness to embrace their lived experience colleagues. Meaningful involvement of EBE in the education of health professionals from the outset is a clear, evidence-based strategy to reduce stigma and enhance professional

respect for the unique knowledge and expertise EBE bring and how it can be used to improve service delivery and promote a genuine recovery approach. EBE don't only teach recovery, they demonstrate recovery. Expanding the number of EBE involved in mental health education and expanding the scope of their roles is the challenge for the future.

Table 1 – Expert by Experience participants by country

Country	Number of EBE	Females	Males
Australia	1	1	0
Finland	2	1	1
Iceland	2	1	1
Ireland	3	2	1
Norway	3	2	1
The Netherlands	3	1	2
Total	14	8	6

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