A Critical Look at Participation of Persons with Mental Health Problems in Training Mental Health Professionals within University Education

Annette Lane, Jeannette Waegemakers Schiff, Esther Suter, and Nancy Marlett

Abstract

Involvement of persons with mental health disorders, with or without addictions (persons with MHA), within mental health education is becoming more common in some parts of the western world, in particular, the United Kingdom. What does involving persons with MHA entail and what are the benefits and challenges in involving these individuals in education? In this paper, we take a critical look at involvement of persons with MHA within the literature and provide a case study of a Canadian inter-professional mental health and addictions course where persons with MHA were included in some aspects of teaching. We present the evaluation of the course, and offer implications for involvement of persons with MHA in university courses.

Keywords: mental health and addictions education, inter-professional education, persons with mental health disorders and addictions

Introduction

Inclusion of persons with mental health disorders, with or without addictions (persons with MHA), as full participants in the education of future helping professionals is becoming recognized as an important facet in university education.[1] The emphasis on involving persons with MHA is situated within contrasting discourses: professionals as experts in the care of mentally ill individuals versus persons with MHA as experts in their experiences and what is most helpful for them (Livingston & Cooper, 2004). This pedagogical approach extends beyond the “practice patients”

[1] The term "persons with MHA" was deliberately chosen for the following reasons: 1) within Canada, this term is preferable over the term "mental health consumers"; 2) this term includes individuals with mental illness and individuals with co-existing addictions.

used in medicine for the education of future physicians – education that is often focused on diagnosis and treatment and not on the interactive elements of the patient experience. Rapidly evolving into a model of education, it stretches beyond persons with MHA providing testimonials within university classrooms about their experiences with a particular illness. Such a model engages persons with MHA in course development and delivery, including working with students on classroom presentations or in group work, as well as final course evaluation (Barnes, Carpenter, & Bailey, 2000). This model respects the voice and rights of persons with MHA and their families and is an efficacious way of educating future professionals to care for the mentally ill.

In this article, we take a critical look at the involvement of persons with MHA in inter-professional mental health and addictions education. We first examine how the involvement of persons with MHA in mental health and addictions education is conceptualized and put into practice within the literature and research. We then situate our experiences and results of teaching an inter-professional mental health and addictions course with what is reported in the research. Finally, we discuss the benefits and difficulties that arose from strong participation of persons with MHA within this course, and implications for future involvement in inter-professional mental health and addictions education are discussed.

A review of the literature

In order to situate our experiences in involving persons with MHA in an inter-professional mental health and addictions course within a broader context, we conducted a literature search accessing four databases (Social Work Abstracts, PsycINFO, CINAHL, MEDLINE). Since inter-professional education is a relatively recent phenomenon in the literature, the search was limited to the years 1999-2009, using the following search terms: consumer participation, mental health, and students. We then ran the same search but substituted the term “addictions” and “substance abuse” in place of “mental health”. The search yielded 26 relevant articles/studies.

The results of this search revealed that the practice of involving persons with MHA in university education varies significantly according to geographical location. For instance, a large portion of literature on participation of persons with MHA within mental health education comes out of the United Kingdom. This is due, in part, to legislation mandating involvement of those utilizing mental health services in training of practitioners. Further, geographical location influences what term is used to describe participation of persons with MHA. Within the UK, the term

"service user" is employed to refer to various degrees of participation by persons with MHA in undergraduate or graduate education (Felton & Stickley, 2004; Forrest, Risk, Masters, & Brown, 2000; Khoo, McVicar, & Brandon, 2004; Lammers & Happell, 2003; Lathlean et al., 2006; Masters, et al., 2002; Townend, Tew, Grant, & Repper, 2008). In the United States the term mental health consumer is most often preferred.

The degree or depth of participation of persons with MHA varies across studies. While involvement of persons with MHA is most often within the university classroom, participation can also be seen in curriculum planning (Jordan, Philpin, Davies, & Andrade, 2000), course delivery and evaluation (Barnes, Carpenter, & Dickinson, 2006), or in the institution of a faculty in an academic consumer position (Happell, Pinikahana & Roper, 2003). Lastly, acceptance towards participation of persons with MHA within the education process differs according to profession. Most frequently, persons with MHA are involved in nursing (Bennett & Baikie, 2003; Forrest et al., 2000; Frisby, 2001; Happell et al.,, 2003; Khoo et al., 2004; Lathlean et al., 2006; Masters et al., 2002; McAndrew & Samociuk, 2003; Rush & Barker, 2006; Wood & Wilson-Barnett, 1999) or social work education (Scheyett & Kim, 2004; Taylor & Le Riche, 2006), and somewhat less frequently in medicine (Butterworth & Livingston, 1999; Campbell, 2001; Ikkos, 2003; Walters, Buszewicz, Russell, & Humphrey, 2003) and psychology (Townend et al., 2008).

Usually, participation of persons with MHA was presented within the auspices of a single discipline, such as nursing or social work, rather than within an interdisciplinary context. A notable exception is the work of Barnes and colleagues. They report on the development and evaluation of a two-year, part time, post licensing inter-professional mental health education program with involvement of persons with MHA at all levels (Barnes, et al., 2000; Barnes, et al., 2006). The degree of participation of persons with MHA is not clear in the initial reporting of the program (Barnes et al., 2000), as this entails an overview of the program and hence does not offer much detail about the extent of involvement. The 5-year evaluation report (Barnes et al., 2006) describes student responses toward participation of persons with MHA in their education. Some students reported that these individuals had a beneficial effect upon learning, while others stated that they did not feel free to challenge their views or were worried about saying something that might upset the mentally ill participants. Based on the evaluation of this program, it appears the educational focus was on developing provider skills in service delivery rather than the interactive component of treatment teams that are a hallmark of inter-professional care (Suter, Arndt, Arthur, Parboosingh, Taylor, & Deutschlander, 2009).

The argument for and against consumer involvement

Arguments have been made in the literature for and against using persons with MHA within mental health education. Involving these individuals in educating future mental health workers has significant benefits for persons with MHA: it gives them a voice, empowers them and raises their self esteem by giving them an opportunity to speak to the experiences of mental illness and teach future professionals (Masters et al., 2002). From the student perspective, those exposed to persons with MHA in their education see the human face within mental illnesses. This increases reflective learning in students and removes some of the hierarchy between professionals and those with mental illness (Barnes, et al. 2006; Rush & Barker, 2006). It also allows students to appreciate the multiple perspectives in human experience and the critical importance of engaging persons with MHA in the therapeutic process.

In contrast, some contend that persons with MHA involved in mental health education constitute an "elite" group, not truly representative of those who suffer from severe mental illnesses (Felton & Stickley, 2004; Forrest et al., 2000). Involving persons with MHA in all aspects of the educational process - planning, delivery and evaluation – also raises questions about compensation and education standards. For example, how are the standards of mental health content and communication skills assured (Livingston & Cooper, 2004), or how do we deal with person with MHA that use the classroom setting as a "soapbox" for their issues and agenda? Professors teaching courses that are "driven" by persons with MHA struggle with a lack of full ownership of a course/workshop (Masters et al., 2002) and students have reported feeling inhibited to challenge or criticize issues when persons with MHA are in their midst (Barnes et al., 2006).

Gaps in the current literature/research

We found that research exploring the involvement of persons with MHA in mental health education focuses mainly on perceptions and experiences of students (Happell et al., 2003; Ikkos, 2003; Khoo et al., 2004; Rush & Barker, 2006; Scheyett & Kim, 2004) and persons with MHA (Jordan et al., 2000), and lecturers (Felton & Stickley, 2004). There is limited research examining the impact of persons with MHA participation on students' learning, knowledge and practice (Morgan & Jones, 2009). Furthermore, an emphasis on participation of persons with MHA usually occurs within the context of mental health education, rather than mental health and addictions education as co-occurring disorders. This is a significant omission given the prevalence of co-occurring disorders

(Drake & Wallach, 2000) and the treatment challenges they pose. Lastly, there is a dearth of research that examines the participation of persons with MHA within an inter-professional education context.

Integrating consumers into an inter-professional mental health and addictions course[2]

The University of Calgary Division of Health Sciences launched an inter-professional mental health and addictions initiative that will result in a certificate and a diploma in this area. The goal of this program is to offer a more comprehensive and practice-relevant preparation for students entering the mental health and addictions field. Foundational to the curriculum is an inter-professional focus that follows a model of multiple instructors from different disciplines co-instructing within a class at all times, with the overlay of persons with MHA as co-educators in the planning and delivery of course material. The course is open to students from a number of faculties and departments (social work, nursing, educational psychology, and community rehabilitation) to promote collaboration and inter-professional learning. The program and the foundational course are described below.

The program

A mental health and addictions task force comprised of University of Calgary academics from various professions and professionals/ administrators from the regional health authority (Calgary Health Region, now Alberta Health Services, Calgary zone) was charged with developing an education program that would better prepare health sciences students for a career in mental health and addictions. The task force identified the following key challenges: the lack of educational offerings in mental health and addictions as co-occurring disorders and the lack of opportunity for students to experience dialogue with future colleagues from other professions. A plan emerged to develop a post-baccalaureate certificate and to initiate this with an introductory course that could be taken at the senior undergraduate or junior graduate level. The first course, which we describe in further detail below, is foundational for this mental health and addictions certificate program. Future plans include expansion to a diploma level program and will include a focus on

[2] Within this paper, there is a strong emphasis on the mental health component of this course. This is intentional as this foundational course forefronts mental illness with addictions in the background.

specialized interventions, as well as an inter-professional practicum experience.

The course

The first inter-professional mental health and addictions course was offered one year ago. The instructors used an inquiry-based format to both promote and facilitate significant student engagement. Students from faculties and departments that are health- or helping- related (nursing, social work, psychology, educational psychology and community rehabilitation and disability studies) - both undergraduate and graduate - formed inter-professional groups. These groups, with instructor assistance, contacted a person with MHA (or a family member of a person with MHA) with diagnoses such as depression, psychosis, anxiety and post-traumatic stress disorder (PTSD). The group then worked with the person with MHA (or family member) on designing the content of the material that was to be presented as an important component of the instructional time within each class. Students and persons with MHA decided on the presentation style most salient to the material. Each group designated a member to call a person with MHA, or a family member (pre-screened by a course instructor), to discuss how to run the class and the role of that individual in the class. Prescreening of persons with MHA was done to ensure that the individuals were articulate, able to engage in what could be an intimidating process, and comfortable with the educational format. It also allowed instructors to establish an egalitarian and collegial orientation to their participation. In some classes, persons with MHA or their family members "ran the show"; at other times, they shared the presentation with students or professionals. Persons with MHA not only presented their experiences, they became part of the inter-professional discussions groups, answered questions and discussed their ideas. These individuals were brought into the class for the entire instructional time and were fully integrated into in-depth discussions at all levels.

Inter-professional groups (and sometimes persons with MHA or family members) worked on case studies of individuals experiencing specific mental health and/or addiction issues. Case studies included a young adult with a psychotic break (diagnosed with schizophrenia), a middle-aged woman with depression, an individual with Posttraumatic Stress Disorder (PTSD) and an older adult with an addiction to benzodiazepines and beginning signs of dementia. The three course instructors - representing nursing, social work, and community rehabilitation and disability studies - were in the classroom simultaneously. This allowed for modeling of inter-professional discourse

among the trio, opportunities for students to experience how differences among the instructors were handled (open modeling), and how instructors interacted with persons with MHA in a recovery-oriented framework. Thus, students were exposed to participation of persons with MHA in classroom education to prepare them as future mental health professionals, inter-professional practice modeling, interaction with mentally ill individuals in recovery, as well as content in this area. The high focus on process and teamwork was designed to help the students develop skills in dealing with multiple disciplines in small groups.

Evaluation of the Course

As we considered the first iteration of an inter-professional mental health and addictions course unique in content, organization and delivery, we believed it was important to evaluate its impact and effectiveness. Evaluation for research purposes was sanctioned by the Conjoint Faculties Research Ethics Board (CFREB). The evaluation had several components. At the beginning of the first class (pre-test) and during the final class (post-test), students completed a 50-item questionnaire that evaluated knowledge and attitudes regarding clinical knowledge, legalities/policies, and inter-professional practice (see Appendix 1). Students were advised that the testing was for course evaluation and had no bearing on their grades. Twenty seven students completed the pre-test and 22 completed the post-test.

All students were invited to participate in a focus group held four months after the course finished to discuss their course experiences and provide feedback on areas for improvement. This group was led by two investigators who were not course instructors. Group transcripts eliminated all student-identifying material. One student was unavailable for the focus group and met individually with an investigator. The time frame was intentional to allow students to integrate material and critically reflect on their course experiences. We hoped to avoid a "halo effect" by allowing for some passage of time. However, in this time period, several students had completed their studies and were no longer available for the discussion group. In total, 6 students participated out of a total number of 20 course participants (30%; four students were no longer available to participate). Participants in the interview and focus group represented three different professions. The interview questions focused on motivation for taking the course, format of the course and impact of the course (see Appendix 2). As there were relatively few students participating in the focus groups, results need to be interpreted with caution.

Impact of course

Although this course involved several unique features – inter-professional context, mixture of undergraduate and graduate students - the students experienced the participation of persons with MHA as having the greatest impact on their learning. Their comments about the impact of these individuals reveal the depth of their affective learning experience, the length of the impact of learning, and how involvement of persons with MHA in group work revealed differences in disciplinary discourses.

Depth of affective learning

Students described the depth of learning that occurred through the participation of persons with MHA as stronger than learning through didactic means. The involvement of persons with MHA went beyond listening to facts offered by an instructor and became experiential. Learning tapped into students' emotions and took on a visceral quality. One student noted:

> *Hearing someone's lived experience. You know, really connecting with someone. You can read it in a textbook and you can synthesize information from a lecture, but it's not until you actually sit down with that person and see them and they're crying in front of you. And you're almost crying with them because it's so moving.*

Another student commented on how her learning was expanded through the involvement of persons with MHA, taking on a "feeling" component.

> *I really enjoyed that aspect of the course. I think everything got a fuller picture of what it means to be living with some of these conditions and fully understand or better understand the impact on families' lives. I have a better feeling for the situation.*

Nursing students and some social work students had already worked with persons with MHA within clinical settings in their undergraduate education. For other students from social work, community rehabilitation and disability studies and psychology, this was a new experience. Even some with prior clinical contact indicated that the in-depth and personal stories of the persons with MHA were well beyond anything that they had experienced in a practice setting. This course, albeit not a clinical course, took on a component of clinical education, as students needed to interact

with individuals impacted by mental illness and addictions in a meaningful and professional manner.

Although the strong affective response to the participation of persons with MHA was usually positive, there were a few instances when students – themselves suffering from mental illness – were traumatized by the stories of the invited persons with MHA or their families. For some of them the experience was overwhelming and they had difficulty completing the requisite course assignments. This became problematic as these students were part of inter-professional groups that relied upon them to complete specific aspects of group assignments. This led to conflict amongst group members when the affected students could not "pull their weight".

While the depth of affective learning was impressive, the improvement between the pre- and post-test scores was less so. For instance, on the pre-test, students scored 70% correct on the clinical questions. On the post-tests, the number of correct responses rose to 76%. Although this is a 6% increase, it barely achieves a 0.05 significance level, and more importantly, the increase was not as high as we had hoped. Perhaps even more disconcerting were the results of the questions that targeted legal/policy issues. On the pre-tests, students chose correct answers 55% of the time. On the post-tests, however, the correct response rates had dropped to 45%. This is a significant drop in correct answers, suggesting that students may have become increasingly confused about legalities/policies that guide mental health care. We hypothesize that this drop may have occurred as students listened to the stories and experiences of persons with MHA. An understanding of legalities surrounding mental health care may be based solely upon their experiences as persons with MHA, and may not be representative of actual policies and laws. Because affective learning is so powerful, students may have assumed that their (persons with MHA) understanding of legalities was commensurate with the law, rather than researching policies/laws themselves.

Length of impact of learning experiences

Not only did active involvement of persons with MHA tap into the affective component of the learning and hence exert a large impact on students, it also stretched the length of the impact. This impact lasted months after the class had ended.

> *I really liked having the consumers involved. It just seemed to make the learning more exciting because it was very real and the people were right in front of us and interacting with them and interacting with the real people. And it just made it seem more - I don't know*

> *what the word is - solidified. You remembered. When I think back, I can remember that whole course a lot better than just a typical where you sit in a classroom. No, I thought it was great.*

This student seemed to suggest that the learning lasted longer because it involved "real people." The presence of "real people" added an affective component to learning - "exciting" - and "solidified" the learning. The use of the word "solidified" seems to suggest that participation of persons with MHA resulted in a consolidation of the student's learning.

Interestingly, the student moves from speaking about "consumers" to "people" to "interacting with real people." This shift in conceptualizing persons with MHA from "consumers" to "real people", we believe, is crucial for human service professionals to deliver compassionate and competent care. Indeed, research examining patients' impressions of the work of mental health nurses suggests that the relationship or connection with mental health nurses is the most therapeutic aspect of their treatment (Horberg, Brunt, & Axelsson, 2004; Lowenburg, 2003).

Revealing disciplinary discourses

By discussing issues related to mental illness with colleagues and persons with MHA or their family members within their small groups, students became more familiar with how varied professions approach work with clients and the disciplinary discourses that underlie these approaches.

> *What I found interesting was when our individual groups actually sat down with some of the consumers. The questions that were being asked from each of the group members, you could see came from community rehab or social work or nursing perspective. Although the consumer wouldn't have necessarily known that, but for me, that was an interesting learning.*

Although students were focused upon the persons with MHA and their stories, a secondary learning occurred. By interacting with the person with MHA in a small group, the students unwittingly observed disciplinary differences, the focus of varied disciplines and how professions conceptualize issues such as rights and autonomy. Understanding how professionals conceptualize and argue for specific approaches on behalf of persons with MHA is important; it raises the argument beyond individual differences to situating those differences within disciplinary discourses.

While observing colleagues from other professions interact with persons with MHA was obviously instructional, we were somewhat

surprised by the results of questions on the pre- and post-tests that examined inter-professional practice. Similar to the results from the clinical questions, students scored correctly on 70% of the questions on the pre-test. On the post-test, the increase in correct answers was 8%. Again, while this result is significant, it is barely relevant. We suspect that this relatively small improvement is related to the questions on the pre and post-tests which might have been too easy or failed to tap into "meaty" inter-professional concepts.

Discussion

Involvement of persons with MHA in the inter-professional mental health and addictions course

The impact of persons with MHA within this course was poignant and moving. Students witnessed firsthand the humanity and courage of the consumers and were inspired by their lives. Students reported that this experience with persons or family members with MHA will impact their future encounters and work with mentally ill individuals. The instructors were moved by the impact that persons with MHA had on the students and felt that their effect on students' affective learning was an important aspect of this course. The authors feel strongly that participation of persons with MHA in this course set it apart from the standard course within our educational setting. However, we struggled to make sense of the disparity between the powerful impact of affective learning and the comparatively small impact on content learning and wondered how a better balance could be achieved. In initial reflection upon the first iteration of this course, we hypothesized that the course was too "packed" with case studies and assignments, limiting the amount of class time to be spent on imparting content didactically.

Upon further reflection, however, we wonder if student learning was stronger than first acknowledged, but that our pre- and post-test questions did not accurately reflect learning that took place. In light of the discrepancy between affective and content learning, the second iteration of this course saw a decrease in number of case studies from four to three. This may allow students to work at a less frantic pace and give instructors the opportunity to debrief the involvement of persons with MHA with students, present content, and help students process the discrepancies between shared experiences and content that is stipulated by the law and health policies. We may also need to change the pre- and post-questionnaires.

We also struggled with mediating the responses of students towards student group members who were experiencing increased symptoms of

mental illness triggered by the stories of persons with MHA. While we recognize that this triggering is a possibility inherent in a topic such as mental illness and addictions, the presence and interaction with persons with lived MHA experiences makes it more difficult for students to avoid the emotional impact of their own experiences through escape into a strictly cognitive discourse. This triggering may necessitate greater flexibility on the part of the instructor. The importance of allowing extra time on assignments for these students needed to be balanced with the needs of group members who were concerned about the impact of unfinished work on their group projects and consequently on grades received for a group project. Balancing individual student performance with the need to participate in and learn group and inter-professional skills will, we suspect, be a recurrent theme in this type of course. We suggest that future iterations of this or similar courses present a balance of individual and group assignments, with students encouraged to address issues as part of the inter-professional practice experience. This may help lessen the strong responses of students toward their emotionally fragile colleagues, as their grades will not be affected as much by their colleagues' work.

Furthermore, in future iterations of this course, we will highlight in the first class that emotional reactions may occur, especially for those students with mental illness. We will suggest that students who anticipate emotional responses during the course contact the university disability resource centre in order to receive authorization for extra time to complete assignments. These students can also be encouraged to seek out the university counseling centre.

Summary

Our experiences with involving persons with MHA within the classroom, as well as the results of our evaluation have convinced us of the importance of this kind of educational model. However, we recognize the importance of balancing the participation of persons with MHA with didactic content that is delivered by course professors, and time for debriefing. In order to achieve a balance, we will need to reduce the number of case studies and assignments. As certificate and eventually diploma programs unfold, we plan to build in evaluation that includes students' knowledge and impact of knowledge on professional practice. This responds to a call in the literature to go beyond research that examines "attitudes" and "experiences". We will further evaluate the impact upon persons with MHA, as well as the overall effectiveness of the program.

If we are able to develop a group of persons with MHA that participate regularly within specific courses, we will likely offer training workshops for them that will address relevant aspects of teaching and working with students. This may help reduce "stage fright" in some persons with MHA and assist them in feeling more confident and prepared to work within classroom settings. We may also need to consider the issue of remuneration. While it is presumed that many persons with MHA participate in mental health education due to altruistic motives, this may not always be the case. As involvement of persons with MHA becomes more frequent within educational institutions, educators will need to grapple with institutional standards and ethical responsibilities to financially reward the work of those who play an integral part in program development, delivery and evaluation.

Conclusions

Persons with MHA and their family members exert an important and powerful effect upon the educational experiences of future helping professionals. However, as noted in the literature and confirmed by our experiences, participation of persons with MHA needs to be carefully and thoughtfully planned and integrated into mental health education. Such planning and integration will provide educational and emotional support to persons with MHA involved in the classroom, as well as emotional support to students processing the often tragic stories of these individuals. Further, significant involvement of persons with MHA in all aspects of mental health courses - planning, delivery and evaluation - will necessitate building in institutional capacity to remunerate these individuals financially and to support their learning needs.

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Authors' notes

Annette Lane, RN, PhD, is an Assistant Professor in the Faculty of Nursing at the University of Calgary. Address correspondence to alane@ucalgary.ca.

Jeannette Waegemakers Schiff, PhD., is an Associate Professor of Social Work at the University of Calgary.

Esther Suter, MSW, PhD, is a Research and Evaluations Consultant in the Health Systems and Workforce Research Unit with Alberta Health Services in Calgary.

Nancy Marlatt, PhD, is an Associate Professor in Community Rehabilitation and Disability Studies at the University of Calgary.

Appendix 1

Sample Questions from Pre/Post Tests (True/False)

Clinical Questions

People with mental illness are not more likely to commit acts of violence than other people.

Nicotine interferes with the effect of antipsychotic drugs.

Treating a person with mental health and addictive problems requires treating the mental illness first.

Detoxification can be a life-threatening situation.

Inter-professional Questions

Inter-professional collaboration requires more effort than independent practice.

Inter-professional collaboration always requires face-to-face interaction with all members of the team.

There are clear boundaries between professional responsibilities.

Legal/Policy Questions

All information about a person with a psychiatric illness is privileged information under all circumstances.

Emergency commitment is usually limited to seven days.

Privacy laws inhibit family members from being involved in the care of a family member.

Mental health professionals must have written permission to talk directly with family members.

Appendix 2

Focus Group Questions

Student motivation

What was your motivation for taking this course?

Specific perspectives they wanted to gain?

Expectations at the beginning of course

Have expectations been met?

Format of course

How was it to learn from consumers/engage with consumers throughout the course?

How was this course different from other mental health/addictions courses you might have taken?

What were the things that stood out? Things that were not good/missing?

How did the co-teaching work for you?

How well did the instructors role model the IP philosophy of the course?

How was the group work?

How would you change the course if we offer it again?

Impact of course

What kind of difference did the course make for you? Attitude, knowledge, skills, behaviour

How did the course (if at all) change your perception of mental health/addiction treatment approaches, the way you view other providers, contributions/roles of other professions?

Were there any real AHA moments?

How has the course added to your preparation for practice in Mental Health & Addictions settings?

How will the course change the way you practice?