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Mental health consumer involvement in occupational therapy education in Australia and Aotearoa New Zealand

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TITLE

Mental health consumer involvement in occupational therapy education in Australia and

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RUNNING HEAD

Consumer involvement in education

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Mental health consumer involvement in occupational therapy education in Australia and Aotearoa New Zealand

ABSTRACT

Introduction: Recovery oriented practice policies and occupational therapy education accreditation standards require that consumers are engaged in the design, delivery and evaluation of curricula. This consumer involvement (sometimes referred to as service-user involvement or patient involvement in other contexts) should go beyond consumers simply "telling their stories" to more meaningful collaboration in curricula. This study was designed to map the current patterns of consumer involvement in occupational therapy programs across Australia and Aotearoa New Zealand.

Method: A survey was distributed to all occupational therapy programs across Australia and Aotearoa New Zealand. The survey included questions related to: (i) perceived enablers and barriers to consumer involvement in education; (ii) organisational structures and support; (iii) ways in which consumer are involved in the design, delivery and evaluation of curricula; (iv) access to remuneration for consumers; (v) overall ratings of the level of consumer involvement in curricula; and (vi) academic confidence in working with consumers.

Results: Usable responses were received for 23 programs from 19 universities (83% response rate). Every program reported some consumer involvement in the curriculum. Consumer participation tended to be mainly focused on curriculum delivery with less frequent involvement in curriculum design or evaluation. The most common barrier to consumer involvement in curricula was "funding / remuneration for consumers" and the most common enabler of consumer involvement was "positive attitudes of teaching staff".

Conclusion: In comparison to previous reports, consumer involvement in occupational therapy curricula has increased over the past decade. However, ongoing effort is required to

support true collaboration in all aspects of curriculum design, delivery and evaluation. While

this will require attention and effort from academic teams, changes at a university level to

establish systems to engage and effectively remunerate consumers for their involvement

(especially in design and evaluation elements) are also required.

KEYWORDS:

Occupational therapy education

Consumer

Service user

Co-design

Mental health consumer involvement in occupational therapy education in Australia and Aotearoa New Zealand

INTRODUCTION

There is a strong drive for re-orienting Australian and Aotearoa New Zealand mental health services to embrace principles of recovery (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission, 2001). Within this recovery-oriented framework, health professionals work in partnership with consumers (individuals who receive mental health services), recognising consumers as experts on their own needs and the processes of setting and striving toward personally defined goals (Australian Health Ministers' Advisory Council, 2013). Occupational therapy competency standards (Occupational Therapy Board of Australia, 2018; Occupational Therapy Board of New Zealand, 2015b) also mandate that occupational therapists develop and maintain collaborative relationships with consumers by recognising and managing inherent power imbalances, a core tenet of recovery-oriented practice.

Meaningful consumer involvement in the implementation and evaluation of services is central to recovery-oriented practice (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission, 2001). The unique perspective of consumers into service delivery can support several outcomes: (i) services that effectively target consumer needs; (ii) upholding basic human rights that allow for choice and control; and (iii) increased consumer involvement in decision-making with the likelihood of achieving positive health benefits and reaching more meaningful goals (New Zealand Ministry of Health, 1995). These policy drivers make it clear that occupational therapists must have well-developed skills to establish genuinely collaborative relationships with consumers of mental health services.

Mental health consumer involvement in health professional education

The growth in consumer participation in mental health services is increasingly mirrored in university health professional education. In 1999, an audit of consumer participation in the education and training of the five major clinical disciplines involved in mental health in Australia (medicine, nursing, occupational therapy, psychology and social work) revealed minimal consumer participation across all disciplines (Deakin Human Services Australia, 1999). Subsequent reviews of mental health curricula in Australian nursing and occupational therapy completed a decade later found limited consumer participation, mostly in the form of guest lectures (McCann, Moxham, Usher, Crookes, & Farrell, 2009; OT Australia, 2008). Significant expansion of consumer participation in nursing education in Australia has since been reported, with the establishment of consumer academic roles in three post-graduate programs, and 78% of all pre-registration nursing programs reporting consumer involvement (Happell et al., 2015). Internationally, research into consumer involvement in education for all mental health disciplines has also been increasing over recent years (Arblaster, Mackenzie, & Willis, 2015a; Happell et al., 2014; Irvine, Molyneux, & Gillman, 2015). Overall, this literature has suggested that consumer involvement in education has been improving. However, financial sustainability to support payment of consumers, lack of organisational supports and additional time required for collaboration have been identified as key barriers.

Greater attention to consumer involvement in mental health curricula in occupational therapy programs is also emerging. While other factors may be influencing this, inclusion of mandates for consumer involvement in the design, delivery and evaluation of occupational therapy curricula in Australian (Occupational Therapy Council of Australia, 2018) and

Aotearoa New Zealand (Occupational Therapy Board of New Zealand, 2015a) course accreditation standards are likely to be key drivers. Notably, these standards require meaningful involvement of consumers that is not "tokenistic" and goes beyond consumers "telling their stories." In addition to satisfying these accreditation requirements, findings from the broader consumer engagement in education literature suggests that consumer input into occupational therapy education has the potential to support development of a range of attitudes and capabilities required for recovery oriented practice (Arblaster, Mackenzie, & Willis, 2015b). The modelling of collaborative engagement between consumer educators and other academic staff may serve to disconfirm stigmatised attitudes and pre-conceptions among students that consumers are unpredictable or incapable (Arblaster et al., 2015a; Happell et al., 2014). Furthermore, consumer involvement may support students' development of empathy and communication skills (Happell et al., 2014). It can promote understanding of recovery and how individuals create and live meaningful and contributing lives, even in the presence of ongoing symptoms (Arblaster et al., 2015a; Happell et al., 2014; Irvine et al., 2015). Consumer involvement may also support critical reflection on the enactment of "person-centred practice", challenging occupational therapy students to question their role as "expert" and its potential for undermining genuine collaboration (Whalley Hammell, 2015).

While consumer participation in health professional education has potential benefits, a range of barriers to meaningful consumer involvement in education programs have been identified. These include: attitudes of academics such as perceptions of consumers as unreliable or vulnerable; beliefs that consumers may use the opportunity to promote their own agenda; limited access to training and support to assist academics to effectively engage with consumer educators; lack of access to funding for remuneration of consumer involvement;

and a lack of university policies and systems to enable participation (Basset, Campbell, & Anderson, 2006; Happell et al., 2015). The lack of research evidence supporting the purported benefits of consumer involvement in education also presents barriers in terms of both what to do and how to do it, especially in occupational therapy education where there are only three published studies to guide practice (Cleminson & Moesby, 2013; Logan, Yule, Taylor, & Imms, 2018; Walsh, 2016). Evidence has emerged mainly from studies exploring student perceptions, addressing a limited range of outcomes with a focus on short term change, particularly in stigma and attitudes (Arblaster et al., 2015a; Terry, 2012). Importantly, there is no existing evidence supporting the effectiveness of consumer involvement in developing capabilities for recovery-oriented practice, or published outcome measures to evaluate student acquisition of such capabilities when learning from consumers (Arblaster et al., 2015a, 2015b). There is also no evidence to support the assumption that learning from consumers will positively influence practice in the long term (Arblaster et al., 2015b). The lack of direction from the evidence is compounded by the lack of any clear guidelines to guide consumer participation in health professional education (Deakin Human Services Australia, 1999; Happell et al., 2015).

A recent study found that Australian mental health consumers were ready, willing and able to participate in occupational therapy education (Arblaster et al., 2018). Their preferred modes of participation span design, delivery and evaluation of curricula and included: (i) participating in simulations, (ii) participating in advisory committees, (iii) teaching in the classroom, (iv) supporting curriculum design, (v) "telling my story", (vi) participating in program review committees, (vii) taking up full or part time academic roles, (viii) assessing student presentations, (ix) participating in research about mental health education in occupational therapy, and (x) marking (Arblaster et al., 2018).

Several models have been developed to represent the spectrum of consumer participation in education including the "Ladder of Involvement" (Tew, Gell, & Foster, 2004) and the "Spectrum of Participation" (Martin & Mahboub, nd). These models show a range of consumer participation: from no involvement and "tokenistic" involvement through to more meaningful involvement at the level of partnership and co-production. Partnership and co-production approaches are seen as optimal and involve educators and consumers working as equal partners to design, deliver and evaluate the curriculum. This means payment at the industry standard for educators, equal decision making and explicit agreements on values and working arrangements that respect both professional and lived experience knowledge, roles and contributions (Dorozenko, Ridley, Martin, & Mahboub, 2016; Martin & Mahboub, nd; Tew et al., 2004). Within these models, consumer involvement that only involves "telling their story" is classified at the lower end of participation. This is because consumers may still be seen as "others" in the process, presentations may be seen as tokenistic, optional "add-ons" or an avenue for voyeurism and potential gains in terms of increased empathy in students may be restricted to the individual educator, or short lived (Irvine et al., 2015; Meehan & Glover, 2007).

Aims

Before working to improve the capacity of entry level occupational therapy programs to meet accreditation requirements and industry expectations, it is important to establish the current status of consumer involvement in mental health curricula, and the factors that support or impede this involvement.

The specific research questions guiding this study were: (1) In what ways are mental health consumers involved in the design, delivery and evaluation of occupational therapy curricula in universities in Australia and Aotearoa New Zealand? and (2) What are the enablers and barriers for occupational therapy educators to involving mental health consumers in their curricula?

METHOD

This study adopted a cross-sectional survey approach and was approved by The University of Sydney Human Research Ethics Committee (approval number 2018/654). Participants were provided with a Participant Information Statement and indicated their agreement to participate at the beginning of the survey.

Recruitment

Information about the study and an invitation to participate was sent to heads of occupational therapy programs via the Australian and New Zealand Council of Occupational Therapy Educators and via an established network of occupational therapy mental health academics. Participating programs were asked to identify one academic staff member with familiarity with the design, delivery and evaluation of the mental health components of the curriculum to complete the survey. Responses were collected and managed online using REDCap electronic data capture tools hosted at The University of Sydney (Harris et al., 2009).

Survey instrument

The survey instrument was purpose-designed for this study. To ensure comparability of responses, participants were asked to only report on consumer involvement during the period

from July 2017 to June 2018. The survey asked only about consumer participation in curricula (rather than incorporating both consumer and carer involvement). To ensure consistency, the following definitions of curriculum design, delivery and evaluation were provided to survey respondents: *Design* – A process of determining and aligning learning outcomes which then support the planning of student learning experiences and assessments (Fry, Ketteridge, & Marshall, 2009); *Delivery* – Teaching and learning activities and assessments undertaken by educators and students to support student achievement of the intended learning outcomes; and *Evaluation* – A multifaceted process involving the collection of information and data to determine the effectiveness of curriculum design and delivery.

A copy of the survey used in this study is provided as a supplementary, online only, file **<<**
insert link to supplementary file here >>. The survey included questions related to several different areas, as listed below.

Enablers and barriers

Participants reported, in free text responses, their perceived enablers and barriers to consumer involvement in the curriculum.

Organisational structures and support

This section included questions in relation to university and faculty or department policies and procedures requiring consumer involvement in curricula, perceived organisational commitment to consumer involvement in curricula and whether participants had access to a lived experience academic on staff (that is, an individual with lived experience of mental

illness and recovery who is employed to embed this expertise through experience into education and research) within their program.

Consumer involvement in design, delivery and evaluation of curriculum

These questions were related to specific ways in which consumers were involved in the design, delivery and evaluation of curricula. Activities listed in these questions were drawn from existing literature (e.g., Arblaster et al., 2015a; Happell et al., 2015). For the design and evaluation sections, participants were presented with a list of types of consumer involvement and asked to rate the amount of involvement in each type of activity on a 5-point scale (1, "not at all"; 2 "to a small degree"; 3, "to a moderate degree"; 4, "to a fairly substantial degree"; and 5, "to a very large degree"). For the section related to delivery of curricula, participants were requested to indicate whether each type of consumer contribution was included in their program ("yes" or "no") and then asked to provide a description of this involvement. Participants were also asked to indicate how they identified consumers who may be able to be involved in their program.

Access to remuneration for consumers

This section included six questions. These questions were related to how easy it was to access remuneration and whether this remuneration was adequate and appropriate in relation to consumer involvement in the design, delivery and evaluation of curricula.

Overall ratings of the level of consumer involvement

Initially, consumer involvement in design, delivery and evaluation were rated on a 7-point scale (with anchor points at: 1, "I think there should be far greater involvement"; 4, "I think that there is about the right amount of consumer involvement"; and 7, "I think there should be

far less involvement of consumers"). At the end of the survey, participants were asked to classify overall consumer participation, based on the "Ladder of involvement" (Tew et al., 2004) (from 1 "Curriculum designed, delivered and managed with no consumer involvement" through to 7 "Consumers involved as equal partners with academics in all aspects of curriculum").

Academic confidence in working with consumers in mental health curricula

Finally, participants rated their own level of confidence in working with consumers in the design, delivery and evaluation of curricula (rated on a 4-point scale: 1, "Not at all confident"; 2, "Somewhat confident"; 3, "Quite confident"; and 4, "Very confident").

Analysis

Quantitative data were analysed using descriptive statistics. As data were not normally distributed, non-parametric descriptive statistics of median and interquartile range were used. Drawing from principles of thematic analysis (Braun & Clarke, 2006) and summative content analysis (Hsieh & Shannon, 2005), free-text responses regarding enablers and barriers were initially grouped using an inductive approach. The first and second author independently coded responses and then these were compared. Discrepancies in coding were resolved through consensus-based discussions. Frequencies of the various types of enablers and barriers were then tabulated. This approach allowed respondents to self-identify relevant enablers and barriers without the restrictions of a pre-populated list, but also allowed for the determination of the most commonly-identified enablers and barriers.

RESULTS

Participating programs

Usable responses were received in relation to 23 programs from 19 universities (two universities provided responses for both undergraduate and graduate entry master programs and one university provided individual responses for each of its three campuses). Eight additional surveys were commenced, but discontinued before any usable data were recorded. At the time of data collection, there were 23 universities offering occupational therapy programs across Australia and Aotearoa New Zealand. This represented a response rate of 83% (19/23 universities) with a 100% response rate (2/2) from universities in Aotearoa New Zealand and 81% response rates (17/21) from universities in Australia. One response contained incomplete data, so numbers of responses for some questions was 22. Seventeen of the 23 responses (74%) related to undergraduate programs and the remaining six (26%) related to graduate entry master programs.

Enablers and barriers

Enablers and barriers to consumer involvement identified by participants are summarised in Table 1. The positive attitude of academic staff to consumer involvement was the most commonly reported enabler. Lack of sufficient funding was the most commonly identified barrier.

Organisational structures and support

At a university level, the majority of participants reported that there were no policies that required consumer participation in curricula (16/23, 70%) or they were unaware of such policies (5/23, 22%). Similar responses were recorded at a faculty or department level with 15 participants (65%) reporting that there were no such policies and an additional three (13%) reporting they were unaware of such policies. In terms of procedures being in place to make it easy to engage consumers in the mental health curricula, a slight majority of respondents

(12/23, 52%) reported this was "partially" the case and an additional two (9%) responded that these procedures were in place. When reporting on overall organisational commitment to consumer involvement in mental health curricula, median responses were 4 ("agree") on the 5-point Likert scale in the areas of "design" and "delivery" and 3 ("neutral") in the area of evaluation. Only two programs (9%) indicated that they had access to a lived experience academic.

Consumer involvement in design, delivery and evaluation of curriculum

Summaries of consumers' involvement in the design, delivery and evaluation of curricula are provided in Tables 2 and 3. Overall, consumers were more frequently involved in the design and delivery phases of curricula and less frequently involved in evaluation.

The most frequently-used strategies to identify consumers who could be involved in education were: Contacting consumers I have met through collaborative / co-designed projects in the past (11/22, 50%); Contacting consumer organisations (11/22, 50%); Contacting consumers who are known to my colleagues (10/22, 46%); Contacting health services to access their consumer / peer workers (9/22, 41%) and Continuing to engage consumers who have been involved in the program previously (9/22, 41%). Eight programs (36%) reported that they used processes to screen or evaluated the suitability of consumers to be involved in the mental health curricula. Half of these used informal discussions, two (25%) used interviews and the remaining two programs used a formal expression of interest and selection process or used recommendations from consumer groups.

Access to remuneration for consumers

The median ratings for "ease of access to funding" and "sufficiency of funding" were "disagree" in relation to consumer involvement in curriculum design and curriculum evaluation (e.g., respondents typically disagreed that it was easy to access remuneration and disagreed the remuneration was adequate and appropriate). In relation to consumer involvement in delivery of curriculum, the median rating for ease of access to funding was "agree" (i.e., agree it is easy to access funding) and the median rating for adequacy and appropriateness of funding was "neutral", although 36% (8/22) of responses indicated that funding was insufficient.

Overall ratings of the level of consumer involvement

Median ratings of consumer involvement in design, delivery and evaluation of the mental health curriculum were 2 on the 7 point scale (i.e., part way between the anchors of 1, "I think there should be far greater involvement of consumers in the mental health curriculum" and 4, "I think that there is about the right amount of consumer involvement in the mental health curriculum"). Five programs (22%) indicated a rating of 4 ("I think that there is about the right amount of consumer involvement in the mental health curriculum") for the elements of "design" and "delivery" and three (13%) rated at this level for "evaluation". No programs rated any element higher than 4, indicating that no programs were considered to have "too much" consumer involvement.

The median rating for overall level of consumer involvement was at the fifth "rung" of the seven "rung" ladder of involvement: "Consumers participate in some (one or two) or aspects of curriculum alongside academics. Examples include teaching in the classroom, developing learning and teaching resources, marking student work, curriculum review". Ten programs (46%) rated the overall level of consumer involvement at this "rung". Two programs (9%)

rated consumer involvement at sixth "rung" ("Consumers involved in elements of design, delivery and evaluation of curriculum, but academics make final decisions") and no programs rated consumer involvement at the highest "rung" on the ladder.

Academic confidence in working with consumers in mental health curricula

Median ratings of academics' confidence in working with consumers in mental health curricula were "quite confident" for both "design" and "delivery". For the element of "evaluation" the median rating for confidence was lower, at the mid-point between "somewhat confident" and "quite confident".

DISCUSSION

Results from this study provide a snapshot of consumer involvement in occupational therapy programs across Australia and Aotearoa New Zealand. This snapshot is useful for benchmarking across different programs as well as creating a baseline for evaluating improvements over time.

All respondents reported at least some participation of mental health consumers in their program. This represents a substantial improvement since the most recent review (OT Australia, 2008) where three out of 10 programs (30%) reported no involvement of consumers and a further two (20%) reported only occasional involvement. Additionally, the proportion of occupational therapy programs with consumer involvement is higher than was reported from a survey of pre-registration nursing programs in Australia in late 2013 (25/32, 78%) (Happell et al., 2015). To our knowledge, the present study is only the second (after Happell et al., 2015) to map consumer involvement in health professional curricula, so comparison with other professions is not possible.

While these results are promising in terms of the proportion of programs reporting consumer involvement, the scope of activities in which consumers are involved remains fairly limited, often restricted to consumers telling their stories only. While consumer narratives can be powerful, when presented in isolation, they may not be enough to challenge the dominant narratives of mental illness and may not shift students' thinking away from concepts of "professionals as experts" (Irvine et al., 2015; Meehan & Glover, 2007; Walsh, 2016; Whalley Hammell, 2015).

Where consumers were involved in the delivery of other content apart from their own stories (Table 4), these topics were generally aligned with mental health consumer priorities for recovery-oriented curricula (Arblaster et al., 2018). Academics seeking to further enhance consumers' involvement in occupational therapy curricula could work collaboratively with consumers and focus on the content areas highlighted by the Arblaster et al. (2018) study.

Notably, results from this study demonstrate that consumer involvement in curriculum design and curriculum evaluation is particularly limited. While consumer involvement in curriculum delivery is likely to have some, at least short term, benefits for students (Arblaster et al., 2015a; Happell et al., 2014), if participation is not embedded throughout the design, delivery and evaluation process, then consumer involvement may be perceived as an "add on" or "optional" component of curricula (Meehan & Glover, 2007). Many barriers to greater involvement of consumers in curriculum design and evaluation were identified. First amongst these was access to remuneration; the majority of respondents disagreed with the statement that it was "easy to access funding to support consumer involvement" for both curriculum design and evaluation. Other barriers included the lack of university policies and processes to

support consumer engagement, the time required to engage and work with consumers and difficulties in finding sufficiently qualified or experienced consumers to be involved. Lower levels of academic confidence in working with consumers in evaluation (as opposed to design and delivery) may also present a barrier to optimal involvement.

One of the most notable barriers to consumer engagement in education highlighted in previous literature has been negative attitudes of academics (Basset et al., 2006). Interestingly, this did not come up as a common issue in this study. Indeed, positive attitudes towards consumer involvement were commonly reported and almost all respondents felt that more consumer involvement in their curriculum was required. These positive results could be due to a number of factors. Firstly, negative attitudes towards consumer involvement could be perceived as "socially undesirable" by respondents, so may not have been reported, even if such views were held. Alternatively, this result could indicate that attitudes are shifting, perhaps partially due to the attention given to consumer involvement in accreditation requirements (Occupational Therapy Board of New Zealand, 2015a; Occupational Therapy Council of Australia, 2018). Additionally, it is possible that this result reflects that the professional values of occupational therapists may be more supportive of consumer involvement in education or could be the result of effective consumer lobbying or advocacy.

While the numerous barriers identified by respondents in the current study are consistent with those reported in previous literature, the existing literature also provides some examples of consumers being engaged in meaningful ways in a variety of health professional education programs. These innovations, described below, can provide practical ideas for educators wishing to enhance consumer participation in their curricula.

The Valuing Lived Experience Project (VLEP) (Dorozenko et al., 2016) has two components. First, a lived experience academic led the development of a unit of study designed to equip consumers for working in partnership with academics to participate in all aspects of teaching and learning (capacity building). Secondly, simulated learning resources (videos) of people with lived experience of mental distress and ill health talking about their experiences were co-designed and developed (curriculum design and delivery). Students who have learned from these lived experience educators report that their practice has been influenced by learning about recovery and critical thinking about psychiatric diagnosis, and that they now seek to privilege lived experience knowledge (Ridley, Martin, & Mahboub, 2017).

Establishing lived experience academic positions (consumers employed in formal, ongoing academic positions) is another strategy employed by a variety of health profession education programs across Australia. Three post-graduate nursing courses reported engaging lived experience academics (Happell et al., 2015). The VLEP program described above is also led by lived experience academics (Dorozenko et al., 2016) and provides input into both social work and occupational therapy curricula. Lived experience academics have the same levels of autonomy in unit coordination as other academics. In one example, a lived experience academic developed and taught a unit of study focused on recovery for mental health nursing practice (Byrne, Happell, Welch, & Moxham, 2013). Evaluation of this unit of study found that students developed enhanced understandings of recovery, holistic nursing care and partnership working (Byrne et al., 2013). Students also demonstrated greater improvement in attitudes towards consumer capacity for participation than those who completed a traditional mental health nursing practice unit (Byrne, Platania-Phung, Happell, Harris, & Bradshaw, 2014).

Another approach is to co-produce a mental health unit of study (Happell, Waks, et al., 2019). Evaluations of one co-production project indicated that students learnt the importance of person centred holistic care, are able to think critically about medical approaches, embrace recovery, and demonstrate more positive attitudes to mental health consumers and to mental health as a future career (Happell, Platania-Phung, et al., 2019; Happell, Waks, et al., 2019).

Other examples from the occupational therapy literature include engaging consumers as members of assessment panels for student vivas (Logan et al., 2018) and reflecting on the importance of acknowledging power and dominant narratives in mental health education ensure that consumers' stories of mental distress and recovery have a transformational effect on student attitudes (Cleminson & Moesby, 2013; Walsh, 2016). Each of these papers related to consumer involvement in occupational therapy education describe the importance of meaningful collaboration between consumers and academics to promote meaningful student engagement and learning.

These examples of good practice suggest that the key to embedding participation in university education is a genuine effort to privilege lived experience knowledge through power sharing. This can be achieved through establishing roles within the academy that hold the same levels of power and autonomy as standard academic roles, or by adopting a rigorous approach to collaboration that ensures equal power for all participants. The principles of co-production are helpful in guiding such collaborative endeavours (Martin & Mahboub, nd; Roper, Grey, & Cadogan, 2018). Occupational therapy programs in Australia and Aotearoa New Zealand can draw on these principles to inform initiatives to systematically embed consumer participation in design, delivery and evaluation of curricula.

When attempting to promote more meaningful engagement of consumers in curricula, occupational therapy educators must remain aware of the power that they hold. If a "one size fits all" or "standardised" approach to consumer engagement was adopted, then the richness and power of learning from lived experience would be lost. Genuine collaborative approaches require the engagement of multiple consumer perspectives and active power sharing. Educators need to be cognisant of the privilege and power that comes from calling in consumers for a pre-determined role, activity or task. The profession's dominant ideology of "client-centredness" can see us willingly invite and consider consumer involvement whilst continuing to operate as the "experts" in the field (in this case as educators). Being critically aware of issues of power and how this is exercised is critical to ensuring true collaboration and that lived experience perspectives are privileged (Walsh, 2016; Whalley Hammell, 2015). Educators need to make efforts to facilitate change to model genuine partnership and collaboration that forms the very foundation of recovery-oriented practice. Much of the transformative learning for students and challenging of inherent stigmas occurs when students can visibly see a repositioning of consumers to the role of educator (Byrne et al., 2014).

Limitations

When considering the results from this study, several limitations should be taken into account. Firstly, this was a "snapshot" of practice in one particular period, so it may not fully capture improvements implemented after the period surveyed or good practices that were temporarily suspended during the survey period. Secondly, as participation was voluntary and not all programs were included, this may result in a response bias whereby those programs with least consumer involvement were not represented. Additionally, as data were self-reported by academics from each of the programs and not independently verified, it is

possible that data provided may be influenced by social desirability or other biases. Finally, as this study was only focused on universities in Australia and Aotearoa New Zealand, results may not represent practices in other countries.

Conclusion

This study has provided an important overview of the pattern of consumer involvement in occupational therapy education programs in Australia and Aotearoa New Zealand. When focusing on increasing the involvement of consumers, education providers should focus on opportunities for consumers to be meaningfully involved in all aspects of the curriculum design and delivery. While consumer involvement needs to be strengthened in all aspects of occupational therapy curricula, extending consumer participation in curriculum design and evaluation is particularly needed. To enable these changes, not only do academics need to prioritise these activities, but universities also need to establish systems that support and enable consumer participation and provide appropriate remuneration.

Future research in this area should explore student perspectives on the benefits of consumer involvement in education as well as the effectiveness of consumer involvement in education and how it supports the development of recovery-oriented capabilities of occupational therapy students. Future research could also explore the lived experiences of consumers involved in occupational therapy education. Additionally, future research should also explore "best practice" in this area and identify how education providers have overcome barriers to meaningful consumer participation. This could contribute to the development of guidelines to support further expansion of consumer involvement in occupational therapy education. .

KEY POINTS FOR OCCUPATIONAL THERAPY

- Involvement of mental health consumers in occupational therapy education programs addresses course accreditation requirements and is intended to promote recovery-oriented practice

- While the importance of consumer involvement is acknowledged, actual participation remains limited

- Strengthening consumer involvement is required, especially in curriculum design and evaluation

DECLARATION OF AUTHORSHIP

AL conceived the study. JNS, AL and KA designed the survey used with input from other authors. JNS and AL completed the initial analyses. JNS, AL and KA prepared the first draft of the manuscript which was then then reviewed and revised in collaboration with all authors.

CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflicts of interest in relation to this study.

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Table 1. Enablers and barriers to consumer involvement in mental health curricula (N = 23)

Factor	*n* (%)
Enablers	
Positive attitude of teaching staff	12 (52.2%)
Management / leadership support	8 (34.8%)
Access to remuneration	8 (34.8%)
Connections with consumers	7 (30.4%)
Requirement for accreditation	3 (13.0%)
Connections with clinicians (to help engage consumer)	3 (13.0%)
Linked to other projects for consumer involvement in the Faculty / University	3 (13.0%)
Campus is easy to access	2 (8.7%)
Involvement of a lived experience academic	1 (4.3%)
Course design is aligned with consumer involvement	1 (4.3%)
Course is valued by consumers who are involved	1 (4.3%)
Access to a network of consumers	1 (4.3%)
Training for consumers available	1 (4.3%)
Barriers	
Funding / remuneration for consumers	16 (69.6%)
No specific funding allocation to planning and evaluation	3 (13.0%)
Restrictive organisational structures	9 (39.1%)
Educators' available time	6 (26.1%)
Recruitment / Accessing consumers for education roles	6 (26.1%)
Level of consumer experience for teaching	2 (8.7%)

Lack of institutional support / understanding	2 (8.7%)
Held stigma	2 (8.7%)
Concerns around consumer capability	2 (8.7%)
Confidentiality concerns	1 (4.3%)
Insufficient evidence base	1 (4.3%)
No access to a lived experience academic	1 (4.3%)
No back up for consumer if unwell	1 (4.3%)
Lack of educator experience working with consumers	1 (4.3%)

Table 2. Median ratings of consumer involvement in curriculum design and evaluation activities

Activity	Mdn[†]	IQR[†]
Design		
Developing lecture materials (for lectures they will deliver themselves)	4	1 to 5
Developing lecture materials (for lectures to be delivered by others)	1	1 to 2
Developing tutorial materials	2	1 to 3
Developing online modules	1	1 to 1
Developing workshop materials	1	1 to 3
Reviewing content of lecture / tutorial / online modules / workshops developed by others	1	1 to 2
Designing assessments	1	1 to 3
Developing marking rubrics	1	1 to 2
Providing general feedback about the overall content and approach of the unit of study	2	1 to 3
Involvement in an advisory committee specific to the mental health curriculum	1	1 to 2
Involvement in an advisory committee for the overall program	2	1 to 3
Evaluation		
Review of content / approach in response to student feedback about the unit provided in unit evaluations / formal feedback systems	1	1 to 2.25
Review of content / approach in response students self-evaluation of learning / attitudes	1	1 to 2

	Mdn	IQR
Review of content / approach in response to evaluation of student learning outcomes for the unit	1	1 to 2
Review of content / approach in response to attitudinal outcomes achieved by students (e.g., evaluation of students attitudes towards individuals living with mental illness)	1	1 to 2
Review of content / approach in response to behavioural outcomes achieved by students (e.g., appraisal of student performance on fieldwork placements)	1	1 to 1
Involvement in evaluating student response to consumer teaching/involvement	2	1 to 2
Involvement in evaluating academic-consumer partnerships in teaching and learning	1	1 to 2.25
Evaluating the consumer experience of participation in the curriculum	2	1 to 2.25

Notes:

Mdn = Median; IQR = Interquartile range.

[†] Rating scale used: 1 = Not at all, 2 = To a small degree; 3 = To a moderate degree; 4 = To a fairly substantial degree; 5 = To a very large degree.

Table 3. Involvement of consumers in aspects of curriculum delivery (N = 22)

Activity	Consumer involvement	
	Yes, *n* (%)	No, *n* (%)
Lecture about their own lived experience / story	18 (81.8%)	4 (18.2%)
Lecture about particular topics / content areas	11 (50.0%)	11 (50.0%)
Facilitating tutorials / workshops / small group activities	11 (50.0%)	11 (50.0%)
Engaged in simulation activities	3 (13.6%)	19 (86.4%)
Engaged in marking student assessment	6 (27.3%)	16 (72.7%)

Table 4. Topics presented by consumers in lectures and tutorials / workshop / small group activities (N = 22)

Lecture topics	n (%)[†]	Tutorial / workshop / small group activity topics	n (%)[†]
Recovery / recovery oriented practice	6 (27.3%)	Recovery / recovery oriented practice[‡]	5 (22.7%)
History of consumer movement	3 (13.6%)	Communication	2 (9.1%)
Psychiatric diagnoses[‡]	3 (13.6%)	Diagnosis / language[‡]	2 (9.1%)
Therapeutic relationship	2 (9.1%)	Risk / dignity of risk[‡]	2 (9.1%)
Trauma informed care	2 (9.1%)	Individualised intervention planning[‡]	2 (9.1%)
Risk / dignity of risk[‡]	2 (9.1%)	Individualised assessment[‡]	2 (9.1%)
Individualised intervention planning[‡]	2 (9.1%)	Story telling	1 (4.5%)
Individualised assessment[‡]	2 (9.1%)	Trauma Informed Care	1 (4.5%)
Peer work	2 (9.1%)	Substance use	1 (4.5%)
Indigenous mental health	1 (4.5%)	Service access	1 (4.5%)

Notes:

[†] Number of programs indicating this topic was covered by consumer presenters. Note that more than one topic could have been reported, and not all programs included lectures and/or tutorial / workshop / small group activities delivered by consumers. Therefore totals do not add up to 100%.

[‡] Note that for two programs, these topics were delivered in the context of a specialist elective unit of study that was not necessarily taken by all students in the cohort.