Erasmus+

Practice Guidelines for Co-Production of Mental Health Nursing Education

COMMUNE (Co-production of Mental Health Nursing Education) is an Erasmus+ Strategic Partnership Project based on the collaboration of experts by experience (EBE) and mental health nursing academics from six European universities and the University of Canberra in Australia. Its purpose was to advance the involvement of those who have experiences of mental health service use (EBE) in mental health nursing education. The project combined experiential and academic knowledge, with the aim of co-producing a module on ‘mental health recovery’ for undergraduate nursing students; *a module that was taught to the students by EBE*. Principles of co-production where followed as much as possible, involving EBE in all stages of the process, from grant application to dissemination. The project tried to move beyond typical service user involvement and towards co-creation of knowledge, where power differentials are acknowledged and equity issues addressed. Barriers to meeting these goals were experienced and will be discussed in this Guidelines.

We hope that these Practice Guidelines will be useful for those who intend to co-produce learning programs or modules in mental health nursing and inspire others to follow similar paths and learn from our experiences, positive or otherwise. These Guidelines provide an overview of our experiences, learnings, limitations and barriers.

The Commune team decided on the term ‘Expert by Experience’ (EBE) to describe the members of the team and other collaborators who has lived experience of mental distress. Other more commonly used terms are ‘service user’, ‘consumer’ and ‘people with mental illness.’ As not all experts by experience are mental health care users, and what constitutes an illness is highly debated, the team decided on a term that more correctly describes and value lived experience.

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Background

Co-production can be described as an equitable partnership between Experts by Experience and clinical academics. Co-production requires active collaboration and constructive dialogue, which challenges traditional assumptions about the nature of knowledge. It offers an alternative approach, creating a mutual space where different social worlds can come together. The COMMUNE project strived for 'transformative co-production', described as a new structure that embeds ideas of mutual trust and reciprocity and brings professionals and EBEs together to identify and manage opportunities to develop and deliver services.

EBE involvement in mental health services is often described as powerful for meaningful change [1]. More substantive and meaningful participation is emerging, with a movement towards co-production [2]. Co-production, in this context is characterised by consumers and health care providers working collaboratively on projects, in a social environment featuring equitable power relations founded on trust and mutuality [3]. Co-productive modalities of work are increasingly reported in research [4], mental health service delivery [5, 6] and education [7].

EBE involvement covers a range of opportunities for exercising influence, from active participation at the micro-level of individual decision-making, to more macro-level involvement in service planning, implementation and evaluation in education, service development, research and training. It includes active collaboration and constructive dialogue between professionals and EBEs with a view to reshaping relationships between EBE, health care professionals and educators. This with reduced stigma and hopefully a more recovery-orientated skill by students.

EBE involvement in the education of health professionals varies from EBE academic positions in some institutions, to EBE contributing to classroom discussions in others [8], and generally, there is a lack of EBE input in develop of education [9]. Research in the area is only beginning to emerge and much of what has been published focuses on student and health professional perspectives, with little known about service user perspectives [8, 10].

In addressing educational and workforce demands, EBE-driven mental health training is particularly effective, as EBEs are best placed to inform and lead engaged discussion on mental illness, services and recovery [9, 10, 11]. It is an increase in EBE contributing to nursing education [12, 13, 14]. However, this involvement is often ad hoc, minimal and often restricted to the telling of story. To facilitate critical analysis by students, EBE's ideally hold roles within nursing education that extends to the development, implementation and evaluation of the education [15]. Both quantitative and qualitative studies, suggest that nursing education centred on EBE content and delivery may effect positive changes in nursing students' attitudes and beliefs in relation to people with mental health difficulties [9].

The Commune Project

The COMMUNE project sought to bring together nurse academics and experts by experience to co-produce a module on 'mental health recovery' for undergraduate nursing students. This was the first known international project where nurse academics and EBE educators came together to develop a teaching unit that has the potential to be adapted for use in other universities and countries at pre-registration level. Achieving an international consensus on the core components of a learning module in mental health recovery provides the foundation for a recovery literacy that may not be present in contemporary nursing education.

This project had seven partner sites: University of Iceland, Reykjavik, Iceland; University College Cork, Ireland; Dublin City University, Ireland; Inland Norway University of Applied Sciences, Norway; Turku University of Applied Sciences, Finland; HU University of Applied Sciences Utrecht, Netherlands; Synergy: Nursing and Midwifery Research Centre, University of Canberra, Australia. The context of nursing education in each of the sites differs somewhat. In Ireland (two sites), students undertake a four year BSc in Psychiatric/Mental health Nursing, which qualifies them with an honours Bachelor's degree and allows them to register as a Psychiatric Nurse with the Irish registry body. In all other partner sites, nurse education is generic/generalist in nature and varies between 3 and 4 years, with mental health/psychiatric qualification being gained only at postgraduate level. Table one summaries the training in each of the sites:

University	Type of training	Year of duration	Exit award
University of Iceland, Reykjavik, Iceland	General Nursing, mental health care integrated	4	BSc Nursing
University College Cork, Ireland	Direct entry Mental Health Nursing	4	BSc (Hons) Mental Health Nursing
Dublin City University, Ireland	Direct entry Mental Health Nursing	4	BSc (Hons) Psychiatric Nursing
Inland Norway University of Applied Sciences, Norway	General Nursing, 27 ECTS in Mental health Nursing	3	BSc Nursing
Turku University of Applied Sciences, Finland	Direct entry Mental Health Nursing	3½	BSc Nursing
HU University of Applied Sciences Utrecht, Netherlands	General Nursing, mental health care integrated.	4	BSc Nursing

University of Canberra, Australia	Comprehensive nursing education	3	BN

Table 1: Overview of participating universities and University of Applied Sciences

The project aim was to deepen the co-operation between the Experts by Experience and universities at local level in every participating country, especially in those countries where co-operation is not practiced on a permanent basis. Internationally, those who have used mental health services are enhancing mental health nursing education, and contributing knowledge drawn from lived experience of recovery from mental distress and related service use [8]. However, systematic involvement in mainstream mental health nursing educational initiatives remains embryonic. Therefore, the purpose of COMMUNE was to advance the involvement in mental health nursing education of those who have experience of being diagnosed with mental illness. The project sought to combine experiential and academic knowledge, to co-produce a module on 'recovery' for undergraduate nursing students across seven partner sites.

The Commune project began with focus group interviews with those who had lived experience of mental distress and mental health service use to ascertain their views on EBE involvement in nursing education. Data were collected and analysed collaboratively between nurse and EBE partners. The results of focus group interviews were used to inform the module design. The module content was developed by 10 nurse academics and 12 EBE's during a weeklong meeting in Reykjavik. It was informed by focus group findings, personal experience and a literature review, with consensus building exercises used to reach agreement. These sources and the Teaching for Understanding (TFU) framework were then used by the consortium as the starting point to address the question 'What do we want students to understand?' In line with co-production, experts by experience and nurse lecturers used a consensus building process (Susskind et al. 1999) to finalise the module content. Through this process, eight themes were identified as forming the core content for the module see figure 1.

The module was implemented at all educational venues between autumn 2017 and spring 2018. While the core themes for the module content were agreed on, each EBE had the freedom to use their own teaching strategies and delivery methods. The effect of the module was evaluated using mixed methods (questionnaires, focus group and individual interviews). It is our experiences of working together for almost three years that have resulted in the recommendations made in this handbook. Our experiences of co-production have not did have limitations, however this allowed us to reflect on not only what we did well, but also what we should have done differently. Overall, these experiences have allowed us to provide the guidelines that follow on co-production in mental health nursing education. Each site has summarized how they delivered the module and made recommendations to the editorial committee for the handbook, these experiences were collated.

The COMMUNE team members with lived experience of mental distress demonstrated preference for the title 'expert by experience' as opposed to 'service user', 'consumer', or 'patient'. It was considered problematic to use a title that was dependent on one's current orientation to service use, and the aforementioned terms lacked cross-cultural validation.

Barriers to Achieving Co-Production

The COMMUNE project aspired to use a co-production approach, with EBEs as partners in all stages of the research process, from grant application, through to dissemination. It is important to note, that while this was the project aspiration, this was not fully achieved. For example, the grant application was primarily driven by the nurse academics, with limited numbers of EBE in a position to join the team. This is not a specific criticism of this project. One of the difficulties in achieving coproduction is that funding is not available to support experts by experience until the grant is awarded. In the case of the commune project there was no funding to support the initial application. Mental health nurse academics were able to contribute as part of their paid roles. Only one expert by experience was employed in a part-time casual position and was able to devote some of that time to contributing to the project. All other contributions were expected to be voluntary. It is also likely that expert by experience who were at that stage few were in number and their nurse counterparts felt intimidated to assertively present their own opinions.

Once funding was received there was more opportunity for experts by experience to participate actively in the project. However, the nature of EBE contracts with the university/ University of Applied Sciences were not the same. Some were employed casually in the project, while others had positions at the university / University of Applied Sciences. This highlighted power differentials between the two groups and limited the impact of the EBE involvement at various stages of the project. This point to a systemic problem of inequity and not a specific criticism of the Commune Project alone.

The development of the learning module provided the best example of co-production from the project. Even numbers of EBE and nurse academics were involved. Funding enabled experts by experience to be employed to undertake the teaching and in some instances to be involved in the evaluation process itself. The nurse academics learnt a great deal about working with EBE colleagues and valuing the unique and important expertise they bring to mental health nursing education. They also learned that coproduction requires equity in access to resources and funded positions before it can be truly achieved. This goal will be difficult to attain and importantly it must be work towards through designated academic positions for EBE wherever possible.

Preparing for Co-Production

Co-production is a process in several stages. This chapter covers what we consider to be good practice in preparing for teaching a co-produced learning module. First, one needs to accommodate for co-production by establishing a team that has the best possible basis for working well together. This is covered in theme 1. Second, the process of designing a learning module depends on both the working process within the team, and the team members' work situation. Our suggestions for best practice in both areas are covered in theme 2.

Aim 1 Open collaboration between team members, addressing issues of power and equity.

Indicator 1 Team members have equitable opportunity to contribute.

Feature 1 All team members are included in the project as early as possible.

Feature 2 Additional team members are recruited by EBEs and NAs together.

Feature 3 All team members are included in all decision making.

Feature 4 All team members are involved in all activities.

Practical Solutions and Limitations

One site in the Commune project addressed this by holding meetings every two weeks with all team members to build relationships and attempt to develop trust. During these meetings, the team reflected and openly discussed issues of equity and power. Specific 'reflective meetings' were also held, a framework was used to encourage the team to reflect upon what was working well and what was not. The team openly discussed what co-production, power and equity meant to them and how they could recognise if co-production was being actualised. Each team member also wrote personal reflections on their experience of the process, which were shared amongst all team members. Of note however, that while this team attempted to address issues of power and equity, the team was not made up of equal numbers of nurse academics and EBE's. Furthermore, as the project progressed and team members (both nurse academics and EBE's) changed, these reflective discussions were not sustained.

Indicator 2 Team members trust each other.

Feature 1 Team members trust that all intentions are good.

Feature 2 Disagreement and criticism is encouraged and handled as matters of different perspectives. The aim is consensus, where people can 'live' with the final product'

Indicator 3 Team members respect each other.

Feature 1 Team members value each other's competence, also when they hold different beliefs.

Indicator 4 Team members discuss the process of collaboration throughout the process.

Feature 1 Time is set aside to discuss the process of collaboration.

Feature 2 Team members discuss potential challenges in their collaboration.

Feature 3 Team members try to see each other's perspectives and understand each other.

Practical Solutions and Limitations

The Commune Project involved seven teams of EBEs and NAs from seven universities in Western Europe and Australia. These teams met three times for workshops and discussions while working on the project. During the first meeting, the topic of distribution of power between EBEs and NAs came up. Concern was raised whether EBEs were as comfortable addressing the group as the NAs. The group decided to immediately explore and handle this concern. This resulted in a session where the EBEs spent 30-45 minutes on their own, discussing, among other things, their roles in the project, their expectations and worries. The EBEs then had a new conversation over the same topics, while the NAs were listening. Finally, the NAs had a conversation about what they had heard, while the EBEs listened. This process was repeated in the second project meeting.

Indicator 5 Team members agree on terminology.

Feature 1 Time is set aside to discuss terminology.

Feature 2 The terminology reflects the team member's equal value.

Feature 3 Team members respect agreements on terminology.

Practical Solutions and Limitations

Two terms became topics of discussion in the Commune Project. The first was what to call those of the team members whose competence was based on lived experience with distress and/or mental health care service use. Some terms previously used to describe this role, are 'service users', 'consumers' and 'people with lived experience (of mental health illness)'. The first two describes the person's relation to health care services. Not all team members in the Commune Project who were supposed to be covered by this term use mental health care services. Neither does the term aptly describe their role in the project. The third term was considered much too long, and also raised the discussion about the second term - what to call the distress these team members had experienced. There is an ongoing discussion about whether different mental health problems should be called 'illness', and if they in fact are health problems, or healthy reactions to an unhealthy environment. Subsequently, it was decided that the team members in question should be referred to as 'experts by experience' (as opposed to nursing academics being 'experts by profession'), and that the common denominator for their experiences was 'distress'.

It proved difficult to use these terms consistently, both in teaching the module that was developed and in the articles written about the project. This was in some instances handled by explaining the use of these terms to the students, as language and labels were central elements in the learning module. Since all permanent team members were co-writers on all articles, the EBEs also had the opportunity to correct terminology that misrepresented them.

Although this issue was discussed in plenary, it was ultimately the EBEs' decision what terminology would be used to describe them and their experiences.

Indicator 6 EBEs and NAs are evenly represented in the team

> **Feature 1** The team has the same number of permanent members from each background.

Practical Solutions and Limitations

Nurse academics all held permanent or long term contracts with their university, collectively they had substantial experience in teaching, research and curriculum design. In comparison only a few EBEs held a university position based on lived experience. Apart from the Irish universities these positions were almost all a short term, part time contract. This difference in expertise by definition limited the ability of the EBEs to influence the process. A strong sense of collaboration within the group overcame these differences to an extent, however the fundamental inequity could not be addressed.

As a result of Commune some of the universities hired EBE and continue to do so for lessons and activities developed in and after the Commune project. However, in all universities the lobby to value all types of knowledge and addressing the institutional hierarchy needs to continue.

Co-Producing a Learning Module

Aim 1 Module content is developed collaboratively between EBEs and NAs.

Indicator 1 The content is based on a broad inquiry about what people with lived experience think is necessary in nursing education.

Feature 1 EBEs and NAs analyse the findings of the inquiry together.

Practical Solutions and Limitations

The team members in the Commune project conducted focus group interviews with EBEs (who were not involved in the project). They were interviewed about their experiences with mental health services and what they think is necessary in nursing education. The interviews were led by one EBE and one NA, and were then analysed by both EBEs and NAs.

Indicator 2 All team members are involved in developing content for the learning module.

Feature 1 Time is set aside to discuss the content thoroughly.

Feature 2 The work methods used ensure that all team members' views are presented and recognised.

Indicator 3 All decisions regarding content are reached together.

Feature 1 Consensus building is the goal of all team members

Practical Solutions and Limitations

The Commune project arranged a workshop with at least one EBE and one NA from each participating university with the goal of consensus building. We split into smaller groups where we discussed what we thought should be covered in our learning module, and also shared ideas about how to teach it. All ideas were written down as key words on separate pieces of paper. The whole group then gathered, and the ideas were put up on a wall. Next, we started grouping all the ideas, while rewriting or modifying some of them. This was done one idea at a time, by a facilitator appointed by the group. Some suggestions were instantly agreed upon, some were discussed back and forth several times. Finally, we decided on eight different groups of ideas, from which the eight themes for our teaching module emerged.

Aim 2 Creating content for course

Indicator 1 Teaching material is developed in co-production

Feature 1 Student course guide is written

Feature 2 Supporting materials are collected

Feature 3 Team members get support and coaching in creating teaching material

Feature 4 Team members are supported in using the universities educational (online) systems for course guides

Indicator 2 Lesson plans are written

Feature 1 Lesson plans are available when teaching classes

Feature 2 Teaching material based on shared language

Feature 3 Teaching material covers the selected themes

Feature 4 Team members get support and feedback while developing lesson plans

Practical Solutions and Limitations

The 8 themes that were developed in the Commune project (see chapter 2) were taken home to the several project universities. There they were discussed with all the local team members. Then the themes were distributed over different lessons, assignments and online learning material. Then these lessons, assignment and online learning features were further developed by team members.

Aim 3 All team members are in a good and secure working situation.

Indicator 1 All team members have secure employments/a predictable employment situation.

Feature 1 Team members are employed throughout the project.

Feature 2 Team members have predictable working hours

Indicator 2 All team members are paid a wage equivalent to other teaching personel.

Feature 1 All team members are paid according to formal or informal qualifications. Contact organisations who employ EBE for guidelines.

Feature 2 Team members are paid an hourly wage based on standard local rates.

Indicator 3 All team members have access to the same office workplace.

Feature 1 All team members have a workstation with access to utilities such as copiers.

Feature 2 All team members have their own computers with internet access.

Practical Solutions and Limitations

In one university one EBE was on a normal contract and automatically received a laptop, email address, coffee and printing card, an online teaching roster and even basic teaching training. Another EBE was on an hourly contract, which meant that such facilities all had to be arranged separately.

Indicator 4 All team members have professional support

Feature 1 It is recognised that teaching from a point of personal experience can be especially demanding on the EBEs. In teams of just one EBE, peer support must be found outside the team.

Feature 2 EBE without sufficient teaching experience get support and coaching before and after teaching.

Feature 3 EBE get access to educational training like other teaching staff

Indicator 5 All participants receive necessary information and training.

Feature 1 All team members participate in all organisational meetings.

Feature 2 EBE who teach but are not on the project team receive the information they need to fully take part in the project.

Delivering Co-Produced Mental Health Nursing Education

After establishing a good co-production between experts by experience and nurse academics as discussed in chapter 2, in this chapter we present good practices with regard to the co-produced development of teaching material and delivery of education.

Aim 1 Students meet EBEs as teachers

Indicator 1 EBE team members have a leading role in the delivery of education

Feature 1 EBE lead the class alone or in pairs.

Feature 2 In classes given by EBE and nurse academics the EBE is a co-teacher, not a guest.

Feature 3 EBE prepare their lessons together with their co-teacher if applicable.

Indicator 2 Team members are supported in developing teaching experience

Feature 1 New team members get access to teaching courses for starting teaching staff.

Feature 2 Coaching and feedback on teaching is provided to all team members

How we did it in the Commune project – practical solutions and limitations

Like most nurse academics the EBE started teaching before having finished or even started an educational training. Because of the special curriculum and the small number of EBE that taught in each site they sometimes lacked feedback or coaching.

Themes of the COMMUNE Learning Module

In the two following chapters the content of the module that the COMMUNE project team delivered and also instructions for various learning activities that were used at the different universities will be described. This is meant to serve as example and inspiration for new co-produced learning modules.

The themes that were developed and used during the Commune project are outlined below:

Theme one – understanding and challenging self
This theme incorporates self-reflection by students on their own values, attitudes and beliefs, questioning and critical thinking, courage and confidence building.

Theme two – seeing and valuing the person
This theme is about facilitating curiosity to develop a relationship with people, understanding the commonality of being human, appreciating individuality and valuing the person.

Theme three – creating connections
This theme focusses on communication, including developing skills in listening, understanding, being present, adopting a positive attitude and being authentic. It also aims to develop students understanding of multiple perspectives on distress and crisis.

Theme four – recognising the impact of language
This theme focusses on developing a student's understanding on the impact of language, how to adopt a strengths based approach, developing respect, understanding power associated with words and reducing objectification of individuals and groups.

Theme five – exploring where power lies
This theme focusses on the concepts of power, powerlessness, empowerment, supported decision making and imbalance

Theme six – beyond labelling
This theme aims to help students to see the person behind psychiatric diagnoses, developing a critical understanding of the history of madness and the use of diagnoses.

Theme seven – interpersonal values

This theme focusses on developing compassion, trust and respect

Theme eight – building hope together

This theme focusses on developing hope, interest, and patience

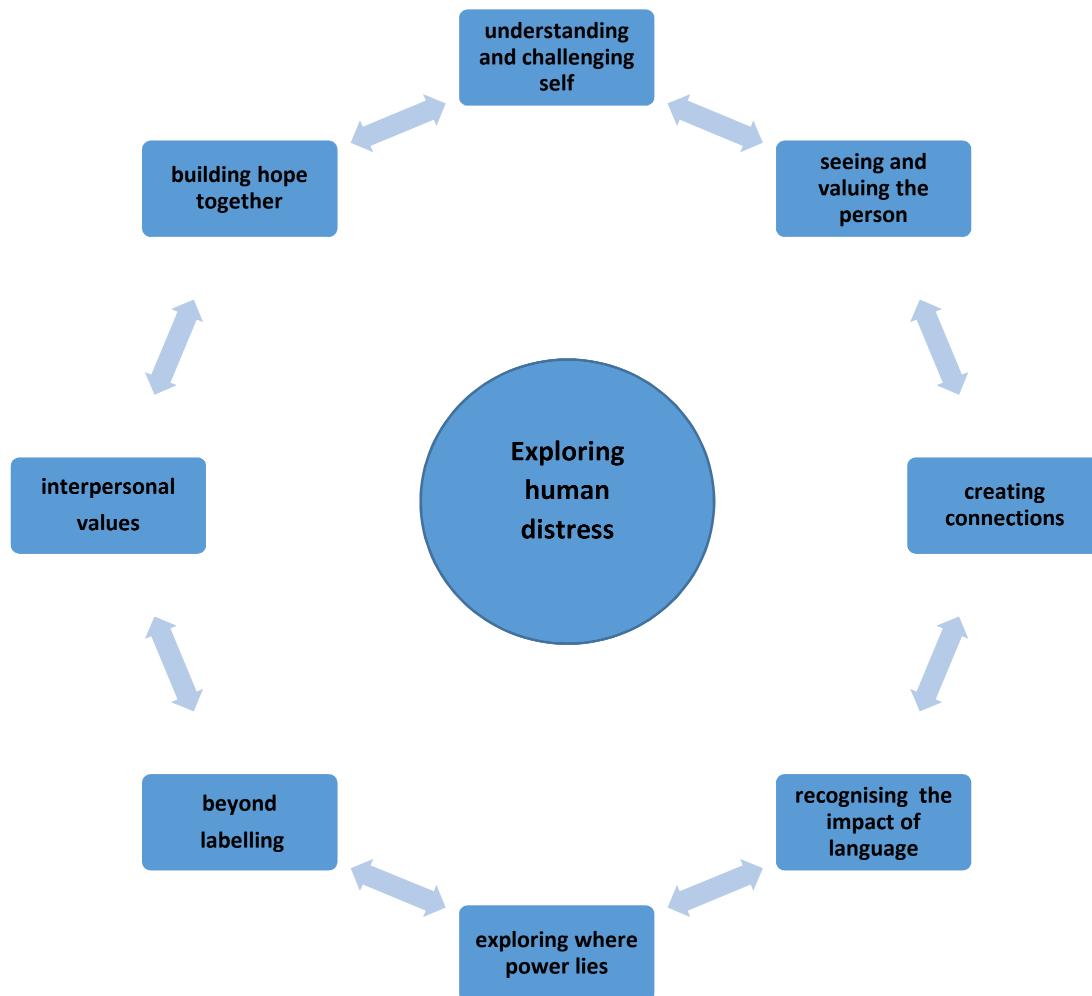

Figure 1 Module aim and content

Activity Recipes

The purpose of the Commune learning module is “to explore human distress with experts by experience”. This exploration means both learning about others and learning about oneself. The aim is to challenge the students and widen their perspective. There are many ways to do this. Below are some of the activities used by the Commune team to facilitate learning and reflection on the topic of mental health.

The themes listed for each activity refer to the eight themes in the framework of the teaching module, these can be found in appendix 1.

1. Presence listening – a pair exercise

Themes	Understanding and challenging self; Creating connections
Group size	Minimum 2
Time	10 minutes
Overview	The exercise develops the students’ listening skills and the ability to stay present
Objectives	The students realise that non-verbal communication and just listening creates a connection.

Instructions

Step 1	Ask students to pair up.
Step 2	Explain the exercise. Each student tells the other about one positive and one negative aspect of their lives right now. The listener will communicate what s/he heard but not offer solutions or conclusions to the matter. The point of the exercise is to listen and be present. Students take turns in talking and listening. Explain that students can decide themselves what they feel comfortable sharing.
Step 3	Give time to execute the exercise (a couple of minutes per person).
Step 4	Ask the students how they felt during the exercise.
Reflection	Ask the students which was easier to talk about/listen to – the positive or the negative aspect?

Tips for facilitators

Some of the students will find the exercise difficult. It’s important to monitor when the students finish completing the exercise and start to do something else. The exercise doesn’t work if the students are not receptive (for instance too tired to concentrate).

Suggestions for follow-up

It’s necessary to discuss with the students about the importance and difficulty of just listening to someone. Sometimes it’s enough to just listen instead of finding solutions and/or conclusions about someone’s troubles.

2. Addressing the label

Theme	Recognising the impact of language
Group size	Minimum 10
Time	40 minutes
Overview	Students are wearing a label and talk to each other, not knowing what label they are wearing.
Objectives	The exercise demonstrates how stereotypes affect the self-perception and behaviour of the person who is stereotyped (i.e., the target of prejudice).
Materials	Adhesive labels
Preparations	Obtain the same number of adhesive labels (e.g., of the kind for file folders) as there are students. Write a stereotypic attribute on each label. Possibilities include feminist, Muslim, obese, HIV positive, ex-convict, child molester, atheist, lesbian, slut, playboy, paraplegic, blind, conservative, depressed, black supremacist, white supremacist, violent, athletic, good at math, cute, overemotional, incompetent, lazy, untrustworthy, unclean, musical, materialistic, unintelligent, exotic, forgetful, frail, etc.

Instructions

Step 1	Explain that you will conduct a labelling exercise to help students learn about how stereotypes work. Participation in this exercise should be optional; anyone who prefers not to participate directly can simply play the role of an observer.
Step 2	Next, attach a label on each student's forehead (or back) so that the label is not visible to the wearer. Make clear that these labels are being assigned randomly and have nothing to do with students' actual attributes.
Step 3	Ask students to spend 15 minutes talking with each other about "future goals" (another general topic can be chosen but this one works well in eliciting responses to the labels). They should circulate in order to talk with several different people. Stress that they should treat one another according to the labelled attribute. For example, someone labelled "forgetful" might be repeatedly reminded of the instructions.

Reflection, part 1

After 15 minutes, reconvene the class and ask students to leave their labels on for a little while longer (if the class size and furniture allows, it's best to sit in a circle). Then ask students to share how they felt during the exercise, how they were treated by others, and how this treatment affected them. Students will often mention their discomfort not only with being stereotyped, but with treating others stereotypically.

Reflection, part 2

Let the students look at their own labels. Then discuss questions such as the following:

- Was the label what you guessed, or were you surprised by it?
- When people stereotyped you, were you able to disregard it?
- Did you try to disprove the stereotype? If so, did it work?
- How did you feel toward the person who was stereotyping you?
- If your attribute was positive (e.g., "good at math"), how did you feel?
- When stereotyping others, how easy was it to find confirming evidence?
- When stereotyping others, how did you react to disconfirming evidence?

These questions offer a natural forum to discuss self-fulfilling prophecies, confirmation biases, belief perseverance, and other psychological factors involved in stereotyping.

3. The lived experience of being admitted to hospital

Theme	Beyond labelling
Group size	About 30 is ideal
Time	30-45 minutes
Overview	This activity provokes critical thinking about a person's journey of admission
Objectives	To promote awareness of the clinical processes from another perspective, empathy for the person and impact of introductions/repeating story
Materials	A china faced doll, about two feet in size. Ten spare chairs (if space permits). A whiteboard and marker. Short case study.
Preparations	Nil. Requires a classroom setting.

Instructions

Step 1	Ask students to put their hands up if they would like to work in a hospital when they graduate. Ask if anyone has done an internship in a hospital. Describe the milieu of an emergency department, with lots of different specialities working together. Ask if anyone who said they did a hospital internship found that difficult to understand. Ask if they have ever thought about it from a patient's perspective. This is what we are looking at now.
Step 2	Introduce the china doll 'Mavis'. She is our patient today. Sit Mavis on a chair where all students can see her in the front centre of the room.
Step 3	Write the following scenario on the whiteboard:

Mavis has lost 15kg since Christmas. She tells her family that she ate a big lunch at uni, but she really only had a bottle of water. Mavis weighs herself every day. She feels incredibly guilty if she eats one thing. Mavis realises she feels completely out of control around food.

Ask the students, what should Mavis do? Where can she get help? Let students discuss.

Step 4 A student will call out 'General Practitioner'. Thank student profusely and put one of the spare chairs next to Mavis. Ask student to come and sit in the chair, as they are now a general practitioner!

Step 5 Ask the 'general practitioner', what would you do? Who would you refer to? Student will usually say psychologist. Ask broader class, who would like to be our psychologist
(or what is chosen)? Wait a little while, and if no takers, choose a confident student. Put a chair next to the general practitioner for the 'psychologist' to sit down.

Step 6 Repeat process being led by the students. A likely Australian chain is ' general practitioner, psychologist, emergency department triage nurse, emergency doctor, psych registrar, admissions clerk, clinical nurse consultant, nutritionist, ward nurse'. Ask each new practitioner what they would do. If they get stuck, open to the whole class. At some stage, there will not be enough room for the chairs. Move Mavis over to the far right of the room and ask students to all move their chairs accordingly. Comment/joke on the number of practitioners.

Step 7 When Mavis has arrived on the ward and is in a bed, ask: 1. how do you think Mavis might be feeling now? She had kept her issues so private, even from her friends & family, and now she has had to be assessed by all of you. How many times did she have to tell her story? Let's count. 2. How many of you introduced yourselves to Mavis? 3. Do you think she would have understood the purpose of your assessments? After some discussion, thank all of the 'health professionals' and ask students to sit down back in their seats.

Reflection

Use the exercise to encourage a critical, different perspective of clinical admission processes and awareness of the person's experience of that confronting journey.

Some suggestions for teaching and reflection points:

- As a nurse, it is easy to be absorbed in our role and not consider the entire mental health admission journey from the person's perspective.

- Hospital nursing tasks involve administration and technical skills. It is also easy to forget the interpersonal side, such as introductions and explaining assessments, when busy. It is important to understand how this impacts on the individual being admitted.

- The mental health care system is fragmented. How many practitioners communicated with each other and worked in tandem? How does this impact on the person and their care?

- This is the process for dealing with distress in our country. How do you think the journey might look somewhere else? USA? South-Africa?

- What would you do if Mavis was one of your friends and she came and told you what I wrote on the board? Would you visit her in hospital? Would you feel strange around her after she was discharged?

- What can I do about this as a mental health nurse?

Tips for facilitators

Be light-hearted and encourage participation throughout the exercise. Create a 'safe' setting where there are no wrong answers and every suggestion is taken with careful consideration.

Suggestions for follow-up

Reflect on your last clincial prac. What is the admission process? How many people in the chain? How do people accessing the service experience it?

4. Categorising things and people

Theme	Beyond labelling
Group size	Minimum 4
Time	45 minutes
Overview	This activity addresses how we categorise everything and everyone around us, and how this affects us
Objectives	To discover that categories vary, and thereby develop a more critical understanding of the use of diagnoses
Materials	One or more sets of small objects. A set can be a pen, a teabag, a matchbox, a match, a safety pin, a nut, a macaroni, a hairpin, a piece of thread, a clothes peg, a safety pin, a piece of Lego, a bottle cap, etc. There should be at least ten objects in each set.
Preparations	Prepare one or more sets of objects. One can also collect various items from the participants (phones, coins, watches, shoelaces, etc.). If making more than one set, the sets should contain similar or even identical objects for the purpose of comparing how the groups categorise them.

Instructions

Step 1 Make groups of no more than four people. Tell the participants to follow the instructions, and not to ask questions.

Step 2 Give each group a set of objects. Tell them to put the objects in different piles. How they group the objects is up to them, but they need to agree why each object should be in the chosen pile.

Step 3 Give them time to finish the exercise, and make sure they agree.

Step 4 Tell them to sort the objects again, this time in different piles than the first time. Again it is up to them how to do it, and again they have to agree. Give them time to discuss until they agree.

Step 5 Have each group share how the process went. Take time to explore different aspects of the process. How did they sort the objects the first time? How did they sort them the second time? What was different the second time? Was it easy or difficult? Why was it easy or difficult? Did anyone in the group disagree, and if so, how was that handled? Typically, they sort the objects depending on function, material, colour or shape. Challenge them to find other criteria, «think outside the box».

Reflection

Use the exercise as a basis for teaching and reflecting on how and why we categorise people, how it can be both useful and harmful. Some suggestions for teaching and reflection points:

- Being quick to categorise is very useful. From an evolutionary perspective: Are big animals with pointy teeth dangerous? If you stop to think, you don't live long enough to reproduce. From an everyday perspective: We live in a complex world and need to make thousands of decisions every day. Making it easier saves limited time and energy.
- In psychiatry, there are different diagnostic «piles» you can be put in. Who decided the criteria for these piles? Are the criteria the same everywhere and at all times? Use examples from different times, and how a patient can get different diagnoses from different doctors. Look at parallels to what came up in step 5 above – how did the group reach an agreement? What happened when they were told to sort the objects a second time?
- How can psychiatric diagnoses be useful? In what situations and for whom? Are there other ways to reach the same goals?
- How can psychiatric diagnoses be harmful?
- Which categories do you belong in? Which categories do others think you belong in? What does it feel like to be told you are something you don't identify as?
- What can I do about this as a mental health nurse?

Tips for facilitators

Be strict throughout the process in the exercise. Some participants might want to be one step ahead and discuss what the aim of the exercise might be. This may interfere with the process and affect what they say, which in turn might hinder reflection later on. Questions during the exercise should be answered with «do what you were told», «find out for yourself» or «we will get back to 'why' later».

Suggestions for follow-up

Read about disagreements over, and research on, psychiatric diagnoses. Read about the process of making the next diagnostic manual. Read about the consequences psychiatric diagnoses have for different people.

5. Card game about the incidence of mental health disorders

Themes	Understanding and challenging self; Beyond labelling
Group size	18-25
Time	15 minutes
Overview	The exercise points out how common mental health disorders are??
Objectives	The students understand that mental health disorders are quite common and they start to realize what the course is about.
Materials	A card deck, tape and a pencil
Preparations	Prepare one card for each students so that about 30% of the cards are labelled with a selection of mental health diagnoses (such as depression, bipolar disorder, anxiety).

Instructions

Step 1	Hand out cards without explaining more about the exercise. Ask the students not to show their card to others.
Step 2	Ask the students with a diagnose in their card to raise their hand.
Step 3	Ask the students to notice the raised hands and explain that they represent the incidence of the mental health disorders in our population.
Step 4	Ask the students with diagnoses in their cards to tell others what they have in their cards.
Step 5	Ask the students what thoughts and feelings the exercise provoked.

Reflection

The exercise points out that mental health disorders are quite common. This is not always understood because one can't see it in everyday life. Approximately one third of population could be diagnosed at some point of their life.

Tips for facilitators

This exercise is good for the beginning of the course. Using humoristic cards help break the ice. Exercise works best with a larger group (10 or more).

Suggestions for follow-up

It's important to discuss about the incidence of mental health disorders with students along the way.

6. Is mental illness a social construct? – A class debate

Themes	Understanding and challenging self; Beyond labelling
Group size	Minimum 10
Time	60 minutes
Overview	A class debate
Objectives	Critical thinking about the nature of mental health
Preparations	Make slide with the following list of arguments:

1. Mental distress is simply behaviours and feelings that are not considered socially acceptable
2. There is no test or scientific evidence of the existence of mental illness.
3. Mental distress is a normal reaction to social issues such as poverty, abuse and unresolved grief.
4. Mental illness is an illness, no doubt about it. It has been scientifically proven.
5. Medication works and cures, and people feel better.

Instructions

Step 1	Inform the students that they will debate mental illness, and that they have to make arguments they don't necessarily believe in themselves. Divide the students into two separate teams.
Step 2	Put the slide up, and assign statements 1-3 to one team, and 4-5 to the other.
Step 3	Give the students at least 15 minutes to prepare their arguments, each team working together developing on the arguments on their list.
Step 4	One student from each team presents their team's arguments to the whole class.
Step 5	After the initial statements, each team get a few minutes to rebut, with time for additional responses after that.
Step 6	The speakers then summarise their team's positions to the class.
Step 7	Finally, conduct a vote to see which speaker or team was the most persuasive.

Reflection

Possible points for reflection, depending on what came up in the debate:

> The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has seen more classifications of mental illness than any previous edition. Does this mean that we are developing more mental illnesses, or are we simply finding new labels for types that have already been around for centuries?
>
> What do you think – is mental illness an illness or a social construct?
>
> How are mental illnesses/problems perceived in the general population?
>
> Does it affect the person with a diagnosis whether his or her problems are seen as an illness or as just varieties of behaviours or feelings?

Tips for facilitators

After the initial statements, have the students follow one line of argument at a time, so that each argument is a response to the previous. Otherwise, they might end up just throwing arguments at each other, not listening to what the previous speaker said.

7. Stigma, discrimination and mental health

Themes	Understanding and challenging self; Recognising the impact of language; Exploring where the power lies; Interpersonal values
Group size	7- 30. Can accommodate more if necessary.
Time	60 minutes (can go for around 10 min longer if time permits)
Overview	A three-part interactive session involving examining stigma using a brainstorm, original diagram and continuum exercises.
Objectives	To explore the construct and impact of mental health stigma, and what this means for nursing practice.
Materials	Whiteboard and dark marker. Ten palm-sized pieces of paper. Yellow piece of A4 paper with 'No' printed on it. Small piece of blue tack/tape.
Preparations	Write statements on to pieces of paper. Decide the best order in which to read them. Number each page and secure with a rubber band.

Instructions

Step 1	Introduce session as being quite fast paced and needing no materials. Are the students ready? They will be curious. Ask for everything to be moved to the side of the room. Bags, pens, yes even table and chairs. Wait until this is done,

prompting if necessary with 'remember I said we have a lot to get through! Let's go' etc

Step 2 Ask students to sit on the floor. Ask if they feel like primary school children. Ask question, 'what words have you heard to describe people with mental illness? They might not be ones you or your friends use, but heard in the movies or online or wherever. It's ok, I know some of them aren't that nice. I promise I will not be offended'.

Step 3 Students will say things like 'psycho, schizo, nutcase' etc. List the words on the left of the board. After about eight stop, and if the students are still coming up with words, stop them and comment on how many words there are to describe people with a label of mental illness.

Step 4 Ask what all the words have in common. Let them think. All/most will be derogatory, but try and tease this out. Say I am going to go through the list and you must shout out yes if you would like to be called that, and no if you wouldn't. Now I am expecting it to get very noisy in here for about 5 minutes. Go through each one and cross it out if students shout no. There will be a short list, if anything left. Summarise that there are not very many positive words to describe someone with mental illness. Ask the students to think of one.

Step 5 While they are thinking, take the marker to the far right of the board. Draw a small stick figure. Ask, imagine this is a person with mental illness. How do you think they feel about themselves? Do you think they feel proud? Class will say no. Draw a circle around the stick figure. Draw another bigger circle around it.

Ask class to imagine this is the person's family. Write 'family' in the top middle of that ring. Are they proud of the mental illness? Is it something they tell their friends, or hide? Wait for students to think. Repeat with another big circle. Write 'community' in this ring. What does the community think of people with mental illness? Prompt discussion. Tell students that as mental health nurses they will be working right here next to the person (point to the stick figure in the middle) in these layers of stigma. And if you stand beside any stigmatised group, you will get criticised yourself. This sounds a bit scary, but I want you to see this as exciting. You have an opportunity to send a very different message from this (point to bullseye diagram) and be an advocate for your patient. People with mental illness get discriminated against everywhere in life, even in public hospitals. You can really make a difference here in someone's life. Not as glamourous as surgery, but just as important. Any thoughts? Allow a short discussion.

Step 6 Tell students they need to get up and stretch as they are going to do a lot of moving. Write 'Yes' on the board in medium sized letters. Stick the piece of paper with 'No' in the middle of the very back wall of the room. Say 'I am going to read a series of statements. If you completely, 100% agree with what I say, come to the front and touch the 'Yes' wall. If you disagree, (walk to the back of the room), come and touch this wall. If it depends on something, like

the age of the patient or the type of illness etc., come and arrange yourself where you think you belong in the room. So if you mostly agree, you would not be touching the 'yes' wall (walk back to front), but be somewhere up this end. We are going to go quickly'. Check the students understand what to do.

Step 7 Read each statement, only 2 minutes on each. Encourage students to share why they are standing where they are. Be encouraging of all positions. Comment on the diversity of values in the room (no criticism). After all statements have been read, thank students and ask them to restore the furniture to the room. Clean board.

Reflection

Some suggestions for reflection points:

- The statements we explored do not have strict right/wrong answers. There are grey areas where your nursing decision making is going to depend on your values.

- Did anyone notice any stigma that they didn't know they held?

- What do you think it would be like to have mental illness and be subject to so much stigma? To be looked down on by your family and society. Who can give me an example that you might have seen on your clinical placement or other part of your life?

- What does this mean for our mental health nursing practice? (prompt for checking for physical health issues due to likely discrimination in primary health care system, consider referrals carefully to ensure mutually acceptable, consider own bias/stigma very carefully, most of all, - take the opportunity to be an advocate for your patient and make a real difference in their world).

Tips for facilitators

Maintain a curious, positive stance throughout the exercise. Foster a dynamic of mutual discovery and be encouraging of student participation. Use student's names where possible. Be extra encouraging to students who share aspects of themselves and their experiences. Avoid criticism.

This session is intended to be fast paced and requires quite dynamic facilitation.

Suggestions for follow-up

Ask students to go home and write down their 'Nightmare Patient'. 'Describe them. The one that they really don't think they could work with in mental health. It might be their diagnoses, age, appearance, involuntary status, criminal history; whatever. Write as much detail as you

can. Think about it carefully and bring the piece of paper to next tute. Without your name on it'.

The homework exercise promotes student self-evolution of their value system. It also can lead on to another exercise in the subsequent tune, where all pieces of paper are placed in a top hat and explored further.

8. Empathising with a voice hearer on their difficulties with communication

Theme	Creating connections
Group size	Minimum four
Time	Twenty minutes (Five minutes per person to experience voice hearing)
Overview	This activity shows that communication can be difficult for those experiencing distress and lack of communication is not always by choice.
Objectives	To create better understanding of what it is like to hear voices and still hold a conversation.
Materials	A piece of paper with a list of five objects e.g. list of groceries

Instructions

Step 1	Make groups of four people
Step 2	Each of the four people gets a turn for five minutes of being the "voice hearer".
Step 3	Person one sits with person two and three standing alongside them speaking into each of their ears.
Step 4	Person four sits across from them and reads out a list of five objects that person one "the voice hearer" must memorise and repeat a few minutes later when asked.
Step 5	Each of the four people in the group rotate so that each will experience being the "voice hearer" who is trying to hold a conversation and memorise what is being said to them.

Reflection

After this exercise is done a group discussion is then had on how it felt to be a "voice hearer", how it felt to try and hold a conversation whilst feeling distressed and distracted, how it felt trying not to react or communicate with the "voices", how it felt trying to memorise things etc.

After this discussion, encourage the students to carry this experience with them when treating service users in the future. Ask them to reflect on the fact that just because a service user may not be communicating with them, this does not automatically mean they do not wish to

communicate their distress. It may rather mean that during times of distress they simply are incapable of hearing the service provider etc.

Tips for facilitators:

Rotate around the room to ensure each group is getting equal time experiencing being the "voice hearer". Also ensure that each of the two people who are the "voices" are constantly speaking, this doesn't matter if it is shouting, whispering, positive or negative talk as long as it is constant.

Variations

This exercise can also be done with different scenarios as long as there are four people in each group. Another variation is the "voice hearer" is attending a job interview and must answer the relevant questions being asked by the interviewer, all the while being distracted by the two voices in each of his/her ears.

Suggestions for follow-up

Research Schizophrenia, Inter-voice, Hearing Voices Movement etc.

Handouts

Information on voice hearing, causes, interventions etc.

9. The difference between empathy and sympathy – a discussion

Themes	Understanding and challenging self; Seeing and valuing the person; Creating connections; Recognizing the impact of language; Interpersonal values; building hope together
Group Size	Suitable for different sizes
Time	15 minutes
Overview	The discussion underlines the difference between empathy and sympathy based on Brene Brown's (2013) video about the subject (link in the materials).
Objectives	The students understand what empathy is and how they can incorporate it in their profession as nurses.
Materials	Computer, data projector, internet connection, Brene Brown's (2013) video (https://www.youtube.com/watch?v=1Evwgu369Jw).
Preparations	Make it possible to watch the video before the class starts.

Instructions

Step 1	Introduce the video and the topic to students.
Step 2	Watch the video.

Step 3 Ask the students if they have any thoughts or questions.
Step 4 Continue the discussion about the topic.

Reflection

The difference of empathy and sympathy can be described in many ways. For example, if someone is drowning, they are helped to shore (empathy). One doesn't jump in the water and complain how bad it is there (sympathy). It's necessary to tell the students that an important part of empathy is taking care of one's own mental health. Going too deep in the service users' problems can lead to a burn out.

Tips for facilitators

For many students this point of view was new.

Suggestions for follow-up

It would be interesting to come back to this after the students have had their practical training in the mental health field.

10. Café dialogue

Themes	Understanding and challenging self; Seeing and valuing the person; Creating connections
Group size	Minimum two. Maximum depends on how many experts by experience are available. Ideally no more than four to five students per expert by experience.
Time	45-90 minutes
Overview	Students have conversations with experts by experience in a more intimate setting outside the classroom
Objectives	The students get to know people with lived experience of distress better, and can ask questions they don't feel comfortable asking in a classroom setting
Materials	One room or secluded table for each group of students and expert by experience
Preparations	Ask the students to prepare questions for the experts by experience in advance. Ask the experts by experience to prepare a few talking points or conversation starters.

Instructions

Step 1	Divide students into groups of four or more, depending on the number of experts by experience available.
Step 2	Send each group to their room or table with instructions to come back after a certain amount of time.

Step 3	The students and expert by experience have a conversation based on the questions and/or the talking points they prepared.

Reflection

At the end, students and experts by experience meet to sum up what came up in the different conversations. Some points to address could be

- What are the students taking away from this?
- What are the experts by experience taking away from this?
- Were there questions that were hard to ask? Why?
- Were there questions that were hard to answer? Why?

Tips for facilitators

Prepare students by encouraging them to ask what they really want to know. Tell them not to worry too much about upsetting anyone, and to take advantage of this special opportunity to learn from an insider's perspective.

Prepare experts by experience by informing them that the students have been encouraged to ask difficult questions. Make sure they have thought through what they are willing to talk about, and what they are not willing to talk about. Encourage openness, but also protection of privacy.

Variations

Depending on the number of students and experts by experience involved, the experts by experience may circulate after some time. Make sure to allow enough time for each group and expert by experience to warm up to each other and have a good conversation before rotating, usually at least 40 minutes.

11. Reflective writing

Themes	Understanding and challenging self; Seeing and valuing the person; Creating connections; Interpersonal values
Group size	Minimum two
Time	From 30 minutes and upwards
Overview	Reading about, listening to, or watching a film about someone's lived experience, or the opinion of someone with lived experience, and then using writing as a tool for reflection.
Objectives	Examining thoughts, attitudes, norms and values.

Materials	An article/a blog/an autobiography/an opinion piece/an interview by or about someone with lived experience, or material about mental health in general.
Preparations	Find a text, podcast, film or similar that presents an experience or viewpoint that can be the basis of reflection. Prepare questions (see below under 'Reflection').

Instructions

Step 1	Have the students read/listen to/watch the chosen material.
Step 2	Instruct them to write down their reflections - either whatever comes to mind, or answering certain questions. Steps 1 and 2 can be done in advance, as preparations for a class session.
Step 3	Talk about the students' reflections in class. Start in pairs or smaller groups before students share with the whole class. Ask about differences and similarities in their reflections, if they discovered anything new about themselves or others, or if there is anything else they would like to share.
Step 4	Have the students write new reflections that have come up when talking about the material with others, and about the process of reflecting and sharing those reflections with others.

Reflection

Points for reflection will depend on the material chosen. The first round of reflections should be about the material at hand. For instance, if reading an autobiographical text by someone with lived experience, the assignment could be imagine you are this person. What is it like being you? How does family and friends treat you? How do other students or co-workers treat you? What is society's view of you?

If reading an opinion piece or an interview, the assignment could be picking out the three most important points that are made. Ask the students to explain why they are important, and to consider if there is something about them, their personal experience or values, that make these points appeal to them.

Other suggestions for points for reflection:

What is power and who has it?

What does powerlessness do to you?

What is a meaningful life?

What would you want and need from others in times of distress?

What is the purpose of hope?

How do you foster hope?

What can take hope away from you?

What is it like being treated as someone you are not?

The second round of reflection, after talking to other students or teachers, should be on a meta-level. Some suggestions for points of reflection:

> What was it like to share your reflections with others?
>
> What was it like to hear others' reflections?
>
> What does your reflections say about you, your norms and values?
>
> How does this affect you as a (mental health) nurse?

Tips for facilitators

Some students are uncomfortable sharing their views, especially when they touch upon personal experiences or attitudes. Be careful to create an accepting environment. Stress that we are all humans and therefore flawed, we are all learning as we go. If necessary, be generous with sharing your own shortcomings in terms of lack of empathy and stigmatising attitudes. Say we are all prejudiced; the difference lies in whether we defend our prejudices or are willing to challenge them. Also, respect the students' right to privacy. No one should be encouraged or forced to share something they are not comfortable sharing.

Suggestions for follow-up

If possible, have the students take a new look at their reflections a year or two later. What do they think now? What, if anything, has changed? Why, if so, has it changed?

12. Cultural awareness and mental health

This session is specifically tailored to suit an Australian context. It is possible to adapt to suit other countries and their minority culture perspective. See 'Tips for facilitators'.

Themes	Understanding and challenging self; Seeing and valuing the person; Recognising the impact of language; Exploring where power lies
Group size	7-25. Can accommodate more if necessary.
Time	60 minutes
Overview	An exercise to consider aspects of Aboriginal culture and how it differs from Anglo-Saxon practices (minority vs dominant group).
Objectives	To stimulate critical thinking about: the experience of being from a minority culture within society, impact on mental health, cultural stigma and student awareness of their own cultural practices/bias
Materials	Map of Aboriginal nations. Shoebox sized box with a lid. Seven palm-sized yellow pieces of paper. Space to sit on chairs in a circle. Power Point projector (if possible).
Preparations	Write one of these words on each piece of paper 'culture, family, trauma, country, community, health, medicine'. Save pdf of map onto thumb-drive for projector.

Instructions

Step 1	Display Aboriginal map with projector. Ask if students have ever seen it before. Talk through how it is divided differently, not by state lines but tribal groups. Point out which 'country' we live in (Ngunnawal), and how aboriginal culture often involves travelling, and how as nurses it will be common to have a patient who away from their country and community, and might be feeling little lost. Encourage students to ask where Aboriginal patients are from to see if this is the case.
Step 2	Personal story. My experience of being in a de facto relationship with an Aboriginal man. I made cultural mistakes; such as not inviting his mother into the kitchen to help me prepare food, as in my culture (British) guests are waited on. She also criticised the Anglo-Saxon practice of distancing extended family members from making parenting decisions. This was true, these decisions are left to the mother and father only. She also did not like my culture's disregard for the environment. Finally, I was out with my partner and a mixed gender group of his Aboriginal friends. We were going to the movies and were late. I suggested we run through the Plaza to not miss the beginning. Everyone laughed at me, as they knew a group of young Aboriginal people running through a shopping centre would quickly be tackled by security on the premise they had committed a crime. This was 12 years ago, not sure much has changed?
Step 3	Ask students to arrange their chairs in a circle. The definition being that all students can see each other's faces without having to bend their necks. Take a seat in the circle with the discussion box.
Step 4	Introduce the box. Students are to pass it around the circle. Every third person must open the lid, and take a piece of paper at random (without peeking). Read the word out loud. Make a statement about that word regarding yourself, something you saw in practice, or nursing in general. Once they have made their statement, other students are welcome to contribute their perspectives and ideas for a short discussion. Put each paper to one side after it has been discussed. Repeat until all the words are used. Encourage students from diverse cultural backgrounds to share some aspects of their traditional culture if they feel comfortable to do so to finish.
Step 5	Thank students for their contributions, particularly if any students shared their traditional practices at the end. Summarise that cultural awareness begins by being aware of our own culture. I didn't think I 'had any' but on closer reflection I do. Ideas around serving guests and parenting. There is cultural difference within this class, and also with the people we will be supporting as nurses. Be curious. Find out the Aboriginal support services where you work, and always build connection. With you as a nurse, and with the right Aboriginal community for the individual (e.g. Ngunnawal, Koori etc.).

Reflection

Use the exercise to reflect on the role of culture in our professional, personal and social context.

Some suggestions for reflection points:

- What do you think it would be like from being from a minority culture with different practices, in regards to healthcare and family etc.?
- Have you seen racism in your nursing practice? What stereotypes have you heard?
- Who can tell me a cultural practice they just realised they had? (e.g. not drinking alcohol before 12, having a sweet dish at the end of dinner, care/no care for elderly, role of women in parenting etc.)
- What does this mean for our mental health nursing practice if we are truly using a recovery-orientated approach?
- If you were in a hospital in another country, what would be comforting for you that fits your culture? Perhaps something from childhood? E.g. in China and South East Asia, congee is served. Can people of different cultures heat food where you work? Would you heat it for them as a nurse? Why? Why not?
- What can I do about all this as a mental health nurse?

Tips for facilitators

This session is specifically tailored to suit an Australian context. It is possible to adapt to suit other countries and their minority culture perspective. First, find a resource with different land divisions from the mainstream state-sanctioned ones. Next, have a guest speaker who is from the dominant culture but has personal experience with the minority culture (if Expert by Experience does not have this). The discussion box words are applicable to every culture.

Maintain a curious, positive stance throughout the exercise. Foster a dynamic of mutual discovery and be encouraging of student participation. Use student's names where possible. Be extra encouraging to students who share aspects of themselves and their experiences. Avoid criticism. If a student says a comment which is racially derogatory, ask the entire class what they think rather than challenging the statement directly.

Students respond well to 'every third person takes a paper'. They listen and watch very carefully to see if it is going to land on them!

Suggestions for follow-up

Make a list of as many of your own cultural practices that you can. Think deeply. Chocolate frog for whoever emails me the longest list. Be alert to racism in your practicum and nursing practice. The life expectancy for Aboriginal people is 25 years shorter than Anglo-Saxon Australians, and this is partially due to a lack of cultural awareness in our health care system. Consider how you are going to connect with people from diverse cultural backgrounds as a mental health nurse, and how your and their beliefs impact on the recovery process.

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