CHAPTER 10

Educators Learning Together: Linking Communities of Practice

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INTRODUCTION

Mental health educators, engaged in shaping tomorrow's professionals, are faced with seismic change – both in mental health policy and practice and in the landscape of higher education. In teaching, as in practice, there are drives towards integrative thinking and interprofessional working, with a move to engage service users/survivors and carers as active partners. Most professional programmes are, however, delivered through academic and professional programmes that are uni-professional, in which institutional and attitudinal barriers to inclusive education may be significant. Moreover, many educators work in a climate where research is prioritised over teaching, and where opportunities to debate teaching, update practice and policy, or plan curricula in conjunction with others may be limited.

In this chapter we analyse this challenging context for educators and, drawing on the work of the Mental Health in Higher Education project (*mhhe*), explore how learning and teaching about mental health can be enhanced through increased networking and the sharing of perspectives and ideas. The challenge for educators in this context is to allow themselves to become learners, working with colleagues from within their own discipline or profession, from other professions and disciplines, with practice colleagues and students, as well as alongside users of services/survivors and carers. The notion of linking and building communities of practice (Wenger, 1998) provides a conceptual basis for such development and transformation.

THE CHALLENGE OF CHANGE FOR EDUCATORS

Educators engaged in teaching and learning about mental health in higher education must respond to multiple challenges of change. There are changing understandings about what constitutes mental ill-health, and how best to promote recovery. There is a growing awareness of the importance of understanding positive mental health, public mental health and health

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promotion. In policy, there is a growing emphasis on the development of the mental health workforce and lastly there is the changing nature of higher education itself; its mission, customers and modus operandi.

Conceptions of mental ill-health and mental well-being have altered dramatically over recent years. Slowly but surely, understanding of the possible causes of mental ill–health has broadened and diversified, with new alliances being formed within and across stakeholder groups. Interventions to support those with mental health problems have begun to reflect not only uni-disciplinary but multi-disciplinary approaches, where scientific, genetic, biological, psychological, cultural, social and spiritual perspectives may all play a role. The views and knowledge base of people with lived experience of mental health problems, service users/survivors and carers, have begun to be recognised as key to the development of understanding. At the same time, a growing interest in notions of positive mental well-being has been accompanied by an acknowledgement of the need for conceptual clarity. Mental health, as opposed to the mental health problems for which the term is often used as a (nonsensical!) synonym, is an issue of relevance, not only to those whose problems have been "diagnosed", but to us all.

This changing emphasis has been reflected in a plethora of policy initiatives foregrounding mental health promotion and the prevention of mental ill-health (DoH, 1999; DoH, 2001; Scottish Public Mental Health Alliance, 2001; Welsh Assembly Government, 2002; WHO, 2005); and understanding of the need for socially inclusive practice is developing (e.g. Social Exclusion Unit, 2004). Set against this, there are however moves to introduce more restrictive legislation, and a corresponding fear that holistic perspectives may be undermined. Despite the drive towards "integrative perspectives" (McCulloch et al., 2005) and the inclusion of service users and carers, concerns about risk and dangerousness still reverberate; thus policy appears to be facing in "two opposed directions at once" (Beresford, 2005).

In terms of practice, interprofessional working has been promoted by the creation of mental health trusts (in England), a range of new crisis management and assertive outreach teams, and by practice and training frameworks such as the *National Service Framework for Mental Health* (DoH, 1999) and *Ten Essential Shared Capabilities for the Whole of the Mental Health Workforce* (DoH, 2004). Recent promotion of "talking therapies" is another indication of the direction of travel (Layard, 2004).

Meanwhile, in higher education, enormous changes have also been taking place, with academics perceived to be "dancing on a moving carpet" (Young & Burgess, 2005). Once again potentially contradictory policies prevail, with the drive towards attaining higher research profiles (and thus increased income) potentially undermining simultaneous moves towards enhancing the quality of teaching (Dearing, 1997). Higher administrative loads, lower staff-student ratios and a diminished per capita spend on students, have been accompanied by increased demands for accountability and quality assurance in teaching. At the same time, there has been acceleration in the growth of knowledge. The ways in which higher education is delivered are being transformed (through the expansion of part-time study, open learning, e-learning and work-based learning routes). There is growing emphasis on approaches that support active learning and reflective learning, and on transferable skills (Young & Burgess, 2005, pp. 2–7).

In a growing number of programmes in which mental health is taught, employers now play a part as active stakeholders, either as commissioners or as partners in programme planning. More recently, service users and carers may also be involved as partners and (partially) funded to contribute to student recruitment and the planning, delivery, assessment and

evaluation of programmes. Indeed, such participation is a requirement for accreditation of the social work degree (DoH, 2002). Whilst welcomed by most academics, the engagement of multiple stakeholders makes the task of programme planning and provision highly complex (Burgess, 2004), and significant barriers to involvement still remain (Basset al., 2006).

The student population has increased dramatically and, where tuition fees have been introduced, students have moved into a different relationship with universities, as their "customers". The drive towards "widening participation" in higher education has brought in students with diverse experience in terms of, class, ethnicity, dis(ability), educational background and age. This has required Higher Education Institutions to re-think how they support students, fuelled by drivers and performance criteria based upon "retention". In this respect, awareness of the mental health of students has been raised (e.g. Stanley and Manthorpe, 2002; RCP, 2003), though so too have concerns about the capacity of Higher Education Institutions to meet this challenge (Baker et al., 2006) . The proportion of students and staff who disclose mental health problems is likely to increase, in line with a growing emphasis on social inclusion, the need to increase recruitment (Ferguson et al., 2005), a duty upon higher education institutions to make "reasonable adjustments" for people with disabilities under the Disability Discrimination Act and the development of substantive roles for service users in education and training fields.

As higher education broadens and diversifies, it becomes increasingly difficult to generalise about the nature of universities and the experience they offer to students, with diversity in terms of the physical environment, the student body, the sense of mission, who is employed to teach and how they are supported. There are well-recognised differences in the respective emphasis placed within different institutions on teaching and research, with teaching often afforded lower status (Young, 2006). In one university, lecturers and students may feel fearful of talking about their own experience of mental health problems; in another, service users may be employed as lecturers. Astonishingly, those two phenomena may co-exist within a single institution.

Between the disciplines most closely involved in mental health teaching too there are well recognised differences, with well established disciplines such as medicine holding much higher status than, for example, relative newcomers to the academy such as social work and nursing (Green, 2006). Differences too can be seen in the degree to which academics remain in touch with practice (Ferguson et al., 2003). Greenbank (2006) argues that "service" should be seen as a third element to be balanced alongside teaching and research – an issue with which professional disciplines have grappled since their inception.

When these worlds – of mental health policy and practice, and of higher education – come together, in learning and teaching about mental health within universities, it is perhaps not surprising that those involved may feel overwhelmed.

TEACHING IN ISOLATION

Of particular relevance here is the isolation experienced by many academics. Brawn and Trahar (2003) describe new lecturers as "isolated in their department, isolated in the university, and isolated by their perceived lack of opportunity to engage in fruitful discussions with colleagues about their teaching" (p. 249). Whilst academic work might appear to take place in contexts which involve cooperation and social contact, "much of that cooperation and contact is tinged with the competition of professional institutional life. There is

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discussion, and there are meetings, but one of the core functions of the academic – to write for publication – takes place in the lonely privacy of the office and the study" (Evans, 2004, p. 129).

In a teaching context too there may be few opportunities for collaborative practice. It is not uncommon, in some disciplines, for the mental health teaching to be done by a single academic, sometimes in a context where the priorities and interests of colleagues lie in other areas. The relative segregation of different departments or faculties within which mental health is taught (such as Medicine, Psychology, Nursing and Social Work) reflects not only the differing, and at times competing, disciplinary cultures (in evidence in practice too), but also the endemic academic "tribes and territories" analysed by Becher (1989). This isolation may be felt most strongly by those coming from more collaborative backgrounds in mental health practice, and by service user educators who successfully acquire an academic post.

The isolation of teachers has also been a theme for those outside the universities, with evidence adduced that educators are out of touch with professional practice (Ferguson et al., 2003), and that their own training needs are not currently addressed (Brooker et al., 2002). This may be most acute in those disciplines where rigid funding streams and inflexibility conspire to deny opportunities for combining clinical practice with teaching and research. Furthermore, educators are often forgotten in the policy and practice development world. It is rare to see the education and training implications clearly drawn out in national policy documents, or the perspective of educators pro-actively sought in consultations. Educators may be omitted from the descriptions of those for whom conferences, discussion forums or policy documents are seen to be of relevance and feel (rightly or wrongly) that these will not speak to them.

Thus, teaching mental health may be an activity that is both isolated or marginalised within universities, whilst in professional disciplines educators may be on the periphery of mental health developments. rather than at the centre, contributing actively to debate and discussion about how both education and service provision can progress.

If the pedagogical and institutional functions of educators completely displace their ability to manifest their identities as participants in their communities of practice, they lose their most powerful teaching asset . . . teachers need to "represent" their communities of practice in educational settings. This type of lived authenticity brings into the subject matter the concerns, sense of purpose, identification, and emotion of participation (Wenger, 1998, p. 276).

A CONCEPTUAL FRAMEWORK – COMMUNITIES OF PRACTICE

Wenger argues that, by dint of being human, we are continually engaged in the shared pursuit of all kinds of activity, whether seeking to ensure that our physical needs are met or seeking to make sense – as in debates about mental health – of the world around us. It is, through this collaborative activity, through engagement both with the world and with each other, that we learn. He goes on to note that: "Over time, this collective learning results in practices that reflect both the pursuit of our enterprises and the attendant social relations. These practices are thus the property of a kind of community created over time by the sustained pursuit of a shared enterprise. It makes sense, therefore, to call these kinds of communities,

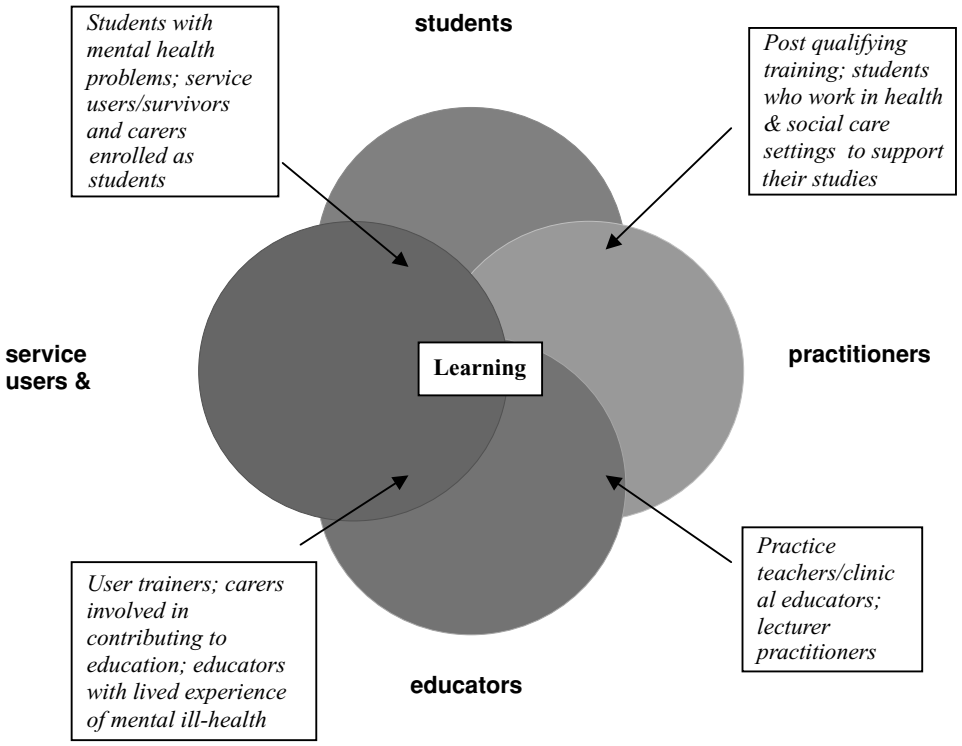

Figure 10.1 Intersecting communities: participants in mental health education

communities of practice" (Wenger, 1998 p. 45). This notion of "communities of practice" provides us with a conceptual framework, to help us both to map and to transform the world of education about mental health.

Traditionally, disciplinary and academic communities can be seen to be cohesive, inward facing, boundaried groups, drawing strength from their differentiation from others and strong roots in the past. There may be diversity within their bounds, but between them can stretch a kind of "no-man's land". It is still, as we have seen, the case that professional bodies, faculties and departments can exist in relative isolation but, as debate opens up we can perhaps see a shift from the notion of no-man's land to one of common ground.

This implies not absolute consensus, nor the loss of one's own identity, but the notion of a safe space in which people can move into closer contact. As interactions between the multiple stakeholders on the common ground increase, as they engage in intersecting communities of practice and, through contact with diverse others, draw increasingly on not just one but on all aspects of their selves – we may move to a position where the isolating forces highlighted above are mitigated. Those employed in higher education and those involved in workforce development may then no longer view each other from opposing trenches. Service users may be or become practitioners or teachers; the prior experience of learners may be fully recognised; opportunities for educators to engage in practice will increase; and all will be linked by our identity as learners (see Figure 10.1).

Furthermore, practice and learning will increasingly span the disciplines and professions, as, for example, social work educators and students start to recognise the importance of

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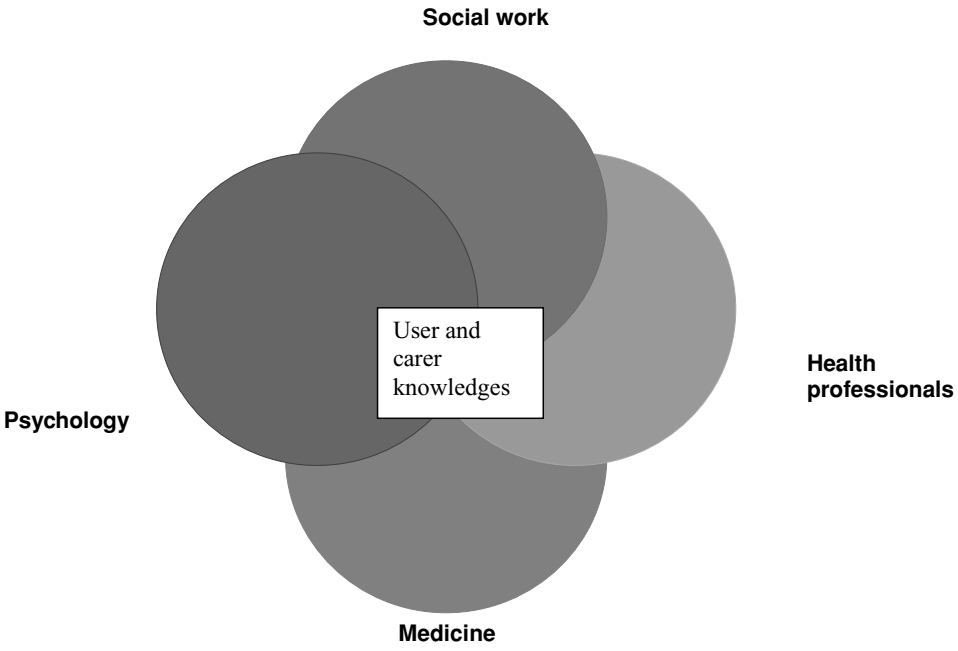

Figure 10.2 Intersecting communities: knowledge in mental health education

general health and well-being as a prerequisite to preventing or alleviating mental distress or ill-health, and as medical educators and students recognise the links between social inclusion and mental ill-health (see Figure 10.2). Theories and intervention strategies may no longer be "owned" by one discipline or profession.

So, how do we create such an arena, within which new communities of practice can be fostered and engaged? In entering, and starting to cultivate, the common ground – moving, eventually to an "interprofessional place of being" (anon in Colyer et al. p. 61) – the task for all of us may be both to understand and to recognise our own language, values, identity and history, whilst not holding on to unnecessary notions of exclusive practice or differentiation. Potential allies in this task can be those who sit at, or move into, the intersections of the overlapping circles: practitioners who have (re)-assumed identities as students; service users and carers who take on the role of teachers; the psychology undergraduate who undertakes an MA in social work; the course director who experiences a period of depression; the medical educator devising an optional module on medicine and art. In valuing the diversity of perspectives we encounter, and valuing the different aspects of ourselves, we can transform the way in which we learn, and in which we learn together. A central task for all educators may be to facilitate this process (Newell Jones, 2005).

ENGAGING WITH EDUCATORS: PHASE ONE

Recent years have seen the gradual transformation of the no-man's land within mental health education into common ground. In the UK, the Mental Health in Higher Education project has had a small but significant role to play in that. Here we describe its genesis.

The Learning and Teaching Support Network (LTSN), an initiative to enhance the quality of teaching and learning in universities, was launched in 2000 from seeds sown in the Dearing report (1997). The LTSN comprised 24 discipline-based subject centres, hosted by UK universities, and a Generic Centre, based in York. In 2005, this became part of the Higher Education Academy, whose aim is "to help institutions, discipline groups and all staff to provide the best possible learning experience for their students". Whilst quality enhancement has been the aim of the Higher Education Academy, much of this has been achieved through the creation of networks and communities of practice.

In recognising the need for inter-disciplinary dialogue about mental health, representatives of four subject centres of the former LTSN (Health Sciences and Practice, Psychology, Medicine Dentistry and Veterinary Medicine, and Social Policy and Social Work) met together in 2002 to debate how the learning and teaching agenda in mental health might be taken forward together.

A lively two-day workshop for educators from a range of professions and disciplines highlighted the need to make links at local, regional and national levels. For some participants it was their first opportunity to debate mental health education and practice in an interdisciplinary group – an early incursion into "no-man's land". Both similarities and differences of approach were highlighted, as people began to explore the common ground. There was strong support for the continuation of dialogue once this had been established. The Mental Health in Higher Education (*mhhe*) project came into being in January 2003 with the aim of enhancing learning and teaching about mental health through increasing networking and the sharing of approaches across the disciplines in UK higher education.

An initial survey (Anderson, 2003) aimed to get a sense of what people were teaching, the extent of their links with other educators and what they saw as key challenges in learning and teaching about mental health.

- Firstly, it revealed that it was not uncommon for educators to lack connection with others involved in teaching within their own discipline (regionally and nationally), let alone those from other disciplines. Co-location in a single institution (or on the same corridor!) was no guarantee that people would be in touch with one another.
- Secondly, and notwithstanding some investigation of teaching in this area (SCMH, 1997), little has been written that sheds light on how, in detail, others approach the challenge of developing students' understanding about mental health.
- Thirdly, the pace of change in mental health policy and practice, had left some educators reeling. Dilemmas associated with an awareness of the difference between education (in its broadest sense) and training (equally necessary, but different) were highlighted.
- Fourthly, educators across the disciplines drew attention to the impact on learning and teaching about mental health of the issues raised at the beginning of this chapter, including widening participation agendas, research pressures, increasing student numbers and new modes of learning.
- Finally, the role of lived experience in learning about mental health was stressed, that of service users and carers contributing to teaching sessions as well as students' and lecturers' experiences of wellbeing and ill-health.

The first phase of the *mhhe* project allowed for the exploration of these themes and their connections. The lack of an existing national database meant that time had to be spent in beginning to locate those involved in mental health teaching across range of disparate

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departments and institutions. The issue of identity was key to this. Whilst in some disciplines, such as social work, those teaching a module on mental health would happily identify as a "mental health educator"; in others, such as medicine, those inputting to teaching in the area of mental health might define themselves as clinicians first and foremost. It was important for the project to reach those involved in teaching in areas such as child protection, the care of older people or physical health, where understanding mental well-being and ill-health is essential.

The database, established with the help of participating subject centres in the project's early days, is (in early 2006) approaching its 1,000th entry – still far from comprehensive, but an achievement nonetheless. With the constituency mapped out, the project embarked on developing lines of communication: a news section on the website; a regular e-bulletin; and – to aid speed and currency – an electronic discussion list. In combination, these increase access for educators to information about policy, practice, educational initiatives, sources of funding, training opportunities and publications. An *mhhe* website http://www.mhhe.heacademy.ac.uk/ provides a focal point for these and other aspects of the project's work: collections of resources, work on good practice, news about events and a feedback form.

The principle of service users/survivor and carer involvement in the project was incorporated at an early stage, though accompanied at times by imperfect attempts to translate this into action. The project owes much to those individuals and groups who bore with us in the early stages. *mhhe*'s first national conference focused on service user and carer involvement in mental health education, and in turn led to a good practice guide "Learning from Experience" (Tew et al., 2004) outlining strategies for engaging with users and carers in teaching and learning about mental health across the disciplines. This was co-written by an academic, service user and carer, and jointly published by *mhhe* with the West Midlands development centre of NIMHE and Trent Workforce Development Confederation. Over 2,000 copies were distributed across the UK and the guide is available on-line from the *mhhe* website.

Strategies for introducing students to the diversity and range of ways of understanding about mental health were highlighted in the second major conference, which offered teaching exemplars of many kinds. The need for holistic approaches to teaching, linking mental ill-health with broader notions of mental health and well-being was highlighted. Problem-based learning, models for building skills in communication, a mental health promotion diary, the use of lived experience, and *co-operative inquiry into the involvement of service users in clinical decisions were all demonstrated.*

The third event had a focus on interprofessional education (IPE) about mental health. There has, until recently (Steinert, 2005) been an almost total absence of attention paid to the need for educators to come together as a precursor to such work. This event highlighted the potential benefits of students "learning together to work together" (Barr, 2002) and shared helpful work on defining what we mean by interprofessional education. It provided cautions too about development of a group of IPE experts "in the know" and others – grappling creatively with the dilemmas who, for want of the "right" language and terminology, may be dismissed or undervalued. In this area, above all, there is a need to ensure that we go the extra mile in understanding one another's differing perspectives and ways of articulating them.

Formal aspects of *mhhe*'s work were complemented by conversations with individual educators, who sought support with teaching. For example:

- Hari, a lecturer in mental health nursing, wanted to establish a service user and carer involvement development worker post, and was looking for exemplars.
- Lara, already in such a role and working with the undergraduate medicine programme team to develop a module on self-harm, sought teaching materials to draw upon.
- Tony, a new lecturer, had been asked to take on the "abnormal psychology" module on an undergraduate psychology degree programme. Keen to abandon the medically orientated textbook used to date, he sought dialogue on teaching mental health from psychological perspectives.
- Chris, a social work educator, in the absence of colleagues with an interest in this area, sought help in working out how mental health might be woven throughout the generic social work degree curriculum.
- Selina, leading development of standards for post-qualifying training, sought university-based educators to contribute to a steering group.
- Darcus, heading up a mental health nursing programme, sought others to contribute to validation of a new post-qualifying programme.

CHALLENGES AND RECOMMENDATIONS FROM PHASE ONE

Issues raised and themes identified in the first phase were encapsulated in recommendations made in a report of the first year of *mhhe* in 2004, as follows.

The implications of overlapping roles – user, carer, teacher, student, practitioner - need to be considered at all times, and in relation to each of the following recommendations. An emphasis on beginning to involve service users and carers in learning and teaching, or on initiating interprofessional education initiatives, can obscure the multiple and overlapping roles, and diverse experience, already present in the group.

Opportunities should be increased for educators to debate their teaching openly, on the understanding that this is a mutual process in which all are prepared to learn. This requires the creation of a safe learning environment, informed by: an understanding of and respect for key differences in disciplinary cultures; a recognition of individual difference and similarities; and the role that input from those with lived experience of mental health problems has to play in facilitating students' learning. Whilst this is easy to write, it is not always easy to practice in the face of deeply held beliefs and differentials in power and status.

Interdisciplinary initiatives need to be accompanied by ongoing opportunities for intra-disciplinary debate. Effective collaboration results where each partner has a sense of their own identity and "community of practice" and is clear about their strengths and what they may have to gain. *mhhe*, in conjunction with the individual subject centres, has had a role in raising the profile of mental health and supporting debate within as well as across individual disciplines.

Support needs to be provided for educators to keep in touch with rapidly changing policy agendas, and to inform developments in policy and practice. Opportunities need to be maximised for the active involvement of educators in teasing out and debating

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the implications for learning and teaching of mental health policy developments. This will have resource (time and funding) implications.

Continuation funding for a systematic network of mental health educators within higher education would facilitate regional and national networking and the dissemination of positive approaches to learning and teaching about mental health. For continuation of *mhhe*'s work, linking and building communities of practice, additional funding was required. It was envisaged that the evolving networks, whilst linking to the agendas of workforce development agencies, would remain independent of government agendas, inter-disciplinary and inclusive.

Further thought needs to be given to support for user and carer involvement in learning and teaching about mental health. It became clear that service user/survivor and carer trainers themselves form an emerging community of practice – part of a wider constituency of survivor workers identified by Snow (2002). Support and capacity building are required, not only for independent trainers and groups, but also for those directly employed (often in quite isolated roles within higher education institutions) to engage and support them.

Higher education needs to be provided in a way that promotes the mental well-being of both lecturers and students. The university as an institution has a role to play in promoting mental well-being, preventing mental ill-health and meeting the needs of students and staff who are experiencing mental distress. Implications need to be drawn out for curriculum delivery in subjects within which mental health is taught. Throughout the project we were reminded of the need for mental health educators to reflect on the links between these levels – the Health Promoting Universities initiative (Dooris, 1999) providing one potential paradigm.

Mental health should be seen not simply as a health and social care issue, but as a fundamental concern of all human beings throughout their lives. An understanding of the concepts of health, well-being and recovery, and the ways in which these are culturally and individually defined, needs to underpin students' learning. Further work could be undertaken to specify mental health learning outcomes for students on generic as well as specialist mental health programmes – in areas such as mental health promotion and the prevention of mental-ill health across the life-cycle – and on the development of teaching materials to support such learning.

Students need to be helped to grapple with complexity and to understand the range of complementary and conflicting perspectives on mental well-being and ill-health. Learning and teaching about mental health brings challenges at many levels. Preparing students to be effective practitioners requires that they are confronted not only with a range of differing and sometimes conflicting explanations, models and perspectives, but that they learn to negotiate the realities of practice within services in flux. Within all curricula there is a need, for a focus on diversity and social inclusion, following concern expressed (in relation to cultural diversity) that "other people's philosophies or world views are not understood or even acknowledged" by mental health staff (SCMH, 2002).

Learning and teaching about mental health needs to be informed by evidence-based practice, the outcomes of research in general and user-led research in particular. Space needs to be created for mental health educators to reflect on the links between their own teaching and research, and to debate the relevance of research findings across the range of disciplines. To date, there has, been only limited research (e.g. Barnes et al., 2000, Carpenter et al., 2003, Carpenter et al., 2006) into the outcomes of different approaches to learning and teaching about mental health, such as interprofessional education or the involvement of service users/survivors as educators. It is important to understand the impact of teaching on students' learning about mental health and, crucially, on the experience of service users. Service user and carer involvement in research has been growing (Turner & Beresford, 2005) and they have a role to play as researchers of teaching and learning.

There is a need for more exploration and the sharing of approaches to interprofessional education about mental health, particularly at pre-registration levels. In recent years considerable effort has gone into promoting interprofessional education, but the learning from this work has not yet widely disseminated. What are the best conditions for promoting interprofessional learning and practice and does it change the outcomes for service users and carers? Further debate is needed about the role of those with lived experience of mental health problems in "interprofessional" education initiatives; an interest of the newly established *Centre of Excellence in Interdisciplinary Mental Health* at the University of Birmingham.

PHASE TWO DEVELOPMENTS

With additional funds from the collaborating subject centres and the Department of Health, *mhhe* entered into its second phase in 2004. Three strands of work were significant, building on the phase one recommendations: regional meetings, intra-disciplinary work and support for service user/survivor and carer trainers.

Whilst national conferences had enabled educators to meet from a broad range of settings and higher education institutions, it became clear that it was not uncommon for academics engaged in mental health teaching within one region, or indeed a single university, never to have met. Moreover, the need to link in with workforce developments locally was underlined by the continuing stream of policy initiatives; new directions within the UK nations, and in England, a growing role for the regional development centres of the National Institute for Mental Health (NIMHE). As new forms of collaborative provision of education and training were emerging, the communities of practice of the workforce and academia were brought together. Thus *mhhe* set out to establish a series of regionally-run meetings, where educators from higher education institutions could meet with service user/survivor trainers, carers, practitioners and workforce leaders to discuss policy developments and exchange ideas and information about teaching. The commonality of task was underlined by the publication in England of the Ten Essential Shared Capabilities for the Whole of the Mental Health Workforce (DoH, 2004), providing an initial focus for debate.

To date, regional networks have been developed in five regions, with work planned on engaging others. Parallel developments in Scotland, Northern Ireland and Wales have been inhibited by lack of resources and capacity. In the most successful meetings, educators

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have been able to forge new relationships locally and regionally, and there has been a positive cross-fertilisation of ideas and practice. Participants have expressed a desire to continue to meet, rotating the venue within a region to enhance accessibility and ownership. There have also been challenges. At times the interacting communities of practice have brought with them clashes in approach, values, language and objectives. Furthermore, it is not easy to build a sustainable network in the face of heavy demands on everybody's time.

The intra-disciplinary work in phase two has been particularly exciting. Stimulated by collaboration between *mhhe* and the subject centres, a number of initiatives have furthered debate within the different professions and disciplines. This has linked to the "New Ways of Working" initiative from NIMHE as, in turn, the role of different professions has been reviewed. In nursing and the Allied Health Professions energy and enthusiasm for networking is high, with an interest in exploring further the links between physical and mental health and their integration into teaching. In psychology, activity has focused around scoping how mental health is taught within undergraduate programmes and counteracting the tendency, in teaching, for educators to "jump ship" to psychiatry, with a focus on medical rather than psychological models and diagnostic categories (Harper et al., forthcoming). In medicine, a review of undergraduate psychiatry teaching has been taking place under the auspices of the Association of University Teachers of Psychiatry. Service users and carers views have been sought on this, paralleling the increased emphasis recently put on user involvement in medical training (Fadden et al., 2005, Hasman et al., 2006). In social work, a recent discussion paper (NIMHE/CSIP, 2006), on the role of the mental health social worker, has reinvigorated debate and – with the development of the Social Perspectives Network – the time is ripe for an increased emphasis on mental health within generic social work education (Tew & Anderson, 2004). Thus the respective communities of practice have turned inwards to identify the challenges they face, and the nature of dialogue within the profession, in order to turn outwards and engage more effectively with those from other communities of practice.

Finally, *mhhe* has acted as broker for the development of a new community of practice – one for workers employed in universities as Developers of User and Carer Involvement in Education (DUCIE). This has provided a means by which those in such roles, often isolated and complex, can meet, support each other, evolve new practice and where necessary campaign for change. Inevitably, within this group there are also differences to contain and address: those who would call themselves survivors of the mental health system, or those who have no personal experience but coordinate the contribution of others who do; those who work on user involvement strategies only in relation to learning and teaching about mental health, or those whose work relates to other service user groups and issues; those who want to meet primarily for support or those who wish to get involved in campaigning. Embryonic networks, such as the Service User Survivor Trainers Network (SUSTN) and Professional Education Public Involvement Network (PEPIN) will, increasingly, enable individual differences in support and information needs to be addressed.

PHASE THREE OF THE PROJECT AND EMERGENT THEMES

At the time of writing, the *mhhe* project is entering its third phase, linked to the two newly designated Centres of Excellence in Learning and Teaching (CETL) about mental health

(at the University of Birmingham and Middlesex University), with additional funds from the Higher Education Academy. The link to the CETLs provides an opportunity for yet another kind of partnership to address some broader questions that are now emerging.

Firstly, how can teaching and learning about mental health be integrated across the curricula of professional courses, rather than remaining confined to a designated "mental health" module or branch programme? Secondly, how can teaching and learning about mental health can be introduced into, or highlighted within, other professional programmes such as teaching, law and the expressive arts? Thirdly, how might concerns to promote student and staff mental health and well-being link to teaching about mental health? Fourthly, how can higher education initiatives in this area (such as *mhhe*) best link with those in other areas (such as training initiatives within Trusts, the voluntary or independent sectors); and professional education and training link with that concerned with workers in new roles? Finally, how might the communities of practice and interest in the UK concerned with mental health education link with others internationally (Deakin Human Services, 1999; McVicar et al., 2005)?

CONCLUSION

In this chapter we have attempted to illustrate some of the complexities and challenges of teaching and learning about mental health in a higher education context. An understanding of these is of relevance, beyond the bounds of higher education, to the myriad communities of interest and practice that have a role to play in transforming education about mental health – through building on uni-disciplinary systems and approaches developed for different purposes and in different times, as well as on a developing history of interprofessional collaboration.

Progress in this transformation will be difficult, and fraught with challenges and ambiguity – as communities of interest, or groups within them, compete for power, or re-engage with former battles for influence. Yet, as Wenger notes, "The need for coordinating perspectives is a source of new meanings as much as it is a source of obstacles. From this perspective, ambiguity is not simply an obstacle to overcome; it is an inherent condition to be put to work" (1998, p. 84).

The Mental Health in Higher Education has been one of a range of initiatives, supporting change in education and training about mental health. Some, like the Mental Health Training Forum, and its associated national mental health education conference, have had a primary focus on training in other contexts and the development of non-professional roles; others, such as Mental Health Nurse Academics UK or the Association of University Teachers of Psychiatry, provide opportunities for educators within a single discipline to meet and develop practice. As the onward drive towards "interprofessional practice and learning" continues, it could be argued that our joint experience in the field of mental health education has much to offer to other areas of education and fields of practice.

In learning together about teaching mental health, educators (of all types), have articulated a set of common goals: to contribute to educating professionals able to provide the high quality services that people experiencing mental health difficulties and their families say they want; to help to promote mental well-being within the communities (including the educational community) in which they work; and to accommodate change and integrative thinking, whilst still being clear about the particular value of their own practice

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and perspective. The common ground is opening up, and the challenge is, together, to put ambiguity to work.

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