Mental Health Consumer Participation in Undergraduate Occupational Therapy Student Assessment: A Comparison Study

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Running title

Occupational Therapy Education Involving Consumers

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Author's Declaration of Authorship Contribution

All the authors are responsible for the reported research. They have all contributed to the research as stated in the manuscript. This includes participating in the concept and design; the gathering of data; and drafting or revising of the current manuscript. All authors have approved the manuscript as submitted.

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Mental health consumer participation in undergraduate occupational therapy student assessment: No negative impact

Abstract

Introduction: Australian accreditation standards for occupational therapy courses require consumer participation in the design, delivery and evaluation of programs. This study investigated whether a mental health consumer – as one of two assessors for an oral assessment in a mental health unit – impacted engagement, anxiety states and academic performance of undergraduate occupational therapy students. **Methods:** Students (n=131 eligible) self-selected into two groups but were blinded to the group differences (assessor panel composition) until shortly prior to the oral assessment. Control group assessors were two occupational therapy educators, while consumer group assessors included an occupational therapy educator and a mental health consumer. **Results:** Pre- and post-assessment data were successfully matched for 79 students (overall response rate = 73.1%). No evidence was found of significant differences between the two groups for engagement, anxiety or academic performance (all p values >0.05). **Conclusion:** Including mental health consumers as assessors did not negatively impact student engagement and academic performance, nor increase student anxiety beyond that typically observed in oral assessment tasks. The findings provide support for expanding the role of mental health consumers in the

education and assessment of occupational therapy students. Development of methods to determine the efficacy of consumer involvement remains an area for future research.

Key words: Accreditation; Occupational Therapy Professional Attitudes and Behaviours; Occupational Therapy Education; Students; Mental Health

Introduction

Recovery and recovery-oriented practice have emerged as the driving force behind mental health system reform across the world (Tondra, Miller, Slade, & Davidson, 2014). To achieve this reform, consumer participation in the education of future mental health practitioners has been recommended because it is thought to assist graduates to develop capabilities for recovery-oriented practice (Arblaster, Mackenzie, & Willis, 2015; Byrne, Happell, Welch, & Moxham, 2013; Felton & Stickley, 2004; Meehan & Glover, 2007). In occupational therapy, Australian accreditation standards now mandate the involvement of consumers in curricula. While evidence of the value of consumer participation in student learning is emerging, the impact on student capabilities for recovery-oriented practice is yet to be established (Arblaster et al., 2015). In addition, there is evidence that students and educators are concerned that consumer participation can negatively impact student engagement because it increases anxiety and reduces performance (Babu, Law-Min, Adlam, & Banks, 2008).

The value of consumer participation

Consumer involvement emphasises to students the importance of fostering partnerships that are driven by consumer preferences, needs and goals (Davidson, Tondra, Staeheli, O'Connell, & Rowe, 2009). When consumers provide meaningful context within curricula, students are able to learn to prioritise consumer goals and become equipped to challenge and shift the inherent power imbalances between 'professional expert' and 'patient' when they enter the workforce.

Professional endorsement of consumer participation

The National Practice Standards for the Mental Health Workforce in Australia outline capabilities required by professionals to deliver consumer focused recovery-oriented services (Department of Health, 2013). These standards are intended to complement discipline-specific practice standards in psychiatry, nursing, social work, psychology and occupational therapy. The Occupational Therapy Council (Occupational Therapy Council (Australian and New Zealand), 2013), have introduced accreditation standards that mandate

consumer participation in education programs. To meet these new standards, occupational therapy programs are required to involve consumers at a broad level, beyond ensuring their perspective of being a service recipient is heard, to that of being included in the design, delivery and evaluation of education programs (Occupational Therapy Council (Australian and New Zealand), 2013). No specific guidelines are provided by accrediting bodies on how to implement these standards, therefore educators are able to explore and develop innovative methods to involve consumers in the curriculum.

Designing Consumer Participation in Entry Level Practitioner Education

Although there is little guidance from accrediting bodies, a 5-level continuum of involvement was identified in the literature for educators to use as a point of reference. At level 1 of the hierarchy, there is no consumer involvement; at level 5, there is joint review and decision-making including when assessing students in clinical areas (Forrest, Risk, Masters, & Brown, 2000). Although this framework holds promise, there is insufficient descriptive instruction on how to execute the 'highest level' on the continuum and on how to evaluate the efficacy and impact on student learning. A review of existing research highlights a weak evidence base to support educators in their curriculum planning (Arblaster et al., 2015) creating a discord with accreditation requirements and the need to deliver recovery-oriented mental health systems.

Concerns about Consumer Participation

Although consumer participation is recommended in all professions and mandated in some, students and health practitioner educators have expressed concerns about consumers' capacity to contribute effectively to the teaching and learning in undergraduate courses (Babu et al., 2008; Edwards, 2003; Ikkos, 2003; Morgan & Jones, 2009; O'Donnell & Gormley, 2013). This is especially true in relation to their involvement in the assessment of students.

Students consider consumers to be subjective, and question the reliability and validity of their contributions due to student perceptions of the consumers' mental state (Babu et al., 2008; Happell, Bennetts, Platania-Phung, & Tohotoa, 2015; Morgan & Jones, 2009). In some extreme cases, students view consumer involvement in assessment as potentially leading to a reduction in the academic rigor and quality of these assessments (O'Donnell & Gormley, 2013). These concerns may heighten the anxiety students experience in relation to an already stressful situation (Babu et al., 2008).

Health practitioner educators express concerns about consumers not being "sufficiently qualified" to contribute to students' summative results (Anghel & Ramon, 2009, p. 189). In addition, educators view themselves as being cognisant of relevant academic

standards and requirements (Webber & Robinson, 2012), making them primarily, if not exclusively, qualified to assess students. At the extremes of this debate are educators' views of the potential harm caused by negative feedback students might receive from "despondent" consumers who are perceived to be more concerned about their own treatment within the mental health system than about the students' performances (Edwards, 2003; Ikkos, 2003). The paucity of studies on consumer involvement in student assessment, relative to the larger number of studies of consumer involvement in other aspects of higher education, may be a reflection of these concerns (Arblaster et al., 2015).

Involving Consumers in Oral Assessment Tasks

In the absence of formal recommendations on how to implement consumer participation effectively in health practitioner programs, oral assessments appear to provide opportunities for consumers to engage directly with students and to perform a meaningful role within a learning activity. Oral assessments that use a panel of 'experts' to provide a diverse perspective during the assessment and feedback process are commonly used in health practitioner education. Assessors' extension questions are a typical feature of oral assessments (Joughin, 2009), providing an opportunity to explore the depth of student understanding around mental health recovery. Oral assessments could also provide the opportunity for the educator and consumer on the panel to role-model to students a collaborative partnership, replicating a desired goal for professional practice in recovery-oriented practice.

A problematic aspect of oral assessments is that students can find the process anxiety-provoking (Joughin, 2009; Marshall & Jones, 2003; Pearce & Lee, 2009). According to Joughin (2009), some anxiety can be beneficial, but anxiety that interferes with students' performance means they will not give a true indication of their ability. Although most students may experience performance anxiety, this is also situated within an underlying population prevalence of anxiety disorders that may be experienced by students: 14% overall, with females being twice as likely as males to experience anxiety disorders (ABS, 2013). It is possible that adding a consumer to an oral assessment panel will increase student anxiety and inhibit, rather than enhance performance.

The intent of including consumers in oral assessments is to increase student engagement to enhance the attainment of learning outcomes. Pearce and Lee (2009) identify that oral assessments typically evaluate: content knowledge; confidence, conciseness, quality, spontaneity and clarity of responses; communication skills; application of theory to practice; body language and professional manner. In contrast to written assessments, students have

been found to be more motivated to raise the standard and effort if required to present their work orally. One factor attributed to an increase in motivation is an attempt to avoid appearing foolish in front of their examiners and peers (Joughin, 2007). Another factor indicating high engagement in this form of assessment is the opportunity it provides for students to demonstrate their skills as a novice professional (Joughin, 2007). Practically, this can translate into students investing more time, effort and energy in this form of assessment. Astin (1984) and Kuh (2003, 2009) have conceptualised these constructs of time, effort and energy as constituting 'student engagement'.

Objectives of the Study

This study aimed to contribute evidence about consumer participation in mental health professional education. We introduced the experience and insights of those with lived experience of a mental health condition into the student learning assessment, and thus into the student experience by adding a mental health consumer to the assessment team. Ethics approval was obtained from the Australian Catholic University Human Research Ethics Committee (#2013 243V) to distribute questionnaires to participants and to access de-identified assessment marks of participants. The following directional research questions and hypotheses were assessed:

(1) Do students who prepare for an oral assessment with one mental health consumer and one occupational therapy educator on their examining panel report increased engagement compared with students whose examining panel includes two occupational therapy educators and no mental health consumer?

Hypothesis: Students in the consumer group experience higher engagement than students in the control group.

(2) Do students with a mental health consumer on their oral assessment examining panel report increased anxiety compared with students whose examining panel includes only educators?

Hypothesis: Students in the consumer group experience higher anxiety than students in the control group.

(3) Do students with a mental health consumer on their oral assessment examining panel perform at a higher level compared with students whose examining panel includes only educators?

Hypothesis: Students in the consumer group perform at a higher level than students in the control group.

Methods

A non-randomised experimental comparison group design was used to compare information on the dependent variables of perceived engagement rates and anxiety levels of students in two groups before and after the oral assessment (Portney & Watkins, 2014). The control group were the students that had two occupational therapy educators on their examining panel and the experimental group had an occupational therapy educator plus a mental health consumer. Finally, the academic performance grade averages for each group were compared at the completion of the oral assessment.

Participants and Recruitment

Students were recruited from an undergraduate occupational therapy program taught across two campuses of an Australian university. All were in the second year of a four-year course and enrolled in the first of two consecutive mental health units in the course. A non-teaching staff member distributed participant information and recruitment letters on behalf of the research team to students outside teaching times and away from tutorial rooms. This was done to ensure students had a genuine opportunity to decline to participate. Written informed consent was obtained from all participating students.

Allocation to group:

As part of the curricular design for the unit, all students nominated to partner with a fellow student for the assessment task four weeks prior to the scheduled assessment weeks. Once they had identified a partner they were then eligible to allocate themselves, via the online learning platform, to one oral assessment time block provided across two weeks. The number of time blocks required were calculated on student enrolment numbers, and then divided equally across the two week assessment period. One week before the first presentations, students were informed whether they were allocated to an assessment panel with educators only (control group; first week of assessment) or a consumer and educator panel (consumer group; second week of assessment). Students did not have the opportunity to meet the consumer assessors beforehand; however biographies of consumer assessors were made available to students on the online learning platform when students were informed of the group allocation. Educators were members of the students' usual teaching teams.

Consumer selection:

Appointment of mental health consumers to sit on the oral assessment examining panels involved seeking expressions of interest from established consumer networks. Interested consumers were shortlisted if they had previous experience in consultation or delivery of consumer perspectives to undergraduate students or health professionals. Consumers were selected based on their experience of occupational therapy in mental health

(e.g., service use, or having worked alongside an occupational therapist). In addition, consumers were asked about their preparedness to give feedback to students.

Training of assessors:

Support and training of consumers to conduct their role included providing them details of the oral assessment task (the vignette and the marking rubric); participation in a cross-campus teleconference between educators and consumer assessors; receiving an overview of the occupational therapy curriculum; reviewing the learning outcomes for the specific mental health unit; setting moderation standards; and instruction on the process for conducting the oral assessments. Integral to the briefing activity was a discussion about the focus of consumer feedback, questioning and marking following the oral assessment. Unique to the consumer panel groups would be a consumer-delivered focus on the extent to which students were recovery-oriented in their choice of language and person-centered in their selection of assessments and interventions. Educators would provide feedback on students' professional reasoning skills to both groups of students. Students were not informed of the oral assessment consumer training process.

Equally important to the pre-assessment briefing, debriefing of consumers was also conducted. This aimed to support consumers through the oral assessment process, to provide an opportunity for questions and discussion around any potential negative impact of presented material.

Data Collection

In the 24 hours prior to completing the oral assessment, students completed the pre-assessment survey. The post assessment survey was completed by students within one week of completing the oral assessment task. The survey was distributed by a staff member outside the teaching team. Panel members did not have access to survey results until after the oral assessments had been completed.

Oral assessment task:

A written vignette describing a mental health consumer was provided to students four weeks prior to the oral assessment. The vignette included a detailed report comprising medical, psychiatric, family and social history, routine outcome measures including the Life Skills Profile-16 (Rosen, Hadzi-Pavlovic, Parker, & Trauer, 2006), Health of the Nation Outcomes Scale (Royal College of Psychiatrists, 1996), Behavior and Symptom Identification Scale (Eisen, Wilcox, Leff, Schaefer, & Culhane, 1999), mental state examination, risk assessment and the Canadian Occupational Performance Measure (Law, 2014). The oral presentations included 15 minutes of students presenting their reasoning for

assessment selection, ideas for collaborative recovery goals and a plan for implementing a treatment approach for a six-week period in an ongoing therapeutic relationship. At the end of the presentation, students responded to questions from the panel for approximately 5 minutes. Students were provided with verbal feedback from both assessors, regardless of group allocation. Consensus-based grading of student performance was completed by the two allocated assessors when the student had exited the assessment venue, using the same rubric. Students were informed that each member of the panel would be involved in determining their final mark. Input from both panel members was sought on each criterion. Where discrepancies between panel members could not be resolved through discussion, it was agreed that the panel member with greatest content expertise (educator or consumer) would decide the final mark for that criterion. For example, disagreement on the use of recovery-language resulted in the consumer determining the mark for that criterion.

Instruments:

The purpose-designed survey sought information about the student's age and the oral assessment panel to which they were allocated: 'educator'; 'consumer' or 'not sure'. Gender demographics were not sought because the cohort was predominantly female and identification of gender may have compromised the anonymity that was offered to student participants. The survey included six Visual Analogue Scales (VAS) and 20 statements from the State-Trait Anxiety Inventory for Adults (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).

Visual analogue scales:

To capture the students' perceptions of engagement, study-specific Visual Analogue Scales (VAS) were developed by the research team based on the previous work of Austin (1984) and Kuh (2003; 2009). VASs aimed to evaluate each student's self-reported expenditure of time, effort and energy in preparing for the oral assessment at two time points: once before the oral assessment experience and later at the conclusion. An example question used to determine student perceptions on a VAS was: '*How much time did you dedicate to preparing for the oral assessment?*' The scales were designed as 10 cm anchored scales with the left hand anchor indicating a 0, or "no time/energy/effort" or "not important", through to 10 being "a great deal of time/energy/effort" or "of great importance" (Figure 1). VAS scores for each of the engagement constructs of time, effort and energy were individually measured and paired for each student for both time points to explore changes over time.

<<Insert Figure 1>>.

State-Trait Anxiety Inventory for Adults:

Developed by Spielberger et al. (1983), the State-Trait Anxiety Inventory (STAI) for Adults evaluates anxiety states and traits in individuals or groups. Anxiety states refer to how an individual reports feeling “right now, at this moment”, whilst traits are considered a more generalised or regular emotional condition. For the purposes of this study, the self-administered S-Anxiety form was included as part of the pre- and post-assessment survey (Welsh, 2014). The S-Anxiety form consists of 20 statements that seek to evaluate the intensity of how individuals feel in the present moment, rated on a four-point Likert scale: (1) not at all; (2) somewhat; (3) moderately; and (4) very much so. Half the statements are framed to elicit anxiety-absent feelings and hence are reverse coded when scoring. A review of studies using the STAI over the past four decades highlights the measure’s ability to detect anxiety, particularly in student populations (Booth, Sharma, & Leader, 2016; Welsh, 2014). Total scores ranged from 20 to 80. Spielberger’s State Scale normative data were not used as a normative comparison of findings in this study because recent findings have indicated Australian and American STAI anxiety rating scores have increased compared to the original published normative data set (Booth et al., 2016).

Grades for academic performance:

Academic grades for the oral assessment were recorded. The oral assessment was marked using a rubric with potential grades ranging from 0 to 20. The rubric, used in the previous year of this unit of study, was developed by the teaching team and underwent a process of moderation by the senior academic heads of department.

Statistical Analysis

Descriptive statistics were used to describe sample characteristics, including distribution of the sample across the two campuses and into study groups. Mean, standard deviations and 95% confidence intervals for VASs and Anxiety States scale were calculated. Repeated measure ANOVA was used to determine the differences between the control and consumer group at two time points. Independent samples t-tests were used to determine the statistical significance of any difference between the two study groups for engagement (time, effort, energy) and performance (assessment marks). Data collation and statistical analysis were performed using IBM SPSS (Version 20).

Results

Participants

Of a total enrolment of 131 students, 108 consented to participate in the study, with three students unable to complete the oral assessment task. Pre- and post-assessment data were successfully matched for 79 consenting students, giving an overall response rate of 73.1%. When asked what group they were allocated to, 29 students reported that they were in the control group, 33 in the consumer group, and 17 students stated that they were unsure of the group to which they were allocated. Students in the “unsure” group were not considered in the planned analysis (comparisons between control/consumer groups), as knowledge of the assessment panel composition was expected.

Student Engagement

Students in the consumer group did not report expending greater time, effort or energy on this assessment task than students in the control group (Table 1). No statistically significant differences in engagement measures were observed between groups pre- or post-assessment.

<<Insert Table 1.>>

Student Anxiety

Table 2 summarises student anxiety scores for each group and time point. There was no evidence that the anxiety ratings were different between the two groups at either pre-assessment (mean difference = 4.3 (Std Error for difference: 3.6); $p = 0.237$) or post-assessment (mean difference = -5.0 (Std Error for difference: 3.6); $p = 0.172$)).

<<Insert Table 2.>>

Academic Performance

Of the 105 consenting students who completed the assessment task, 59 were allocated to the control group and 46 to the consumer group. The marks for the control group were $M = 14.23$ ($SD = 3.13$; range 6.25 to 19.25) and for the consumer group $M = 13.87$ ($SD = 2.03$; range 8.5 to 17.75), with no statistically significant difference between the scores ($p = 0.5$).

“Not sure” Group: Post-hoc Analysis

Students ($n = 17$) who were unsure of their assessment panel’s composition were included in a post hoc analysis for comparison with the control and consumer groups. One-way analysis of variance showed no statistically significant difference in self-reported time, energy or effort spent on their assessment task (at pre- or post-assessment time points) or in anxiety scores (data not shown).

Discussion

This study investigated the effect of expanding the involvement of mental health consumers within the occupational therapy curriculum as a response to changing accreditation requirements. Our approach was to include a consumer on an assessment panel in an oral examination in a second year unit of study. This represented an expanded role from our prior curriculum in which they had been engaged to tell of their experiences as service recipients of occupational therapy. We chose the oral assessment as one place in the curriculum where consumers could be engaged in a meaningful way, arguably in a way that has greater fidelity with authentic professional activities. We chose to evaluate the effect on students in making this change to our curriculum to understand whether there were any benefits or negative consequences to student learning.

Student Engagement

There were no detectable differences in the levels of engagement between the students in the control and consumer group at either time point, suggesting that consumer presence did not raise the level of student engagement. Students in both the control and consumer groups at pre and posting testing consistently rated themselves at the upper end of the VAS, as seen in mean scores for time, effort and energy being > 7 , with the exception of consumer group rating of time being 6.55(SD2.4). These levels of engagement are consistent with findings from studies that measure motivation and effort of students in oral assessments, indicating a desire to raise their performance in this format (Joughin, 2009).

We aimed to determine if the students in the consumer group would have an increased level of engagement in the oral assessment process compared with those in the control group. A Type II error is possible as sample sizes may have been insufficient to demonstrate statistical significance. Although not statistically significant, the group that trended towards higher self-reported levels of engagement was the control group and not the consumer group. This finding however, although unexpected, is consistent with the literature on consumer involvement in health practitioner higher education that suggests that students may be dismissive of consumer involvement and less engaged (Babu et al., 2008; Morgan & Jones, 2009; O'Donnell & Gormley, 2013). The absence of a negative effect on student effort does, however, lend support to the notion of including mental health consumers in assessment panels.

Student Anxiety

Student anxiety is a complex and multifaceted state that can be influenced by numerous factors. A potential source of student anxiety was hypothesised to be related to the consumer's role on the panel, specifically students' perception of their capacity to undertake the assessment task in a manner that was equitable, reliable and valid (Babu et al., 2008; Morgan & Jones, 2009; O'Donnell & Gormley, 2013). Results indicated no significant difference in the anxiety scores between the control and consumer groups: consumer involvement in the assessment process did not increase student anxiety in this process. Anxiety states across both groups were already somewhat elevated, which is consistent with previous studies that found oral assessments are an intense and anxiety-provoking form of student assessment of learning. Adding a consumer to the student assessment experience, in this study, did not have an appreciable impact. The high anxiety scores may be in part explained by the predominantly female cohort with national prevalence rates of anxiety disorders being higher for females (ABS, 2013).

To recruit suitable candidates with an interest and background in education, investigators distributed the expressions of interest to established consumer networks. This meant that the position was targeted towards consumers experienced in a variety of education and training roles. Although we aimed to recruit consumers with experience in providing a consumer perspective to students and health professionals, investigators still expected that students in the consumer group would respond to the change to traditional assessor roles with increased effort and anxiety.

Academic Performance

This study found no evidence that students who received assessment by a consumer had a different grade compared to those who were assessed by educators only. This finding should in part alleviate the anxiety of students about whether reliable and valid grades can be awarded by consumers. It is possible that this consistency was influenced by the consistent presence of the educator in both groups. Unlike other studies, where the educator controlled the student's assessment grade, this study employed a consensus approach to marking. Educators have indicated that the involvement of consumers is worthwhile in the training of health practitioners; however, they rate 'assessment' as the domain that should be exclusive to educators (Webber & Robinson, 2012). The findings from this study would challenge this belief with consumers demonstrating their ability to be consistent with educators in marking students collaboratively. This indicates the format employed for the oral assessment contains vital mechanisms, such as the previous experience of consumers in providing consumer

perspectives and the briefing and debriefing for consumers that reinforces and safeguards the academic rigour for assessments.

Student attention to the panel composition

The formation of the third 'not sure' group, who were unclear about who was on their assessing panel was unexpected. This option for students to select 'not sure' when asked about their assessment panel was provided because we did not want students to guess. Numerous communication strategies were used to inform all students about the assessment panels, including announcements in lectures and tutorials and via the online learning platform; follow-up emails to students about the research study; distributed study information sheets and biographies of the consumers. It is not possible to determine why students felt unsure about the identity of their oral assessment panel despite these varied communication strategies. Interestingly, those students in the 'not sure' group tended to rate themselves as spending more time than the other groups in preparing for the oral assessment. It does, however, appear that this group did not spend time accessing the recommended preparation resources, such as those provided about the background and qualifications of their assessors that were provided through the communication strategies.

Future research and implications for academic preparation of practitioners

This research provides support for expanding the inclusion of mental health consumers in the education and assessment of undergraduate occupational therapy students. This suggests that educators can proceed to recruit, brief and debrief, to be able to include consumers in this aspect of occupational therapy education. The high levels of anxiety reported by students surrounding the oral assessment process is of interest, and warrants further investigation into the impact on student performance.

An unexpected finding of the project was the influence of the consumer perspective on the occupational therapy educators. Anecdotally, educators reported experiencing a deeper understanding of recovery as a result of working with consumers in their role as assessors, hinting at a parallel learning process. This is in contrast with previous evidence that highlighted health practitioner educator concerns that only educators held the relevant knowledge of academic standards to be able to carry out assessments (Webber & Robinson, 2012). Further research could investigate the impact of consumer participation on educator understanding of the complexity and individualised nature of recovery. An investigation into the consumer experience of being involved in the oral assessment format is needed to determine their perspectives and understanding of the role. Finally, a qualitative exploration

of student experiences of being assessed by a consumer is needed to determine if it enhances recovery-oriented capabilities for future practice.

Limitations

This study used a convenience sampling approach which may not produce a representative sample and self-report questionnaire design which could have introduced a response bias. The small numbers of students from whom matched surveys were available reduced the power of the study, introducing a risk of a Type II error. The design did not elicit a sufficient volume of qualitative data to provide further in-depth understanding of the student experience. A further limitation was the absence of data on how often the educator and consumer assessor differed in their marking. Future investigations into this assessment format should aim to examine any power differential and impact on consensus marking.

Conclusion

Recovery-oriented practices require mental health professionals to be able to prioritise the preferences, needs and goals of consumers. Consumer participation in the design, delivery and evaluation of health professional education is one method of ensuring that capabilities that support health professionals to achieve consumer-driven recovery remain high on the agenda and are delivered with a unique consumer perspective. An outcome of this study was emerging evidence to begin to challenge student and educator concerns regarding consumers' ability to achieve the academic rigour and quality required for the student assessment process. This study indicated that consumer involvement in an oral assessment did not influence student engagement. There was also no evidence that consumer involvement influenced the levels of students' assessment results or performance anxiety. Findings from this study can be used to assure accrediting bodies that the 'consumers as assessors' format can provide an opportunity to embed the consumer perspective in a meaningful and authentic manner. This assessment format has implications for contexts beyond mental health education. Recruitment of other health service users (consumers and /or carers), with an interest in education and training, should be considered to provide a consumer or carer perspective on assessing panels within a multitude of health disciplines.

Key Points for Occupational Therapy

- Oral assessment panels provide meaningful opportunities to involve mental health consumers in the curriculum.
- Students are engaged and perform to the same academic standard to their peers when mental health consumers are involved in their oral assessment.
- Oral assessments remain highly anxiety provoking for students.

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Author's Declaration of Authorship Contribution

All the authors are responsible for the reported research. They have all contributed to the research as stated in the manuscript. This includes participating in the concept and design; the gathering of data; and drafting or revising of the current manuscript. All authors have approved the manuscript as submitted.

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Table 1. VAS scores of student engagement, consumer and control groups (pre- and post-oral assessment)

	Pre-Oral Assessment			Post-Oral Assessment		
	Control (n=29)	Consumer (n=33)	p	Control (n=29)	Consumer (n=33)	p
Time	7.00(2.2)	6.55(2.4)	0.44	7.48(1.8)	7.48(2.1)	1.0
Energy	7.48(2.0)	7.06(2.3)	0.44	7.72(1.3)	7.52(2.4)	0.67
Effort	7.72(1.7)	7.09(2.0)	0.19	7.90(1.3)	7.73(2.0)	0.7

Table 2: Anxiety raw scores for two group comparisons at two time points

Group	N	Pre-Oral Assessment			Post-Oral Assessment		
		Mean (SD)	Minimum	Maximum	Mean (SD)	Minimum	Maximum
Control Group	27	56.0(14.0)	31.0	80.0	45.4(13.9)	20.0	74.0
Consumer Group	28	51.7(13.5)	26.0	78.0	50.3(12.6)	28.0	76.0

Note. Anxiety scale data were incomplete for seven students (n = 2 control group; n = 5 consumer group). Mean anxiety raw scores for the student cohort were 53.8 (SD 14.1) and 47.6 (SD 13.5) for pre-and post-assessment time-points, respectively.

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