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Storytelling and Beyond: Integrating Lived Experience into Mental Health and Addiction Health Education

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Abstract

The overseas literature emphasises the importance of lived experience of mental health and addiction being integrated into the education of health professionals. It is also clear that existing mental health and addiction education programmes do not adequately meet the content requirements for integration of lived experience into mental health and addiction health curriculum. Drawing core themes from the existing literature, semi-structured interviews were undertaken with a cross-sectional of participants, being those with lived experience of mental distress and/or addiction who work in the mental health and addiction sector, and representatives of organisations who are involved in mental health and addiction education and workforce development. The research methodology was thematic analysis, supported by a phenomenological theoretical position. The study found that currently there is limited integration of lived experience across mental health and addiction health curriculum in Aotearoa New Zealand. Contributing to this are differing attitudes held by mental health and addiction education providers towards lived experience, some of which constitute a barrier for change. The study also found value to student understanding of mental distress and addiction by integrating lived experience into mental health and addiction health education and that this is optimised when taught by people from the lived experience community. Deeper understanding of lived experience could also be achieved by introducing lived experience principles into mental health and addiction education. If lived experience is to coexist in mental health and addiction education it will require acceptance and recognition by mental health and addiction education providers and equal participation of the lived experience community in the design, development, and delivery of lived experience content. Recommendations to assist with the integration of lived experience into mental health and addiction education have been made within the thesis.

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Glossary of Terms

Allied Mental Health and Addiction Health Professionals: Are qualified health professionals who are not classified as part of medical or nursing professions. These people have specialised expertise and work across a range of mental health and addiction treatment services (Ministry of Health, 2023).

Holistic Approach: Provides support that considers the whole person, including their physical, emotional, social, and spiritual wellbeing.

Lived Experience/Peer Support Work: Is the practice of advocating recovery by giving support, information, and practical assistance to others who are experiencing mental distress and/or addiction.

Mental Health Consumer/Service User: A person who is receiving or has received professional support for mental distress and/or addiction. Note: The use of consumer and service user has been used interchangeably throughout the thesis.

Recovery: Is the process a person takes to accept and overcome the challenges associated with mental distress and/or addiction.

Recovery-oriented approach: Mental health professionals support people to take control of their lives and choose what is important for their wellbeing (Ng et al., 2011).

Recovery-oriented practice: There is a belief that recovery is possible, and a person is seen as an expert of their own experiences. Hope is fostered, and a person's individuality and self-determination are supported.

Storytelling: A learning approach used to help students develop a sense of understanding and meaning to mental distress and/or addiction. People with lived experience of mental distress and/or addiction are invited into the classroom to tell their personal stories of recovery (Mancini, 2019).

Chapter One: Introduction

"It takes strength to be with people who are experiencing some of the hardest times of their lives when your core being remembers exactly how that feels" (Te Pou, 2020, p3).

The aim of this study was to develop recommendations for how lived experience (LE) can be integrated into educating allied mental health and addiction (MHA) health professionals, so they have LE principles as the foundation of their practice. In the context of this study the definition of LE is personal experience of mental distress and/or addiction and the understanding of what people accessing mental health (MH) services are experiencing (Repper & Carter, 2010). The study's objectives were:

1. To explore how LE is integrated into current MHA health education;
2. To explore how to operationalise MHA strategy and policy that is inclusive of LE within MHA education;
3. To explore how integrating LE into MHA health education can lessen stigma and discrimination; and
4. To explore what value is added by integrating LE across the different stages of allied MHA health professionals' education.

At the design stage of the study due consideration was given that this study was student research bounded by; an established maximum word limit, time limits due to the duration of the course, and that the study was self-funded. Each of these elements were considered when deciding the parameters of the research. The study sought a cross-sectional perspective that is inclusive of an organisational and individual point of view, though it was not a comparative study. The research methodology was thematic analysis and was supported by a phenomenological theoretical position. The method was semi-structured interviews.

This chapter discusses how the paradigm of LE has developed over time and has been integrated within the MHA health system overseas and in Aotearoa New Zealand (Aotearoa). Part of LE's integration in Aotearoa has been the development of a LE peer support workforce within MHA services. Understanding the background of LE provides context to the current situation of LE and its integration into MHA education.

Background

MHA in Aotearoa

Mental distress and/or addiction impacts on many peoples' lives and 50–80% of New Zealanders will experience mental distress and/or addiction issues in their lifetime. The number of people accessing MHA services is growing and people seeking MHA services has increased 73% since 2007 (Government Inquiry into Mental Health and Addiction, 2018; Mental Health and Wellbeing Commission, 2020).

The MHA health system in Aotearoa is in a process of transformation and this has been driven by results from the Government Inquiry into MHA. The purpose of the Government Inquiry was to listen to people and their whānau/families with LE of MHA, and from people working in the MHA sector, on the current approach to MHA and what needs to change. A recommendation from the Government Inquiry was the reestablishment of an independent Mental Health and Wellbeing Commission to provide oversight and leadership of the MHA sector in Aotearoa. The objective of the commission is to support equitable MHA outcomes for people and to have a lasting role in transforming approaches to MHA in Aotearoa (Government Inquiry into Mental Health and Addiction, 2018; Mental Health and Wellbeing Commission, 2020).

What is LE? – Birth of Consumer/Survivor Movements

To understand what LE is and where it fits within the current MHA health system requires looking back to the rise of the antipsychiatry and consumer/survivor movements in the 1960s and 1970s. Cummins (2017) described these movements as supporting a counterculture of how people experiencing mental distress should receive support and treatment. At that time paternalism was the dominating therapeutic relationship model used. This model proposes the clinician makes decisions based on what they determine to be in the person's best interests, even for those who can make decisions for themselves. An outcome for the recipient of this type of care, particularly for people who have spent time in MH inpatient services, is they can lose faith and trust in their own ability to assert control over their MH decisions (Ministry of Health, 1995).

The antipsychiatry movement questioned psychiatry's existing treatments and practices, which were often punishing and harsh (Kavirayni, 2019). For example, a prominent treatment was electroconvulsive therapy, which was often used without the use of anaesthetic or muscle relaxants. This treatment was often obligatory and without an attempt to seek the person's consent or explain potential treatment benefits and limiting side effects. A key principle underpinning the antipsychiatry movement was the idea that psychiatry was a form of social control and not a humanitarian intervention aimed at relieving distress and encouraging wellbeing (Cummins, 2017). Social control in a medical context arises when power comes from having authority to define certain behaviours, persons, and things (Conrad, 1992).

A contention of both the antipsychiatry and consumer/survivor movements was that psychiatric practices saw people through a lens of illness, believing that the lives of people experiencing mental distress were unlivable without psychiatric intervention and medication.

This was seen as taking away peoples' hope. Another issue was the use of large MH hospitals, and these institutions were viewed as dehumanizing environments of neglect and social isolation where people were being deprived of their fundamental human rights and citizenship (Cummins, 2017).

From the 1950s through to the 1970s there was radical restructuring of MH systems within many Western countries. This involved deinstutionalisation (the closing of MH hospitals), the availability of new psychotropic drugs, the evolving concept of consumer rights, and the consolidation of the antipsychiatry and consumer/survivor movements (Kavirayni, 2019). According to Cummins (2017) the supporters of antipsychiatry significantly influenced the call for deinstitutionalisation while at the same time encouraging the development of a community care model as an alternative psychiatric intervention for treating mental distress.

The consumer/survivor movement aimed to build a workable alternative system underpinned by the philosophy of empowerment. This would give people using MH services control over their decisions on the types of treatment they would receive. A principle of the consumer/survivor movement was that people had special insight into mental distress by having experienced it. It was on this principle that survivors of mental distress, as individuals and in groups, began to stand up for their right to speak on their own behalf and called for a shift in the power dynamics between clinician and consumer. This shift towards empowering people to have more control over their MH was the driving force behind integrating the concept of LE or a recovery-oriented approach within the MHA health system in Aotearoa and other mainly Western countries. (Coney, 2004; Mental Health Commission, 1998; Tobin et al., 2002; Tomes, 2006).

LE in Aotearoa Policy and Strategy

The concept of LE is not new to Aotearoa. People have been active participants in the wider health sector since the nineteenth century and many initiatives from individuals, groups and communities have helped build Aotearoa’s health system (Coney, 2004). LE as it relates to MHA is seen as an activity undertaken by people where they have influence on a system that affects or has affected their lives (Wade, 2001).

The late 1980s and 1990s saw the inclusion of LE in health systems become internationally important. This led countries, including Aotearoa, to write LE into their national MH strategic plans policy documents (Gordon, 2005; Tobin et al., 2002). A guiding document introducing LE into Aotearoa’s health system was the Ministry of Health’s (1995) A Guide to Effective Consumer Participation in Mental Health. This document explained why LE was necessary and included strategies to effectively integrate LE into MHA services. LE was further embedded into the MHA health system in 1997 with the publication of The National Mental Health Sector Standards (NMHSS). These set out performance standard requirements for all government funded MHA services and Standard Nine was specific to individuals with LE being involved at all levels of MHA services (Matua Raki, 2010). Following the introduction of the NMHSS the Ministry of Health (1997) released Moving Forward: National Mental Health Plan for More and Better Services. This document established a landscape for integrating people with LE across planning, policy, funding, and delivery of MHA services with the expectation that these people would be trained and employed into LE specific roles. However, a review of the plan’s implementation taken after two years found progress was extremely slow and the integration of people with LE was varied across the different areas of the MHA health system. Importantly, the review highlighted there was little LE participation within addiction services

(Mental Health Commission, 2000). To address this, Standard Nine of the NMHSS was included in the 2003 Alcohol and Drug Treatment Sector Standards. It is important to point out that historically the addiction sector has employed people with their own LE of addiction and these people enter the MHA workforce mainly as addiction practitioners (Matua Raki, 2010). Despite the addiction sector having people with LE working in addiction treatment services and having a culture of peers supporting peers there has been little written about people with LE working in the addiction sector in Aotearoa and there is no information relating to integrating LE into addiction education.

Current State of LE within Aotearoa's MHA Health System

To operationalise the integration of LE into the MHA health system, the MOH through the District Health Boards of the time, provided the funding for people with LE to be employed across the whole MHA health sector (Ministry of Health, 1997). One outcome has been the development of a small LE peer support workforce that sits separate to other health disciplines working in the MHA health sector. The minority position held by the LE peer support workforce was strongly echoed in the Government Inquiry into MHA report which states, "…[The] consumer voice needs to be supported, strengthened, and included in all aspects of the system, from governance to service delivery" and LE continues to be on the "…periphery of service design and delivery, rather than at its centre" (Government Inquiry into Mental Health and Addiction, 2018, p.159). The report affirms the current approach to integrating LE into the MHA health system to date has not been hugely successful.

The Ministry of Health (2018) Mental Health and Addiction Workforce Plan 2017-2021 had two objectives which were significantly relevant to MHA education and LE's future standing within Aotearoa's MHA system. The plan states:

1. The LE peer support workforce has an important role in influencing the training and development of the overall MHA workforce; and
2. Strengthening the LE peer support workforce will provide opportunities to build capacity across the whole MHA workforce.

Although the plan recognises there is an important role for LE in MHA education, it doesn't go as far as to make recommendations for developing a plan to include LE in the education of other health disciplines who work in the wider MHA health system. Similarly, the aim of strengthening the LE peer support workforce to build capacity also lacks planning to achieve this.

Two MHA workforce reports (Te Pou, 2014a; & Te Pou, 2018) give insight into the growth of the LE peer support workforce between 2014 and 2018. The table below is a comparison between the LE peer support workforce and total MHA workforce including percentage growth between 2014 to 2018.

Table 1

Comparison LE peer support workforce, total MHA workforce, percentage growth

	2014	2018	% Increase
Total MHA workforce	9509	10832	13.9%
LE peer support workforce	216	317	46.8%
LE peer support workforce as % of total MHA workforce	2.2%	2.9%	0.7%

Data taken from: More Than Numbers Adult Mental Health and Addiction Workforce 2014 Survey of Vote Health Funder Services (Te Pou, (2014a) and More Than Numbers Adult Mental Health and Addiction Workforce 2018 Secondary Care Health Services (Te Pou, 2018).

The table shows almost a 50% growth in the LE peer support workforce between 2014 and 2018. However, this increase compared to the total increase across the whole MHA workforce, was less than 1%. The numbers illustrate the slow progress being made to integrate LE into MHA services. Although the MOH reports strengthening and developing the LE peer support workforce will assist in educating the wider MHA workforce and build capacity within the MHA health system it will be difficult to attain these objectives when LE peer support is very much in the minority. It is noted reporting on the state of the MHA workforce in Aotearoa is four-yearly and at the time of submitting this thesis Te Pou confirm the 2022 report is still to be published.

Educating the LE Peer Support Workforce

Development of a separate education pathway for LE peer support workers has gone hand in hand with the emergent LE peer support workforce. Originally LE education was developed inhouse by non-government organisations involved in delivering community-based MHA services and specialist peer-led support services. This informal approach was limiting as the education was siloed within organisations resulting in a lack of consistency across the education programmes. In 2014 a significant step forward came with the release of two documents: Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce (Te Pou, 2014b); and Service User, Consumer and Peer Workforce: A Guide for Planners and Funders (Te Pou, 2014c). The Competencies describe the attitude, knowledge and skills required for LE peer support roles and suggests the Competencies be used to guide development of LE peer support education programmes. The planning guide recommended the development of a national qualification and career pathway for the LE peer support workforce. Progress in developing a LE peer support qualification has been slow. The only formal qualification in LE peer support sits at entry level within the tertiary vocational education sector. Currently there are no qualifications above this level available for people to progress their education in LE peer support other than undertaking further education in another health discipline within the wider MHA health sector. This would indicate that despite there being a focus of having LE at the centre of MHA health system, MHA education may not have the same focus.

Educating Aotearoa's MHA Workforce in LE

There is little information available informing the breadth and depth of LE content that has been integrated into MHA education in Aotearoa. One approach taken in Aotearoa and other countries (i.e., Australia and United Kingdom) has been to invite people with LE into the classroom to tell students about their experiences of mental distress, their use of MH services, and their process of recovery (storytelling). This approach in Aotearoa and Australia has been led by MH nursing and occupational therapy education. However, the MH nursing and occupational therapy literature signals there is still much work to be done before it can be seen that LE is fully integrated across both disciplines (Byrne et al., 2013; Happell et al., 2016b; Schneebeli et al., 2010).

Chapter Summary

The MHA health system in Aotearoa is in a process of transformation and this has been mainly driven by the outcomes of the Government Inquiry into MHA. The Government Inquiry report affirmed that LE needs to be strengthened and integrated across the whole MHA health system including MHA education. LE has developed from the consumer/survivor movements of the 1960s and 1970s who aimed to build a MHA health system underpinned by the principles of empowerment, in turn giving people using MH services control over their decisions to the types of treatment they would receive. The end of the twentieth century saw the inclusion of LE become internationally important and this has led countries, including Aotearoa, to write LE into

MHA strategy plans and policy. In Aotearoa this has led to the development of a small LE peer support workforce which remains a minority group compared to the overall MHA workforce. Currently in Aotearoa there are no formal qualifications above a level four certificate at tertiary level available for people to progress their education in LE peer support, even though the aim is to have people with LE support the education of future MHA health professionals. There is little information available within an Aotearoa context regarding LE being integrated into the education of other health disciplines.

The next chapter is a review of the literature and will focus on understanding the current level of involvement of LE in education of MHA health professionals inside and outside of Aotearoa.

Chapter Two: Literature Review

My [family member] attends a support group run by people with mental health for people with mental health and this for him is one of the most important therapies that he attends (Family member). (He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, 2018, p. 60).

Introduction

Over the past several decades there has been major restructuring of mental health and addiction (MHA) health systems within many Western countries, including Aotearoa New Zealand (Aotearoa). One concept to be introduced is that people with lived experience (LE) of mental distress, addiction and recovery be actively involved in decision making across all levels of the MHA health system. A natural extension to assist with integrating LE into the MHA health system is for LE to be included in the education of MHA health professionals. For this study education refers to formal qualifications and does not include inhouse training and professional development programmes. Involving people with LE in educating MHA health professionals is an emerging practice that may move the system changes required to integrate LE into MHA health professionals' practice. It is not clear how these changes, which will involve substantial shifts in knowledge, skills and attitudes will occur.

The literature review focusses on formal health qualifications that include a LE perspective in their curriculum and the studies reviewed in this chapter were chosen for their relevance to understanding the current level of involvement of LE in the formal education of MHA health professionals. The literature review gives a broad overview of the progress made to integrate LE into MHA health education, it identifies how LE has been integrated into mental health (MH) curriculum outside of Aotearoa and explores what work has been done to integrate LE into MHA health curriculum within Aotearoa. This review indicates that the integration of LE appears to be undertaken predominantly in four key health disciplines: psychiatry, mental health nursing, social work, and occupational therapy, and is primarily being directed by national policy and professional body requirements (Arblaster et al., 2015; Feeney et al., 2013; Happell et al., 2015a; McCusker et al., 2012; Newton-Howes et al., 2018; Prytherch et al., 2018; Rhodes, 2012; Sowers et al., 2016). This chapter will provide an overview of current evidence for the integration of LE within these four disciplines, starting with psychiatry education.

LE in Psychiatry Education

According to Ng et al. (2011) a challenge facing psychiatry is the need to update empirical knowledge and professional skills that are inclusive of LE principles. They believe the hardest challenge will be to shift the existing attitudes of MHA health professionals away from the biomedical approach focusing on treatment for the reduction of symptoms, towards a recovery-oriented approach of supporting people to take control of their lives and choose what is important for their wellbeing. Ng et al. suggests a way of countering this is at the earliest stages of professional training with a curriculum that teaches the key LE principles, processes and practices which support recovery-oriented practice.

There are some examples of teaching programmes that follow Ng et al.'s suggestions for integrating LE, including that of Sowers et al (2016) who focuses on developing a curriculum for equipping psychiatrists with the tools of recovery-oriented practice. Sowers et al. outlines a training course designed to demonstrate LE principles and practices for psychiatrists in the United States to apply in their day-to-day clinical practice. The curriculum content is comprised of a series of learning modules that address specific aspects of recovery-oriented practice ranging from; engagement, person-centred planning, shared decision making, and peer support. The curriculum content is delivered online, or face-to-face with a psychiatrist and a person with LE co-facilitating. The added value of the face-to-face training is that it gives opportunity for questions and discussion. The curriculum was piloted across the United States involving psychiatrists, psychiatry-residents, and medical students. Most participants reported their LE knowledge was improved and that they were likely to apply this new knowledge to their clinical practice. Although the researchers acknowledged the results did not provide rigorous data on the curriculum's educational effectiveness, the participants' feedback was used to amend the curriculum to include additional case studies and video interviews with people in recovery. The researchers concluded the curriculum brought together all the elements of recovery-oriented practice required for psychiatry and this was confirmed when the curriculum was endorsed by the Institutional Review Board of the American Psychiatric Association.

Initially information underpinning the development of the psychiatry education programme by Sowers et al. was gathered from various stakeholders including people with LE. However, once the curriculum was developed, feedback received was limited to psychiatrists and medical students, excluding feedback from the stakeholders who were initially involved, specifically those with LE. The researcher's data may have given a more meaningful perspective if feedback had included these stakeholders and the LE facilitators co-facilitating the curriculum. The literature cautions there is risk of tokenistic participation if people with LE are not involved across all stages of integrating LE into MH health education, and emphasises tokenism is less likely to occur when people with LE have equal authority and are employed in roles where they can make a difference (Byrne et al., 2018; Happell et al., 2015a).

While the inclusion of individuals with LE in psychiatry education programmes may be advocated for as best-practice, there is evidence that this may still result in mixed feedback on its effectiveness for reasons related to perceptions of the traditional relationships between MHA health professionals and service users. A qualitative study by Agrawal et al. (2016) involving the pairing of fourth-year Canadian psychiatry residents with people with LE as their advisors was undertaken over a period of six months. The study's objectives were to improve psychiatry residents' understanding of LE and to reduce any negative perceptions they may have had towards people with LE of mental distress and/or addiction. This study reported on the feedback given by both the psychiatry residents and the LE advisers. Feedback from the psychiatry residents was mixed, some participants were enthusiastic about the course, others took a neutral stance, and some were dissatisfied. The enthusiastic participants valued meeting people with LE and discovering the humanity they shared. Other participants described having learnt how to instil hope and to partner with people with LE as individuals. A concern raised by the psychiatry residents was the experience of unfamiliar boundaries within the relationship with their LE advisor. The researchers explained this may have been in part due to the novel learning environment the psychiatry residents had been placed in. This also could be viewed as creating a role reversal for the psychiatry residents outside of the customary therapeutic relationship where the psychiatrist is seen as the trusted expert. The researchers noted they were not surprised by the concern expressed as they saw this as a parallel to the clinical working environment where the inclusion of people with LE is frequently met with resistance.

Although the purpose of the study by Agrawal et al. was to deepen psychiatry residents' understanding of LE and reduce prejudices held towards people with LE, it also highlighted the differing perspectives between the psychiatry residents and the LE advisers. The LE advisors voiced strong support for the course which was not the case for the psychiatry residents. The LE advisers appreciated the opportunity to improve the lives of others experiencing mental distress and/or addiction by influencing the practice of future psychiatrists. However, although the psychiatry residents mentioned the value of meeting people who have LE, they did not discuss how this would influence their future practice. There was no follow-up to observe any delayed flow-on effects the learning may have had on the psychiatry residents' clinical practice. The study concluded that positioning people with LE within psychiatry education may help to broaden new psychiatrists' understanding of the process of recovery from mental distress and/or addiction, while also developing an appreciation of the active role people can have in their own recovery.

In addition to the previously identified studies from the overseas psychiatry literature, there is also evidence of the integration of LE within psychiatry education programmes in Aotearoa. Associate Professor Sarah Gordon and colleagues from the University of Otago medical teaching programme have undertaken some of the principal work in Aotearoa concerning how LE may be integrated within existing psychiatry curriculum. Gordon et al. (2014) contends medical education needs to include opportunities for students to have meaningful involvement with people with LE of mental distress, addiction, and recovery. They believe one way of improving student contact with people with LE is by involving people with LE as educators in medical education.

Gordon et al. undertook a quantitative study that examined the effect on sixth-year medical students of embedding recovery-oriented approach tutorials in a psychiatry course that were developed and delivered by people with LE. Students were assigned to a control group (who received the standard course without the tutorials) or an intervention group (who attended one tutorial in the first week of the course and one at the end of the third week). The students completed a Recovery Attitudes Questionnaire-16 at the beginning, end, and three months after completing the course. Eighty-four students participated in the pre-intervention phase and 62 students participated in the post-intervention phase. The results showed no significant differences between the groups at pre-intervention and the students' attitudes were to some extent positively aligned with a recovery-oriented approach. Also, there were no significant differences between the groups at post-intervention. To explain these results the researchers posited that the tutorials' limited effectiveness was because elements of the course that included; other teaching, learning materials, placements, supervision, and assessment, were not aligned with and supportive of LE principles. They acknowledged the possible inadequacy of the measurement tool used made it difficult to assess the impact of the tutorials. Overall, the study concluded that the course required re-orientation to align it more with the recovery-oriented approach. Subsequently, 50% of the following year's clinical practicums were replaced with LE, peer-led recovery focused placement settings.

Following on from Gordon et al.'s study, Newton-Howes et al. (2020) describe other modifications made to the programme over time. They report that the overall goal of the programme is to change negative attitudes and behaviours by medical students and psychiatry registrars towards people with LE of mental distress and/or addiction. Acting on the outcomes of Gordon et al.'s study the programme leaders extended the programme to include fifth-year medical students and postgraduate psychiatry registrars. They also revised the existing curriculum to include a recovery-oriented approach student assignment and two topics on human rights and social inclusion (the process by which efforts are made to ensure equity for everyone). Both of these topics are an important element of LE and are consistent with its values. The undergraduate fifth-year learning objectives promote recovery and wellbeing and the impacts of stereotypes, prejudice, and discrimination on recovery. The undergraduate sixth-year learning outcomes focus on respecting and protecting peoples' human rights and the impact of denial of human rights on recovery. At postgraduate level there are two stages to the programme, the first stage focuses on a move away from substitute decision making (when decisions are made in the best interest of the person) and ending the use of seclusion, restraint, and coercion (other forceful or threatening practices). The second stage focuses on promoting supported decision making (putting the person at the centre of all decisions that concern them) and promoting person-centred approaches through advanced planning (involving people at all stages of planning for their future health care).

A mixed method approach (quantitative and qualitative) focusing on change over time was taken to evaluate the impact of the programme on the students' attitudes towards recovery. The quantitative evaluation surveyed students before and after attending the programme in their fifth and sixth year using the Recovery Attitudes Questionnaire RAQ16 and the Opening Minds Stigma Scale for Health Care Providers. Newton-Howes et al. (2021) found the inclusion of a service user led programme was associated with a significant improvement in medical student recovery attitudes, more so than the students who attended the standard programme. The qualitative evaluation was in two parts, first a thematic analysis of students' assessments was made to determine what they understand about recovery, stigma and discrimination, and human rights in response to attending the programme. Newton-Howes et al. (2018) found students understood the concept of recovery, they believed the right attitudes and right support were critical elements for recovery, and they were open to the differing perspective offered by a recovery-oriented approach and had awareness of the tensions between the biomedical model and recovery-oriented approach. The second part of the qualitative evaluation was individual interviews and focus groups with both undergraduate students and psychiatry registrars. The evaluation sought to understand practical behavioural changes which may have come about because of attending the education programme. A search of the literature has not found publication of the results of this evaluation.

Newton-Howes et al. (2020) points out that central to the integrity of the programme is that LE educators are involved across all aspects of the programme ranging from; co-production with other academics, teaching, research, and evaluation. To strengthen this commitment LE leadership is encouraged, and the programme is now supported by a LE academic. Fostering relationships between those with LE involved in the programme and other academics is seen as a critical element to the programme’s success.

In summary, the literature specific to the inclusion of LE in medical and psychiatry education indicates that there is evidence that some medical and psychiatry education programmes, both overseas and in Aotearoa, are attempting to integrate LE, though with mixed success as it relates to health professional feedback. Medical and psychiatry education programmes appear to be in the early stages of integrating LE. In relation to Aotearoa, a lead is being taken by University of Otago and there appears to be a genuine commitment to integrate LE into the education of medical students and psychiatry registrars.

LE in Mental Health Nursing Education

Many of the studies undertaken on the integration of LE into MHA health education programmes stem from the literature on nursing education, particularly in the United Kingdom (UK) and Australia. This may be due to the inclusion of LE being mandatory in both countries. A study by Kuti and Houghton (2019) explored UK undergraduate nursing students’ perspectives of a coaching style learning initiative called Patient as Coach Team (PaCT) which involved nursing students being taught by a LE educator. The 321 participants were final year nursing students who after attending PaCT sessions completed a structured questionnaire. The participants agreed that the LE educator created a comfortable learning environment and promoted critical thinking and self-directed learning. Participants identified the PaCT learning initiative went beyond a traditionally taught academic lesson and the coaching learning style had a positive impact on their learning and future practice. Although similarities can be made between the learning approaches used by Agrawal et al. and Kuti and Houghton, when comparing participant attitude towards the involvement of people with LE, there was not as positive acceptance by the psychiatry residents compared to the high acceptance of the nursing students. This may in part be due to the mandatory inclusion of LE in undergraduate nursing education and the nursing students' acceptance of this, compared to the psychiatry residents who were already working in the wider MHA health system.

Jack (2020) evaluated a short six-day course that used storytelling (inviting people with LE into the classroom to tell their story) as a learning approach to teach final year undergraduate UK mental health nursing students about supporting people experiencing mental distress. The course was facilitated by a MH lecturer practitioner and three LE educators. The LE educators shared their personal experiences of mental distress, use of MH services and recovery. An objective of the course was to expose nursing students to a humanistic perspective of mental distress by highlighting the importance of interpersonal skills, the use of appropriate language, and to give understanding to the effects of stigma surrounding diagnosis of a mental illness. An evaluation of the effectiveness of this education approach found using storytelling to demonstrate a LE perspective offered nursing students an alternative and potentially transformative learning opportunity. The results indicated that the most power to facilitate learning came from the LE educators telling their personal stories in real time. The nursing students valued hearing the LE educators' personal stories and they acknowledged that having listened to these stories, priorities they previously held as key for their decision-making may not have always been in the best interests of the service user. For example, describing minimising risk in terms of professional and organisational liability over service user's wishes, and prioritising completing paperwork over spending time with the person.

The outcome of this study reflects that introducing people with LE into the classroom gives unique insights and awareness to what LE offers and allows nursing students to reflect and gain a new perspective of mental distress, addiction, and recovery. This approach to learning differs from more traditional learning methods, based on theoretical knowledge taught through textbooks, lectures, and hypothesized case scenarios. The findings inform the current research being undertaken as it focuses on the value of a humanistic perspective in the treatment of mental distress and/or addiction by involving people with LE as educators. A limitation was the participants were drawn from final year undergraduates and therefore only gave the perspective of one cohort of nursing students at a single point in their education. The study could have been broadened to include nursing students at different stages of their education from first year onwards.

In addition to the work in UK nursing education, there has been a considerable amount of work undertaken to integrate the teaching of LE in MH nursing education programmes in Australia. One of the most substantial studies was by Happell et al. (2015b) who undertook a national survey across 32 Australian universities involving nursing academics who coordinate MH nursing education programmes. The aim of the study was to find out the extent of LE involvement and LE content being taught in undergraduate and postgraduate nursing curriculum. The researchers found that the most frequently used learning approach in these programmes was storytelling. Although the researchers acknowledged storytelling can be a powerful learning approach, they also warned this approach could expose the people telling their stories to vulnerability.

Having identified the importance given to storytelling in this 2015 survey, Happell, then undertook research to further explore this. Happell and Bennetts (2016a) took an exploratory approach to present the views of LE educators and nursing academics on storytelling as a learning approach in the education of Australian mental health nursing students. The LE educators believed telling their personal story helped normalise mental distress and demonstrates that people can recover wellbeing. They described storytelling as bringing a personal and human lens to mental distress which offered an alternative perspective to the biomedical model of clinical assessment and diagnosis which underpins MH nursing education. Similarly, the nursing academics expressed that LE educators sharing their experiences brought a unique dimension to nursing students' learning while at the same time facilitating teaching in a broader sense by discussing aspects of nursing that is helpful or not so helpful.

In the study by Happell and Bennetts the potential vulnerability and negative impacts associated with storytelling were discussed both by the LE educators themselves and the nursing academics. LE educators talked about being asked to tell their story without always knowing what that meant, how it would feel and the impact it would have on them later. One LE educator described this as being asked to talk about deeply personal experiences in a room full of strangers with little or no preparation or idea what it was going to be like. The nursing academics expressed similar concerns particularly the potential for LE educators to be re-traumatised through conveying deeply personal information which could possibly compromise their recovery. The LE educators also closely related the issue of vulnerability to a discussion on preparation and support. Preparation and understanding of what was involved in storytelling was considered particularly important. It was suggested that preparation might also be relevant for those requesting storytelling and to consider more clearly what they wanted from this approach. These two studies highlight the need for the education providers to prepare and support LE educators as they may be vulnerable to being retraumatised by reliving their experiences.

While progress has clearly been made in the integration of LE within MH nursing education programmes overseas, there is little evidence from the literature that the integration of LE has been a major focus in Aotearoa, and whether LE is mandatory within nursing curriculum. An exception to this was a study by Schneebeli et al. (2010) who evaluated the involvement of a LE consultant (LEC) role in a MH component of an eight-week course delivered in the second year of a three-year programme at Auckland University Bachelor of Nursing Programme. The course prepares nursing students to respond to the MH needs of people in all health settings including the provision of clinical skills underpinned by a recovery-oriented approach, eight broad capabilities based on Nursing Council of New Zealand competencies for nursing practice, and a four-week placement within a MH setting. The theoretical component of the course was taught by clinical/academic nurses, and other health professionals from MH settings, some of whom had their own LE.

Similar to the previously reviewed overseas studies, Schneebeli et al. reported that the nursing students' feedback was positive and highlighted the value the nursing students placed on the LEC's involvement in their learning. Many of the nursing students acknowledged that the LEC influenced their understanding of mental distress and the interventions they could offer service users while on placement. General feedback included students requesting more class time with the LEC and one student said the LEC's input "…was probably the best part of our learning during those weeks of theory" (Schneebeli et al. 2010, p. 33).

In summary, the overseas and Aotearoa literature on the integration of LE into nursing and psychiatry education programmes indicates that they are at different stages. Overseas, particularly in the UK and Australia, for nursing, LE education is more integrated than in psychiatry and this may be due to LE being mandated into nursing programmes. In Aotearoa however, where LE education is not known to be mandated in psychiatry or nursing, it appears to be more advanced in psychiatry education, although there is little research and evaluation to support this understanding with the exception of University of Otago's medical and psychiatry programmes (Gordon et al., 2014; Newton-Howes et al. 2018; Newton-Howes et. al. 2021).

LE in Social Work Education

Recent research indicates there are few studies that document how LE can be embedded within social work (SW) curriculum (Dorozenko et al, 2016), and this aligns with the literature pertaining to psychiatry and nursing. Much of the existing work on integrating LE into SW education programmes stems from the UK and Australia.

Unwin et al. (2018) evaluated student classroom learning experiences from having service users and carers (SUACs) involved in SW, MH nursing and social welfare courses at a university in the UK. The study explored the diversity of student experiences with the purpose of identifying new perspectives that would add to the existing knowledge base. One of the researchers had LE which allowed the study to benefit from their unique expertise. Also, the university had built a collaborative working relationship with the wider LE community outside of the university and saw meeting regularly and including SUACs in the classroom "…might be seen as more than a tokenistic compliance with policy” (Unwin et al., 2018, p. 378). Final-year students within the university’s social welfare, MH nursing and SW programmes participated. The students reported significant benefits from having SUACs in the classroom, including developing empathic and interpersonal skills and linking theory to practice. Students reflected their skills were particularly enhanced by being able to engage with a SUAC for the first time in a safe classroom environment as opposed to their first experiences being on placement where there may be fear of being judged or receiving a negative assessment outcome. Some students emphasised the impact of being exposed to deep levels of emotions shown by some SUACs. They viewed this as a positive learning experience and that it prepared them for real world experiences they would face when entering the workplace.

Students in the Unwin et al. study also identified that good practice measures may be required to develop a supporting environment so SUACs and students could introduce and discuss issues of sensitivity and manage any surrounding discomfort that may arise. They suggested holding pre-course discussions between academic staff and students in terms of asking questions and discussing boundaries and that students be advised of appropriate support/counselling available. Other suggestions made were: opportunities for SUACs to present their own situations as real cases as this was seen as being more meaningful than hypothetical case studies; for SUACs to provide a feedback loop by listening to students’ reflections on their placement experiences and issues that may have arisen; the possibility of buddying a SUAC with a student throughout the course to assist reflective practice and embed the principles of a SUAC perspective; and the introduction of a joint teaching session where a SUAC and an academic shared their individual perspective on the same topic to assist with consolidating how theory can be applied in practice. Students across all of the three disciplines asserted that involvement of

SUACs was sporadic and not consistent over the duration of their qualifying programmes. The researchers stated this would require a change in curriculum planning that gave appropriate priority to SUAC involvement.

Unwin et al. illustrates how LE can be integrated into the education of multiple MHA health professional groups. Involvement of SUACs was across the three disciplines and no matter what discipline the students were in, they all received the same exposure to the SUACs perspectives. Early exposure to SUACs was given before the students undertook their practicums, thereby assisting to prepare them for any risk situations that may have arisen. Unique to this study, and not found in other studies, was the emotional impact on students from listening to deeply personal stories of the SUACs, and they were able to suggest strategies to mitigate this. The students pointed out that their learning from SUACs was not consistent throughout the duration of their education and the researchers responded with a recommendation that SUAC sessions be introduced across the full duration of each programme. The researchers acknowledged the university's commitment to reaching out to the LE community and involving them in both research and teaching within their curriculum, demonstrating a genuine collaborative working relationship.

Fox (2020), a UK academic with LE, believes having the LE community involved in SW education is essential to the effective development of future social workers and therefore it is important to equally understand the process as well as the outcomes their involvement has on SW education. Fox's study provides an account of service user carers (SUCs), whom Fox describes as educators in SW education who have their own LE. The study found that the SUCs identified as experts of their own LE, they were also highly skilled educators, and the combination of this expertise allowed them to contribute to the development of evidence-based

SW theory and practice. They identified varying reasons that motivated them to be SUCs which ranged from having a voice and being able to make a difference, to influencing SW practice because of their personal experiences of social services. The SUCs believed being recognised as an equal to other education professionals was important. One SUC explained being involved permitted them to feel recognised, which in turn validated the relevance of their experiences. Another stated, "… it was important to mix with professionals as equals, removing the us and them divide." (Fox, 2020, p.10).

The SUCs identified an important element of their role was to assist in transferring SW theory into practice. For example, SUCs role-played scenarios that were authentic and real-world experiences for the students. Students were given feedback by the SUCs that enabled them to reflect and further develop their skills. The SUCs viewed role-play as an opportunity to challenge any underlying prejudices, stereotype, or discriminatory beliefs. Overall, the SUCs recognised their sense of cohesion and support of each other was a key factor in their effective involvement and strengthened their impact on SW students' learning.

To be effective the SUCs explained that it was important for all those involved in the delivery of SW education to value knowledge from different perspectives equally. They advised when this did not happen it was a challenge to sustain the motivation to be involved. Two issues identified as challenging their effectiveness were academics' own stereotypes and sometimes the lack of preparing students when SUCs were invited into the classroom. Furthermore, the SUCs emphasised the necessity for ongoing research and evaluation to critically examine the impact of involving people with LE in SW education. One service user carer saw the future for effective involvement comprising of co-production where researchers, academics and SUCs work together to reach a collective outcome and said, "… it's that full involvement from conception through to development and delivery and review process … 360 degrees, that whole cycle” (Fox, 2020, p. 16). A feature of the study was that the group worked together to deliver a LE perspective within a SW curriculum. Working as a team supporting each other was key to the programme delivery. An example being the real-life role play scenarios and the opportunity for SW students to work with educators who have LE and to receive their feedback. These two studies from the UK demonstrate how LE can be integrated into MH education by MH education providers drawing on the LE community to work collaboratively with them to develop and deliver a LE perspective.

Compared with the UK the integration of LE in SW education in Australia is still in its relative infancy, although research provides insights into its emerging importance. Ridley et al. (2017) explored how learning from an LE educator influenced Australian SW students’ practice during their first placement within a MH setting. Before going on placement, the SW students attended a SW and MH course taught from a LE perspective and delivered by an LE academic. The SW students were asked to report on the LE learning they had received prior to going on placement, how the learning influenced their practice while on placement, and the usefulness of including LE in a SW course. They reported that learning from a LE educator was more authentic and valuable than provided by the academic staff. All SW students reported an understanding of how people can recover and how the LE educator had empowered them to think critically about diagnosis of mental distress. The outcome was that SW students viewed diagnosis as being less central and not the only defining feature of a person experiencing mental distress.

In summary, the evidence on the integration of LE into SW education programmes in the UK and Australia shows the effectiveness of education providers and the LE community working collaboratively. Also, the benefits of introducing LE education early in SW education prepares SW students for going on placement. No SW studies were found in Aotearoa.

LE in Occupational Therapy Education

In addition to the disciplines of psychiatry, nursing and social work, there is some evidence that LE has also been integrated within the educational programmes of occupational therapy (OT). In Australia and Aotearoa, for OT workers to be registered, it is mandated they must receive LE education in their formal training (Scanlan et al., 2020). Scanlan et al. suggests recovery-oriented practice policies and course accreditation standards mandating the inclusion of LE education in OT curriculum is the key driver for the integration of LE. The OT course accreditation standards require involvement of people with LE at design, delivery and evaluation of curriculum. They view this participation as going beyond people with LE telling their story. To establish the current status of LE involvement in OT curriculum and the factors that support or hinder this involvement, Scanlan et al. surveyed all university OT programmes across Australia and New Zealand. The participants were academics familiar with the design, delivery and evaluation of MHA content within OT curriculum. The questionnaire asked about the involvement of people with LE in OT curriculum.

All respondents reported some level of LE involvement in their programmes, however, participation of the people with LE was mainly focussed on teaching and there was less involvement in design and/or evaluation. The majority of participants stated there should be more LE involvement across all levels of the curriculum. The two most commonly reported enablers to LE involvement were a positive attitude of teaching staff and support from university management and leadership. The most commonly reported barriers related to systemic issues such as restrictive organisational structures, specific allocation of funding for planning and evaluation of courses involving LE, and lack of adequate funding to remunerate specific LE roles. Some participants reported final decision making was by the academics.

Key information that comes from this study that differs from the other studies reviewed is that the participants were only academics and from their perspective they were stating that LE was under resourced and underfunded. It also identified there is not full collaboration, as people with LE were not necessarily involved in the development and design of LE content.

Chapter Summary

The review of the existing literature on the integration of LE within MHA education programmes highlights four key findings. First, there were relatively few studies globally that have evaluated what the integration of LE within such programmes looks like and how it is optimised. This suggests that while studies are being conducted this is an area of research in its infancy and standardised LE content is yet to be established. Second, despite the limited number of studies found, there was consistency across the existing evidence for different health disciplines (psychiatry, MH nursing, social work, and occupational therapy) that LE added value to the students' learning and common features emerged. Third, the existing studies in this area highlight that a factor driving the inclusion of LE in MHA education is that health disciplines such as SW and nursing in the UK (Health Care and Professions Council, 2014; Ridley et al. 2017; Fox, 2020) and OT in Australia and Aotearoa (Scanlan et al. 2020) have mandated that LE be included in their MH education programmes. Fourth, the studies reviewed in the literature were mostly limited in scale and by the relatively small number of participants and there is little indication as to whether those currently involved in the curriculum development process (people with LE and people without LE) agree on how LE can best be integrated and taught in MHA health education programmes.

The literature confirms there is limited information on LE content which can optimise the value LE adds to the education of MHA health professionals and there is not a lot of agreement how LE is best integrated. This is particularly the case in Aotearoa where there is limited information on the scope of LE education and not much research has been undertaken. Therefore, further research is required on what learning approaches are needed to teach LE other than the predominant storytelling and to identify what course content can best optimise the value LE brings to enhance students understanding of mental distress and/or addiction. Research is also required to understand the perspectives of MHA education providers, academics and the LE community on who should be involved in the development and delivery of LE education. Therefore, the research question asks: How can LE be integrated into and optimised in the education of allied mental health and addiction health professionals?

Chapter Three: Methodology

All research is anchored to basic beliefs about how the world exists. (Pascale, 2011, p. 3).

Introduction

According to Canadian contemporary phenomenologist Max Van Manen (1990) a research methodology ought to reflect and maintain a synergy to the deep interest of the researcher. Therefore, it needs to be known that the researcher's motivation to undertake this study was twofold. First, my own lived experience (LE) as a parent of someone who has experienced addiction and recovery and as a witness to the effects addiction has on whānau/family members. Second, the inspiration received from colleagues who have their own LE of mental distress and/or addiction. Not only do they face the day-to-day challenges of working in the mental health and addiction (MHA) sector but at the same time work to maintain their recovery.

The quest to have a deeper understanding of the impacts of addiction on a person's wellbeing was my motivation to undertake formal studies in MHA and this led to me qualifying as an addiction practitioner. I have been privileged to have had the opportunity to support and work with people across various treatment intervention services including; residential and community alcohol and drug services, drug treatment programmes within our prison system, and kaupapa Māori problem-gambling. I currently hold a position as a lecturer teaching MHA at undergraduate and postgraduate level. I still remain connected to the MHA sector through maintaining registration as an addiction practitioner and accredited clinical supervisor.

Van Manen (2016) contends the research process is a way of investigating certain kinds of questions. He sees the starting point is not with the research method but with the questions themselves and the way they are interpreted. Van Manen states the way a researcher expresses certain questions will relate to the method the researcher will identify with, this in turn will create an interaction between the research question and the research process. Similarly, Rossman and Rallis (2017) see a unique feature of qualitative research is that although the data collected are representations of each participant's truth, it is the researcher who transforms the data through analysis and interpretation into information that can inform knowledge. Essentially, Rossman and Rallis are emphasising the power the researcher has in influencing each stage of the research process, contrasting to a quantitative research paradigm which is characterised by the researcher's detachment and impartiality.

Study Structure

The study is about exploring how LE can be integrated and optimised in the education of allied MHA health professionals. Braun and Clarke (2006) see that it is important for the researcher to recognise and acknowledge that the research methodology and method match what the researcher wants to know. It was from this position the research was structured to support answering the research question. The starting point was to look at the different characteristics of qualitative research.

Qualitative research has a broad approach using multiple and varying methods and procedures to study different phenomena (Holloway & Todres, 2003; Rossman & Rallis, 2017). The qualitative approach has a sustained focus on context and assumes that the understanding of human experience is gained by exploring people within their natural setting and helps to describe and understand their everyday life experiences. Hence qualitative research explores ways to systematically understand people's lived experiences and adopts the stance that people use what they see, hear, and feel to make meaning of the world in which they live (DePoy & Gitlin, 2011; Rossman & Rallis, 2017). DePoy and Gitlin (2011) view the structure of qualitative research as exploratory that allows for new insights and understanding to be revealed in contrast to the predetermined concepts of quantitative research that maximise control over the research process.

Qualitative research's multiple approaches used to explore phenomena allowed a cross-sectional perspective to be used in this study that included an organisational and individual point of view. The focus on a cross-sectional perspective centred on the depth and meaning of LE, and not on a comparison between the two different perspectives. Selecting a qualitative approach enabled the study to be structured as exploratory in nature, while at the same time giving flexibility to select a methodology that would meet the study's aim and objectives.

Methodology: Thematic Analysis

Thematic Analysis (TA) was identified as the most appropriate methodology to answer the research question. This decision was made after considering other pattern theme-based methodologies (i.e., grounded theory and pattern-based discourse analysis). TA is a recognised methodology within qualitative research, which has a clearly defined set of procedures that allows a systematic approach for identifying, analysing, and reporting patterns or themes across a dataset. A unique element of TA, and what arguably sets it apart from other analytic methodologies, is that it is not tied to a particular theory. It does not prescribe to any specific method used for collecting data, theoretical perspective, or any one epistemological position. Consequently, TA's theoretical freedom allows it to be a flexible and versatile tool for analysing data that can provide a rich and detailed account (Braun & Clarke, 2006; Braun & Clarke, 2013). However, Flick (2018) in his critique of TA, raises several concerns with TA as a methodology. Flick acknowledges TA as providing the researcher with a strategy for analysis based on coding and creating themes, but sees it limited by not having any complex or challenging objectives such as developing theory. He argues, that if data analysis is stripped away from its methodological framework there is a risk of lessening the analysis to a type of applied process. Flick summarises by saying that TA offers a generalised model comprising of steps to follow in analysing data rather than more clearly outlining what to do methodologically. The researcher contends, Braun and Clarke address Flick's concerns by acknowledging that TA is not related to any pre-existing theoretical frameworks and see this as one of its advantages. However, they point out what is important is that the theoretical position is made clear, and that the research structure and method align to what the researcher wants to know. They see any theoretical position comes with assumptions about the nature of the data and what it implies, and that good TA will make this transparent (Braun & Clarke, 2006).

Theoretical Position: Phenomenology

The theoretical position taken for the research is phenomenology and was selected because its philosophical assumption offers a rich source of thoughts about how to observe and understand LE (Smith et al., 2009). An aim of phenomenology is to gain a deep understanding of the meaning of everyday experiences (Vagle, 2018). Husserl, a leader in phenomenological philosophy, considered that phenomenology involves thoughtful investigation of human experience. Husserl was also interested in discovering a process by which someone might come to precisely know their own experience of a phenomenon at a depth which would enable them to recognise the essential qualities of their experience and in doing so illuminate a given experience for others also (Koch, 1999; Smith et al., 2009). Qualitative inquiry into human phenomena requires interpretation and understanding (Van Manen, 1990), therefore, when researchers apply a phenomenological perspective to phenomena they systematically try to reveal, describe and interpret the meaning, structure and essence of that phenomenon. In this study the researcher is looking for a deeper understanding of what the participants' said, and therefore phenomenology as the theoretical position aligns with the study's structure and its aim and objectives.

Research Preparation

The first step in preparation for this study was a review of the grey literature (guidelines and reports published by government ministries and policy makers) to identify official confirmation regarding where LE should be currently located within Aotearoa's health and education systems. Empirical studies were also found although they were limited in scale and scope. The information gathered from the grey literature and empirical studies helped to guide and refine the research question.

The second step was to establish a reference group of individuals who identify as having LE and work as clinicians and/or educators in the MHA and/or education sector. Reference groups offer an opportunity for researchers to have people with LE contribute their knowledge and expertise to the scope and design of a study that is relevant and appropriate to the research topic (Lammers & Happell, 2004). The purpose of the reference group in this study was to discuss and give feedback on the aim and objectives of the research and give input to the design of the research information sheet and interview guides for the semi-structured interviews. They also checked that the language used aligned to LE principles (Te Pou, 2021). The group was to meet fortnightly, however, this process was severely interrupted by the COVID 19 pandemic and the different alert-level lockdowns. During this process contact with one of the group members was lost and another became unavailable due to maternity leave. This left one remaining member who was met with via Zoom meetings. Although this group member's role was in the initiation and preparation stage of the research we continued to meet, and this allowed a LE perspective to be maintained throughout the duration of the study.

Ethical Considerations

The researcher endeavoured to protect and uphold the participants' autonomy. Sensitivity of the topic and the potential negative impact on individual participants versus the study's benefits in educating allied MHA health professionals in LE was discussed by the researcher with her academic supervisors. Trustworthiness was established and achieved by the researcher's 16 years experience as a registered addiction practitioner and four years experience as a lecturer teaching MHA at undergraduate and postgraduate level.

Informed Consent

The information sheet (Appendix 1) advised participants the key elements of the research. It contained information on how the research would proceed, why they had been invited to participate, what their participation involved and contact details for the researcher and academic supervisors. All participants signed a consent form (Appendix 2) prior to partaking in the interviews.

Confidentiality

The researcher endeavoured to protect the confidentiality of the participants and information gathered was treated as confidential. Participant identity was concealed with the use of a code for each participant. Interview recordings and hard copy documentation are stored in a locked cabinet in the researcher's home office. Consent forms are stored in a locked cabinet separately from other data. Electronic data is stored on the researcher's computer and is password protected.

Potential Risk

The research topic involved a level of sensitivity. A possible source of harm was for the individual participants to experience a level of unpleasant emotions and distress. If that occurred, the researcher had the expertise to assist with referral to appropriate services for support if required. The information sheet had contact details for 24/7 mental health helplines. To mitigate a situation arising outside of the interview, the researcher had a list of support services available within the participant's region and this was available at the time of the interview.

With the support of two academic supervisors and the remaining reference group member the study's ethics application was lodged with the Massey University Human Ethics Committee: Southern A, and approval to undertake the study was given. Human Ethics Application SOA 20/15.

Method: Semi-structured Interviews

Semi-structured interviews were the method selected for collecting the data. According to Braun and Clarke (2013) the strength of semi-structured interviews is that a small sample of interviews can generate sufficient and suitable data. Also, this type of interviewing allows for open-ended questions that can open a discussion with participants and allows the researcher to gain a deep and rich understanding of the participants' knowledge and opinions.

The objective was not to confirm any preconceived notions or assumptions but to allow the participants to inform and deepen the researcher's understanding of their experience of the topic. The interviews, where possible, were to be face-to-face as this enables the interviewer to have an active role in the interview process by co-constructing meaning with the participant (Braun & Clarke, 2006; Braun & Clarke, 2013). Interviews that were not able to be face-to-face were to be by Zoom or telephone. However, to maintain the study's timeline, the interviews needed to be undertaken during COVID 19 alert levels three and four. Due to the restrictions in these alert-levels the interviews were switched to Zoom or telephone. This ensured compliance with the Government COVID 19 alert level protocols and minimised any risk to health and safety for the participants and the researcher.

Participants

Participant recruitment was guided by the researcher wanting a cross-sectional perspective from both organisations and individuals. Purposive sampling was used to identify potential participants. This involved the researcher purposively selecting participants based on a pre-defined criterion (DePloy & Gitlin, 2011). The criterion was organisations from the MHA and/or the MHA education sectors who are involved in the development and/or education of people with LE, and individuals who were allied MHA practitioners who have their own LE and were currently working in the MHA sector. All participants were from Aotearoa, and they were not excluded on where they were located. The expectation was to have six participants, three from organisations and three allied MHA practitioners.

Organisations were identified that fitted the criterion and an initial telephone call was made to the organisation to establish a contact person. An email was sent to the contact person introducing the researcher, advising an outline of the study, and included an information sheet. If no response was received a follow up telephone call was made. Four organisations were approached and three agreed to participate. They included a MHA education provider, a peer-led training organisation, and a MHA workforce development organisation. To assist with finding the individual participants, dapaanz (Addiction Practitioners' Association Aotearoa New Zealand) the registering body for addiction practitioners was approached. They were supportive and electronically advised their members of the study and people were invited to contact the researcher directly by email. Twenty-four people with their own LE responded. Each was sent an information sheet and consent form. The first three signed consents were selected to participate. An email was sent to those people who had not been chosen thanking them for their willingness to participate and their support of the research. It was explained that the scope of the research didn't allow inclusion of many people. An offer was made to add them to the mailing list to be informed of the research findings when completed.

Procedure

Two interview guides were developed to guide the interviews, one for the organisations and one for individual participants (Appendices 3 and 4). The design of the interview guides was influenced by two LE peer support values: mutuality - building an authentic relationship and respectful language; and experiential knowledge - valuing life experiences to build trust and connection (Te Pou, 2021). Feedback on the interview guides' design was sought from the reference group member and the researcher's academic supervisors. Due to time limitations the interview guides were not trialled.

Prior to the interviews participants were sent a copy of their respective interview guides giving them an idea of the different discussion points. After introductions and thanking them for participating, the researcher recapped on the information they had received previously. They were advised the main aim of the interview was to see things as they saw them, with a focus on their experience, opinions, and what they thought and felt about the topic being covered. They were asked if they had any further questions and if not, could they reconfirm their consent. The interviews were audio recorded and lasted for approximately 60 minutes. At the end of the interview the participant was thanked for their time and the researcher explained that their interview would be transcribed and that they would have the opportunity to review the transcript and give approval to include it in the study. At the end of each interview the researcher spoke to each participant who came with their own LE about the sensitivity of the topic and how this may raise a level of unpleasant emotions and distress. They were given details of the 24/7 mental health helplines and a list of the support services available in their communities. Each was appreciative of the information and advised the researcher that it was part of their recovery to have these supports close at hand.

Data Analysis

According to Braun and Clarke (2006) before analysis of the data can start, and depending on the theoretical position taken, the researcher must make several decisions around how the analysis is framed. Also, any questions arising from these decisions should be carefully measured before analysis of the data is started and that the researcher undertakes an ongoing reflexive discussion about these decisions throughout the analytic process.

Analysing the Data

The interviews were manually transcribed by the researcher. According to Smith et al. (2009) the manual process of transcribing gives the researcher deep insight into the thoughts and attitudes of the participants. Smith et al. also believes it is important to engage and listen attentively to absorb the person’s LE otherwise the data will be too thin for analysis. The analysis was also guided by the concept of analytic sensibility (reading and interpreting data through the chosen theoretical lens) which gives understanding and meaning of the data that goes beyond the obvious or surface-level content of the data to seeing patterns and meanings (Braun & Clarke, 2006).

Coding

Systematically and repeatedly reading the data's content initiated the coding process of identifying aspects or features of the data relating to the research question. A complete coding approach was taken by first coding anything that was of interest or of relevance across the whole of the data, and second to code the data in as many ways as it fitted with the aim and objectives of the study. These codes captured the essence of why a certain word or short phrase may be useful. The codes were data-derived, giving explicit content of the data which in turn reflected the language used by the participants to describe their experiences and opinions of the topic. The process was consistent across each piece of data coded. As the data became more familiar codes were modified and merged to include new information. Once the coding was finished the codes were reviewed, looking for any overlap and ensuring each code was distinct from the others. The final step was to collate the coded data. For each code all the excerpts were collated where the code appeared in the data. The coding overall was an inductive (bottom-up) process which enabled the codes to be strongly linked to the data (Braun & Clarke, 2013). The inductive process started with writing the individual codes onto post-it notes. A different coloured post-it note was used for each participant so each code could be referenced back to the participant's interview transcript if needed. The code's excerpts were collated onto large sheets of paper blue-tacked to the walls of the researcher's office. It was at this point in the analysis the process of identifying broader patterns or themes across the data was started.

Themes

In TA each theme has a central organising concept which is the theme's essence, a notion that describes an important and logical pattern in the data (Braun & Clarke, 2013). The process of identifying themes started with reviewing the codes and collated data relating to each code to identify any similarities and overlaps between codes. This process involves looking for different topics and issues the codes relate to and can be used as central organising concepts that capture the most important patterns relevant to meeting the study's objectives. The themes created at this point were provisional or candidate themes. The provisional themes were further analysed using thematic mapping, a method to visually explore relationships between codes and themes and assists with categorising any identified overarching themes and subthemes (Braun & Clarke, 2013).

Validity and Reliability

The validity of the study was established through the conduct and rigor of the research approach. The reliability of the study was supported by TA which enabled the researcher to get a rich and detailed understanding of the topic being researched.

The researcher had awareness of the risk of researcher bias and steps were taken to ensure the trustworthiness and honesty of the study. A reference group member gave input into the development of the interview guides, and it was reviewed by the researcher's academic supervisors. Due to COVID 19, interviews had to be conducted by Zoom and telephone and the researcher ensured that the participants were in a safe and private place where they could speak confidentially. The data was accurately collected by recording the full interview and the researcher took notes. The data was transcribed by the researcher and sent to each participant who verified its accuracy.

The data analysis involved repeatedly reading the transcripts. A meticulous coding approach was taken where the codes were data-derived, giving explicit content to the data. Themes were identified through the process of systematically looking for different topics and issues the codes related to. Thematic mapping was then used to visually explore relationships between the codes and themes. Findings were described in depth and were supported by participants' quotes from the interviews.

The next three chapters present the research findings and discussion of the overarching themes and subthemes used to explore the research question.

Chapter Four: Research Findings and Discussion

The purpose of providing findings and associated discussion across three distinct chapters is twofold. First, the chapters reflect feedback and discussion specific to each of the three overarching themes of the study which are deserving of discussion in isolation from the other two themes. Second, presentation of combined theme findings and discussion for each theme independently (as illustrated by Missen et al., 2013) offers greater clarity regarding how novel subthemes have emerged and are potentially reflective of existing issues in lived experience (LE) and how they relate to ongoing research.

The overarching themes ascended from the interviews were:

1. What LE Brings to Education;
2. Barriers to LE in Education; and
3. Integrating LE into Education.

What LE Brings to Education

The first theme guiding participant interviews was an exploration of "What LE Brings to Education" in mental health addiction (MHA) education in Aotearoa. Five bridging subthemes identified from the interviews were:

1. Value of LE in Education;
2. Holistic Approach;
3. Value of Sharing Stories;
4. Value of LE Principles; and
5. Sense of Self and Self-care.

Each subtheme will now be explored. It is noted that going forward the participants' quotes will be italicised.

Value of LE in Education

Whether participants had LE themselves or not, there was clear consensus for the inclusion of LE into MHA education. Participants identified the value of LE inclusion for the insight it may provide allied health professionals, and the value in reducing stigma for those with LE. Two participants said:

> *It would be really nice, is to have a component of LE, there's still stigma and discrimination. In my training there was no space for self-disclosure*. (P5)

> *[LE] provides a safe space, you can talk to someone who has LE, you can ask questions. …it explodes myths having LE people involved. …it makes a difference, it provides context to different things*. (P6)

The inclusion of LE in education as a means to reduce potential stigma and discrimination often associated with self-disclosure is supported by research undertaken by Happell et al. (2014) who found a significant decrease in stereotypical thinking in students taught by a person with LE, compared to a traditionally taught MH course. Similarly, Matua Raki (2012) in their discussion paper Consumer Involvement in Education, recommended people with LE be involved in MHA education programme development and teaching, particularly in areas of raising awareness and challenging student attitudes and values. All the participants believed bringing people with LE into the classroom exposes students to an alternative way of understanding what it means to experience mental distress and/or addiction and recovery. The concept of having people with LE in the classroom to talk about their personal experiences (storytelling) of mental distress, and/or addiction, services and recovery is not new and has arguably been the primary learning approach used to teach LE within MHA education (Arblaster et al., 2018; Happell & Bennetts, 2016a; Ourconsumerplace, 2015; Jack, 2020; Scanlan et al., 2020).

Another value participants thought that LE would bring to MHA education was to humanise what is traditionally taught as theory-heavy perspectives of MHA, thereby connecting theory with the reality of the experience of mental distress and/or addiction. Two participants with LE experience said:

> *My degree was very theoretical. It didn't go very deep into the individual struggle of experiencing mental health and addiction issues*. (P4)
>
> *Education providers took the spiritual element out, it was quite academic, it was black and white, and it was structured*. (P5)

Some of the participants believed that recruiting people with LE as educators was a fundamental way to address the apparent disconnect between their formal education and personal experience of mental distress and/or addiction (sometimes their own experience). They believed this would provide more balance between the theoretical perspective and the applied practice of supporting people with mental distress and/or addiction. Participants also suggested that having LE educators in the classroom could positively engage students, allowing time for students to listen, ask questions, reflect and in some instances challenge any preconceived ideas or assumptions held toward people who experience mental distress and/or addiction. This is supported by emerging evidence from nursing and social work (SW) education literature that suggests students who have experienced LE educators in the classroom develop a greater understanding of mental distress, addiction, and recovery (Byrne, et al., 2013; Classen et al., 2021; Happell et al., 2016b; Horgan et al., 2018; Irvine et al., 2015; Ridley et al., 2017; Schneebeli et al., 2010).

The notion of academics and LE educators working together to deliver MHA education was touched on by one organisational participant who already does this:

> *I'd like to see more of the co-facilitation … within formal education. … it does have an impact. Programme delivery is co-facilitated, someone with LE and another health professional or teacher*. (P6*)*

This participant sees the value of having academics and LE educators co-facilitate delivery of LE content. This is consistent with the co-facilitation approach in psychiatry education as previously discussed by Sowers et al. (2016) in the literature review. However, the literature advises that the potential benefits to students having LE educators working in partnership with traditional academics is being hindered by systemic and structural barriers and an overcautious approach to embracing LE educator roles (Happell et al., 2020b; Horgan et al., 2020). This hinderance by education providers to include LE into MHA education is in turn delaying the inclusion and teaching of a LE perspective that optimally should be taught by LE educators (Happell et al., 2016b; Horgan et al., 2020).

The subtheme "Value of LE in Education" reflects there is significant value in having LE educators in the classroom. LE educators and traditional academics working collaboratively provides greater balance between MHA theory and applied practice, although this is being hindered by systemic and structural barriers, including a cautious approach to recruiting LE educators.

Holistic Approach

Some of the participants spoke about the importance of having a holistic approach to supporting people experiencing mental distress and/or addiction. One participant said:

> *It's understanding how these things play out in an individual's life. …It's focussing on the person's whole life, a holistic approach*. (P5)

This highlights a current tension in the MHA sector, specifically, the philosophical differences between the Western biomedical model, with its heavy emphasis on diagnostic approaches, to the identification and treatment of mental distress and/or addiction and the recovery-oriented approach that sees people in the context of their whole lives and not just their mental health and/or addiction (Byrne et al., 2016; Mental Health Commission, 2001). Over past decades the recovery-orientated approach has been progressively introduced into MHA treatment services both overseas and in Aotearoa, primarily through the development of a LE peer support workforce. However, integrating this workforce into traditional MHA treatment services has not been without its challenges. For example, research shows that the integration of LE peer support workers and their recovery-oriented approach into traditional services and teams faces significant difficulties, largely as it contrasts with the biomedical culture these services and teams operate within (Chisholm & Petrakis, 2020; Gagne et al., 2018). An organisational participant described this tension in navigating both perspectives as follows:

> *The tension between lived experience versus Western health systems approach. It's an ongoing dialogue to keep those two things in balance*. (P1)

Most participants believed teaching students a recovery-oriented approach in their formal education assisted with balancing the biomedical model and the recovery-oriented approach when treating mental distress and/or addiction. They saw having a more holistic approach encouraged students away from having just a single focus on the causes and effects of mental distress and/or addiction. This view is fundamental to the recovery-oriented approach and the need to look beyond the symptoms and diagnoses of mental distress and/or addiction (Byrne et al., 2015; Solomon et al., 2021; Sreeram et al., 2021). One LE participant described the recovery-oriented approach as:

> *We're trying to be humans with humans and that's what works for people, it's the relationship that heals people…If we approach things compassionately and kindly and listen to the person's story, then that's where the answers will lie and the chances of the best kind of support for the person at that time*. (P6)

This participant is talking about empathy, they are describing two core values of LE which acknowledge that people experiencing mental distress and/or addiction are above all human beings with unique strengths, values, opinions and needs, and the importance of relationship building. Research shows that many MHA health professionals may not be aware of the importance of relationship building and its relevance to recovery-oriented practice (Coffey et al., 2019), and even when knowledge is high a lack of genuine engagement can still reduce health professionals' capability to successfully facilitate a recovery-oriented approach (Cusack et al., 2017). The difficulty in integrating a recovery-oriented approach within a system reflecting a biomedical model of care suggests that systemic and organisational change is needed within the MHA health sector in order to value and support the LE peer support workforce in their holistic approach to supporting people experiencing mental distress and/or addiction (Byrne et al., 2016; Chisholm & Petrakis, 2020; Gagne et al., 2018; Kortteisto et al., 2018). This indicates a need for greater training and support for MHA health professionals to further develop their skills and confidence in applying recovery-oriented practice.

The subtheme "Holistic Approach" reflects the importance of teaching a holistic approach to MHA health professionals and how this will assist with reducing philosophical tensions between the biomedical model and the recovery-oriented approach. It also reflects the importance for MHA professionals to build genuine relationships that provide a supportive healing environment for the people they support.

Value of Sharing Stories

The value of sharing stories, referred to as storytelling, was highlighted by all the organisational participants, particularly the power in using recovery narratives or storytelling when teaching LE. The value in these stories as a learning approach is evident whether the stories stem from LE educators themselves or having graduates with LE return to their education institution to share their LE experience stories with other students:

> *Students respond to the heart stories the most, and that's where they get their 'aha' moments. Lived experience educators bring some of that in, it's really powerful and inspiring to have as part of education and training. Why wouldn't you want your biggest customers as part of your training regime*. (P6)

> *Seeing people with lived experience come through and flourishing and finding employment, and then coming back and sharing their experience with other students, we place a high level of value on that. I don't know if it's written down*. (P1)

> *…you've got people facilitating who they see as educators, but then they start sharing their moments when they weren't well and it puts them in a different light, it's wonderful to see. For me it's the most enlightening thing that you can hear and see*. (P3)

Sharing experiences or telling your story is a distinguishing characteristic of LE and the literature indicates storytelling has a significant role to play in LE peer support work (Mancini, 2019; Piat et al., 2019). Similarly, storytelling is found to be the most common and accepted learning approach currently being used by education providers when teaching LE (Happell et al., 2015b; Happell & Bennetts, 2016a; Jack, 2020). For example, Ramon et al. (2019) found that SW students in the United Kingdom and Israel perceived service users' experiential knowledge as critical to SW knowledge and practice. The study highlighted the value students put on listening to service users' experiences throughout their education, and the researchers believe this type of experiential learning can lead to transformative knowledge that SWs can apply in their practice.

The subtheme "Value of Sharing Stories" reflects storytelling is a distinguishing characteristic of LE, it has a significant role to play in LE peer support work, and it is the most common learning approach used when teaching LE to MHA health professionals. However, the expertise of people with LE can be further drawn upon and go beyond storytelling and add further value, for example through the teaching of LE principles.

Value of LE Principles

An aspect that has been given little focus from a LE teaching perspective is LE principles. Having LE educators to teach these principles will take their role beyond storytelling. LE principles can be described as the values and beliefs that underpin the competencies that guide the LE peer support workforce. There is no one specific set of LE principles and there is no fixed definition. Table 2 below, is the researcher's interpretation of LE principles.

Table 2

Interpretation of LE principles.

Principle	What does this mean?
Hope	Believe there is always hope through encouraging people to have dreams and goals that are meaningful to them. That life challenges can be opportunities for learning and growing.
Experiential knowledge	Telling stories of personal experience relevant to the process of recovery.
Uniqueness	Know recovery is unique to the individual person, and that they are an expert on their own life.
Respectfulness	Be respectful and honest always and using supportive and respectful language.
Self-determination	Empower people to make their own choices about how they want to live their lives.
Fairness and justice	Advocate against prejudice and bias, and challenge stigma and discrimination.
Connectedness	Promote opportunities for positive social connection; family, friends, and the community.

Adapted from: Competencies for the Mental Health and Addiction Consumer, Peer Support and Lived Experience Workforce (Te Pou, 2021) and Australian National Health Strategy: National Standards for Mental Health Services (Australian Government, 2010).

Participants were asked how LE principles assist in delivering positive outcomes for people experiencing mental distress and/or addiction, most believed when using LE principles better outcomes were achieved:

> *LE principles assist with better outcomes for people, it's the mirror type of thing, somebody is sharing their LE, they sat in that chair you sat in, so there's hope, there is opportunity. I don't think there's anything more powerful*. (P3)

> *Better outcomes for people using MHA services is a driving principle of LE practice. No one goes into a role … who doesn't want to be delivering positive outcomes for people, and that's why people do it*. (P6)

LE principles are important from an Aotearoa perspective as inclusion of LE is written into the MHA service delivery sector standards (Matua Raki, 2010). Therefore, MHA health professionals need to understand LE principles and how they apply to their practice. A recent study by Happell et al. (2022c) reported LE educators believe using LE principles assists students to understand the process of recovery while at the same time challenging any negative perceptions the students may have of people who use MHA services. Similarly, this was acknowledged by one of the participants in this study who said:

> *I think LE principles can lessen stigma and discrimination*. (P2)

It is noted that stigma and discrimination will be discussed as a subtheme in the following chapter, "Barriers to LE in Education".

The subtheme "Lived Experience Principles" reflects, that by teaching LE principles students will have a deeper understanding of LE and how it is applied to their practice. With experiential knowledge LE educators are well placed to teach LE principles.

Sense of Self and Self-care

All individual participants stressed the importance to them of a sense of self and self-care. People with LE imparting their knowledge of who they are introduces the human reality of LE to students so they can recognise and understand the LE paradigm. Students also need to know about the importance of self-care for people in recovery. The individual participants all had a strong sense of who they are, and they gave a deep insight into what sense of self and self-care means to them:

> *I'd say that, still recovery is probably one of the best things that has happened to me. I guess it's where the passion comes from. … All that sort of comes into what it is I do [in my work] …. (P5)*
>
> *In my own journey I have lived experience, so I need to be gentle with self, and those are skills I have had to learn over time and continue to develop to maintain my wellness. (P2)*
>
> *[It's] knowing how to stay well and be resilient when you work in a really tough field. …if you are not well you can't be as effective for people you are working with, especially if you don't have a critical reflection on where you are at right now. (P6)*

These participants show how people with LE are in a position to convey to students their insightfulness and ability to critically reflect on the reality of recovery and how it empowers and motivates them to make their own choices about how they want to live their lives. Awareness of sense of self and self-care is an important part of the holistic understanding of LE and its principles which compliment traditional teachings of the biomedical model.

The subtheme “Sense of Self and Self-care” adds value to LE education as it deepens students’ understanding of the principles of LE and the importance of people with LE teaching this unique perspective. The strong sense of self and self-care takes LE beyond storytelling.

Chapter Summary

This chapter presented the findings and discussion relevant to the overarching theme “What LE Brings to Education”. Participants believed there is significant value in having LE educators in the classroom. However, the literature and some of the participants identified that systemic and structural barriers, including a cautious approach to recruiting LE educators, are hindering LE integration into MHA education. Teaching a holistic approach would reduce tensions between the biomedical model and recovery-oriented approach. It is important for MHA professionals to build genuine relationships that provide a supportive healing environment for the people they support. Storytelling is a distinguishing characteristic of LE and organisational participants spoke of the power in using storytelling when teaching LE to MHA health professionals. LE principles should be embedded into LE content within the MHA curriculum and MHA health professionals need to apply these principles to their practice. To optimise understanding of LE principles they need to be taught by LE educators and to achieve this, MHA education providers and academics need to accept and support the inclusion of LE principles. An awareness of sense of self and self-care deepens the understanding of LE principles.

The next chapter presents the second overarching theme “Barriers to LE in Education”.

Chapter Five: Research Findings and Discussion

Barriers to LE in Education

Despite the evidence of the value people with LE bring to student learning there is still resistance to accepting LE into mental health addiction (MHA) education. This resistance can come from within MHA education providers' policies and processes and from the academic staff themselves (Happell et al., 2020a; Happell et al., 2021a; Happell et al., 2021b). This was clearly reflected by this study's participants in the second overarching theme "Barriers to LE in Education" that explored the barriers to LE being integrated into MHA education. Three bridging subthemes identified from the interviews were:

1. Battle for Recognition;
2. Scepticism and Tokenism; and
3. Stigma and Discrimination.

Each subtheme will now be explored.

Battle for Recognition

The quest for LE to be recognised as authentic and valued was a dominant subtheme to emerge from the interviews. It is the responsibility of MHA education providers to continually strive to improve the quality of MHA education, including the integration of LE content into their curriculum (Classen et al., 2021). One organisational participant spoke about the difficulties faced when working with a MHA education provider to develop a LE peer support qualification which included people with LE as educators:

> *We worked hard to get the level four qualification. We had to jump through hoops.* (P3)

Although LE has moved steadily into the MHA health system it continues to struggle to gain legitimacy alongside other health disciplines. Legitimacy within most health professions is achieved through formal academic qualifications, whereas legitimacy for LE is achieved through an individual's experiential knowledge (Scott, 2015). Unfortunately, this can lead to discriminatory attitudes and stigma occurring from those who do not value experiential knowledge as an equal to clinical expertise (dapaanz, 2017). While there remains the issue of finding legitimacy and acceptance that LE is a credible paradigm, integration of LE content and recruitment of LE educators in MHA education will be impeded.

All participants spoke of how LE struggles to find legitimacy within the MHA health system including MHA education. The opinions below are from an individual and an organisational participant:

> *There's still the medical model thing, we're still fighting that. [We are] often seen as only having LE. It's not only our LE that makes us good at our job. LE is not all we offer, our LE is just a small part of our whole*. (P6)

> *My lived experience gives me a lot. It makes me cross the way services look at lived experience, I think there is still stigma involved. I haven't been the person who has always been quite faithful about my lived experience. I've been quite you know, in the background with it. My degree was in alcohol and drug studies but at the time it wasn't really recognised in the sector. There was snobbery around at that time.* (P4)

This reflects a perception that the area of alcohol and drug education broadly, and the specific lens of LE in particular, is seen as less professional than other medicalised health disciplines. This further emphasises the perception of discriminatory attitudes towards LE and that it lacks legitimacy within the wider MHA health system. If stigmatization of LE continues, then LE will remain on the periphery of MHA health system, as identified in the Government Inquiry into MHA in Aotearoa.

The experiences described by these participants illustrate the dominance of the biomedical model which extends from deciding what qualifications are acceptable and what are not, to whether a practitioner with LE feels safe to be open about their LE and confident to include it in their practice. This is also reflected in the literature, for example Mirbahaeddin and Chreim (2022) believe the prevailing biomedical culture supports a hierarchical structure in which the power balance strongly favours MHA health professionals with a medical or clinical background. If people within the MHA workforce, such as addiction practitioners with LE and LE peer support workers, are not seen by the majority medical fraternity as credible professionals and being equal to clinical expertise it will remain difficult to fully integrate LE meaningfully into the MHA health system that includes MHA education (dapaanz, 2017).

Happell et al. (2015a) acknowledge that having people with LE participating in the education of health professionals has the potential to positively influence the attitudes of the next generation of health professionals. They emphasise that for LE to reach its full potential MHA education providers must have a genuine commitment to promote the involvement of people with LE at all levels of the curriculum (design, teaching, assessment, and evaluation). They contend this will require a significant change in the current power dynamics that favour a traditional biomedical model that at varying levels circumvents the LE paradigm.

The subtheme “Battle for Recognition” reflects alcohol and drug education in Aotearoa and particularly the lens of LE is seen as being less professional than other health disciplines, furthering the perception of discrimination and stigma held towards people with LE. Experiences described by participants illustrate the dominance of the biomedical model and that LE lacks legitimacy. Without change LE will remain on the periphery of MHA education.

Scepticism and Tokenism

Scepticism and tokenism were a reoccurring theme raised by all participants and was an important issue for them. Despite facing discriminatory attitudes within their education and the workplace, most of the participants acknowledged there was positive change happening towards LE within the MHA health sector. However, both the individual participants and organisational participants expressed concern that the changes might not be genuine:

> *Slowly it's shifting and changing, however over and over again we have to keep proving our value and worth. …there's a long way to go for the recognition of LE.* (P6)

> *The MHA sector has changed, but how much they've changed is the big thing. [It's] nice to see some of the stigma go away. CEOs [chief executive officers] are starting to value having lived experience members on advisory groups. I hope it's not tokenism, hopefully they're listening to those people*. (P2)

These participants illustrate the scepticism held toward the MHA health system, including MHA education and its genuine commitment to integrating LE. On the one hand there is anticipation there will be change, but on the other, there is scepticism that it will not result in outcomes that align with the expectations of those with LE. This indicates that although advocates for LE and the development of a small LE peer support workforce have made some inroads, most participants in this study remained doubtful and mistrusting the commitment is genuine. As P2 said, they hope it is not tokenism which is a practice that gives the appearance of inclusion without giving support to maximise its meaningful impact (Lefkowitz et al, 2022).

A tokenistic approach towards LE is discussed within MHA education literature (Happell et al., 2015b; Lefkowitz et al., 2022; McCutcheon & Gormley, 2014; Ocloo & Mathews, 2016). Lefkowitz et al. (2022) sees a factor that drives the perception of tokenism is that over time health educators have struggled to understand and operationalise LE into health education. These researchers believe this is in part due to health educators not having a clear understanding of what people with LE represent in MHA education, and hence it becomes difficult for them to value what LE brings to a student's learning. The researchers warn that if health educators cannot resolve this dilemma, and if people with LE are not given power to influence the learning outcomes for students, then education will further perpetuate the perception of tokenism. Therefore, if LE education content and the participation of LE educators is to be successfully integrated into MHA education, it will require a shift to find common ground that allows traditional MHA education and LE to coexist.

The subtheme "Scepticism and Tokenism" reflects LE has made some inroads into the broader MHA health system, although all of the participants were sceptical and mistrusting that the commitment to change is genuine. There is a reluctance to integrate LE into MHA education and this may in part be due to health educators lacking a clear understanding of what LE represents in MHA education, and what value LE brings to students' learning. The literature warns, if people with LE are not given autonomy by health educators to influence the learning outcomes for students, then the perception of tokenism will continue.

Stigma and Discrimination

Participants were asked what value LE can bring to MHA education that may lessen stigma and discrimination? Most participants described their exposure to stigma and discrimination within both MHA services and MHA education. Despite these negative experiences, many acknowledged there has been significant progress made in reducing stigma and discrimination within MHA services, however, this was not the case for MHA education which they believed would take further work, particularly as it relates to people who are in recovery from addiction. One organisational participant who has in the past been a service-user spoke about their experiences:

> *It is really nice to be able to see some of that stigma going away, because mental health services which I was involved with were the most stigmatising places to be. You know, that's where people experienced the greatest discrimination*. (P6)

One factor that may be contributing to this participant's view of positive change towards stigma and discrimination is Aotearoa's national public health programme "Like Minds, Like Mine". Over two decades a particular task this programme has undertaken is to change the perception and behaviour of individuals who are in most contact with people experiencing mental distress and/or addiction including the MHA workforce. A key component of "Like Minds, Like Mine" is to ensure people with LE are at the heart of the programme as the decision makers and education providers and they are not side-lined as advisors and/or storytellers. Evaluations of the programme have demonstrated some success in shifting negative attitudes and there are indications discriminatory behaviours are also reducing (Cunningham et al. 2017).

Another education programme, "Let's Get Real" may also be attributing to changing discriminatory attitudes and behaviour by MHA health professionals in Aotearoa. This programme focuses on attitudes and skills required by people working in the MHA health sector. MHA education providers are encouraged to include "Let's Get Real" within their MHA curriculum (Matua Raki, 2012; Te Pou, 2022; Thornicroft et al., 2014). For example, the Open Polytechnic Te Pukenga has "Let's Get Real" embedded into their Bachelor of Social Health and

Wellbeing, MHA major which prepares graduates to work in the MHA health sector (Open Polytechnic, 2022).

Evaluation of overseas anti-stigma education programmes have similar findings to Aotearoa. For example, a programme in the United Kingdom found a small change in peoples' negative attitudes towards people experiencing mental distress and/or addiction (Hermaszewska et al., 2022) and in Australia anti-stigma programmes that focused on education and involved people with LE were particularly effective (Morgan et al., 2021).

According to Sukhera et al. (2022) stigma and discrimination persists in MHA education and is often found within informal or hidden facets of an educational programme. Discriminatory processes within MHA education were highlighted by individual and organizational participants, specifically how LE posed a barrier to MHA education access:

> *I remember the stigma around people with LE and how they were viewed. I think people had to be three years clean.* (P4)
>
> *Some people who make the decisions about who comes in [to the programme] and who doesn't, come out of a white middle class background and they use a white middle class lens to look at who's a fit and proper person. Staff worry about past criminal offending. I say look past the offending, that past history is gold dust. It's really precious for the journey forward, it's not a deficit. Diversity is not well represented [but] the flipside is they want more diversity with the student cohort*. (P1)

Both participants illustrate the enrolment criteria for some people is different to others, albeit they are enrolling in the same MHA education programme. This supports Sukhera et al.'s notion that discriminatory processes can lay hidden and undetected within MHA education programmes. Both participants' experiences highlight the negative attitude that is often held toward people who have LE of illicit drug use and the illegal activities often associated with this lifestyle. For people in recovery from addiction and who may also have been in the justice system, this is a hurdle they must overcome as they work towards regaining citizenship within their community (Mezzina, et al., 2006).

Stigma can be a disabling factor that can influence peoples' recovery processes (Hill & Leeming, 2014; Mezzina et al., 2006; Rwatschew et al., 2019) as not only must people in recovery continue to manage the harming symptoms of mental distress and/or addiction but they also often have to cope with the social exclusion from their whānau/family and communities (Flett et al., 2020). To effectively address how stigma is manifested in MHA education programmes attention must be paid to MHA education providers' culture, policies, and practices (Sukhera et al. 2022). Therefore, if MHA education providers want diversity within their student cohort, which includes people with LE, they must be proactive in dismantling any structural stigma which may exist and demonstrate empathy towards students with LE. This will assist in supporting peoples' ongoing recovery and the aspirations of people with LE are not hindered by barriers restricting their participation in MHA education (Rwatschew et al., 2019).

The subtheme "Stigma and Discrimination" reflects anti-stigma education programmes within MHA education can make some positive change in peoples' attitudes. However, this may not necessarily be so for people with LE of addiction wanting to enrol in MHA education in Aotearoa. The literature indicates to effectively address discriminatory attitudes and behaviour, and for people with LE to have equity within MHA education, providers need to breakdown any structural issues within their culture, policies and practices that may be perpetuating stigma.

Chapter Summary

This chapter has presented the findings and discussion relevant to the overarching theme "Barriers to LE in Education". LE struggles to find legitimacy across the wider MHA health sector, and although participants acknowledged LE has made some inroads into the broader MHA health system most remained sceptical and mistrusting the commitment is genuine. There is a reluctance to integrate LE into MHA education and this may in part be due to health education providers lacking a clear understanding of what LE represents and what value LE brings to student learning. The differing views held by academics towards LE suggests that academia may in part be hindering the integration process. If this issue is not resolved, and if people with LE are not given autonomy to influence the learning outcomes for students, the perception of scepticism and tokenism will continue. Participants acknowledged there has been some positive progress made in reducing discriminatory attitudes held by some MHA health professionals, however, the same was not said for MHA education. Participants highlighted the discriminatory attitudes faced by people with LE of addiction wanting to enrol in MHA education to become addiction practitioners. Stigma and discriminatory practices can be often hidden within education culture and policies. Hence for people with LE to have equity within MHA education, discriminatory attitudes and behaviours that may exist must be addressed.

The next chapter presents the final overarching theme "Integrating LE into Education".

Chapter Six: Research Findings and Discussion

Integrating LE into Education

The last of the overarching themes explored was “Integrating LE into Education”. This sought to ascertain the participants’ perceptions and opinions of how lived experience (LE) can be integrated into mental health addiction (MHA) curriculum. Three bridging subthemes identified from the interviews were:

1. Lack of LE Integration Plan;
2. What is Needed to Integrate LE? and
3. What Stage Should LE be Integrated?

Each of these subthemes will now be explored.

Lack of LE Integration Plan

The literature advises that there is some LE content integrated into MHA education in Aotearoa, however, it is difficult to gauge the extent of this due to the lack of published research. A search of the literature found no studies relating to the inclusion of LE content specific to addiction education. All the individual participants, who were addiction practitioners, advised they had experienced little or no teaching of LE in their formal education. P2 points out the process of integrating LE into addiction education in Aotearoa is still to begin:

> *People with lived experience have not been involved or engaged in any of my formal training. A consumer advocate came as a guest speaker for one hour, so that is my experience of integrating lived experience into education. It’s been non-existing. My higher education has gone further away from people, it’s become more academic. I guess the heart stuff or that person-to-person connection. There’s a big piece of work that hasn’t been tackled*. (P2)

While strategy and policy drive the involvement of people with LE in MHA treatment services (e.g., National Mental Health Sector Standards and Alcohol and Drug Treatment Sector Standards, Matua Raki, 2010) there is little strategy and policy supporting the inclusion of LE content and LE educators in MHA curriculum in Aotearoa. Consequently, there has been little focus and attention paid to integrating LE into the education of MHA health professionals (Matua Raki, 2012). This may help to explain why the individual participants report having little or no experience of being introduced to LE content and LE educators in their formal education.

Currently in Aotearoa the involvement of people with LE in MHA education is largely undocumented and this is evidenced by the minimal research available (Classen et al., 2021; Matua Raki, 2012). There are two distinct parties involved in the development of MHA curriculum, one being traditional academic educators who hold the authority for the design of MHA education programmes and the other being educators or practitioners with LE who do not hold any such authority. One participant said:

> *Academia can get in the way of authentic lived experience co-development. Education structures that have been there forever are barriers to changing a type of thinking or training.* (P6)

Reflecting this disparity between the two groups, P6 emphasises that MHA education that appropriately reflects LE content and related LE aspirations can only be achieved through cooperation and codesign between these two parties. Although the literature acknowledges that meaningful inclusion of LE within MHA education has the potential to facilitate more positive attitudes by health professionals towards people who experience mental distress and/or addiction (Arblaster, et al., 2015; Bocking et al., 2019; Classen, et al., 2021; Happell et al., 2019) this has not resulted in an increase in LE content and involving LE educators in MHA education (Classen, et al., 2021; Happell et al., 2022a; Scanlan et al., 2020).

According to Happell et al. (2022b) LE educator roles will only increase if MHA education sees these roles as adding value. Some academics doubt whether LE educators add any value to student learning experiences and others question whether LE content is actually necessary, suggesting that academics could use their own professional and personal experience to provide a LE perspective (Happell et al., 2020a). Therefore, to successfully integrate LE into MHA education, time needs to be provided for both parties to explore their concerns.

The subtheme “A Lack of LE Integration Plan” reflects there is little strategy and policy supporting the integrating of LE in MHA curriculum in Aotearoa, this may explain why individual participants reported none or little LE content in their formal education. MHA education that appropriately reflects the aspirations of the LE community can only be achieved through cooperation and codesign. LE educator roles will only increase if MHA education providers see these roles as adding value.

What is Needed to Integrate LE?

Participants were asked how did they see LE being integrated into MHA education? There was an underlying consensus by all the participants that there was a responsibility on the part of MHA education to support the inclusion of LE into the MHA curriculum. One individual participant went so far as to suggest:

> *It needs to be mandated and resourced. There needs to be a group to oversee the implementation*. (P5)

As discussed, little strategy and policy is in place to drive the inclusion of LE in MHA curriculum in Aotearoa (Matua Raki, 2012). However, the release of a Ministry of Health (MOH) strategy Kai Manawanui Aotearoa: Long Term Pathway to Mental Wellbeing (KMA) in 2021 has the potential to change the status quo. It is noted this document was released after the research was undertaken and the researcher and participants had no knowledge of this strategy prior to its publication. The strategy's overarching aim is to transform Aotearoa's approach to MHA and wellbeing (Ministry of Health, 2021). At the time of KMA's release, the MOH also announced the formation of a monitoring group of experts, including people with LE to oversee the strategy's implementation (Radio New Zealand, 2021). This group aligns to P5's recent quote above suggesting the integration of LE into MHA education be monitored.

The KMA strategy recognises a need to strengthen relationships between the Ministries of Health and Education, which would give momentum to integrating LE into the education of MHA health professionals. Within this context an important element of the strategy is a call to review education curriculum to ensure MHA education reflects contemporary models of practice, including the recovery-oriented approach. Therefore, with a closer alliance between the Ministries, a review of MHA curriculum, and a monitoring group of experts, there is a commitment at government level to integrate LE into MHA education. The strategy also lays out a commitment to support the provision of career opportunities that will include academic roles, which may in turn open career opportunities for people with LE to be recruited as LE educators.

Recruiting people with LE into MHA education as LE educators was raised by one of the organisational participants:

> *We have people with professional qualification as teachers or as guest presenters who have lived experience, particularly in the addiction sector, less often in mental health, but*

> *they do come through. Getting people with lived experience from the coalface into teaching roles is not easy. They go down the professional training track first*. (P1)

This participant highlights recruitment of LE educators is difficult, and that those who are recruited are mainly from the addiction sector who also have LE. The development in the late 1990s of an addiction specific undergraduate qualification and the establishment of dapaanz (Addiction Practitioners' Association Aotearoa New Zealand) as the registering body for addiction practitioners, became a pathway for people with LE to become addiction practitioners. It appears that those with LE of addiction who have chosen a clinical pathway first, are the preferred recruits of MHA education providers to teach LE. However, Matua Raki (2012), which was at that time the National Addiction Workforce Development Centre, signalled to MHA education providers that although it is important to value people with LE who have a recognised health qualification, it is equally important to remember the essential qualification required for people to teach LE is their LE and not a recognised health qualification. It would seem according to P1's recent quote above there still remains a preference to recruit people with LE and a health qualification versus looking to others with LE whose expertise or qualification is their LE.

Not all people with LE will be suited to being a LE educator. Participants indicated the need for a cautious and stepped approach in the appointment of people into LE educator roles:

> *…one of the mistakes in the early years for a lot of places was oh! any consumer will do, and so they'd put people with the wrong skills or into roles that were going to fail. I saw that happen in teaching as well and education. And that was, … very token[istic] if you like. Because, it hadn't been thought through*. (P6)

> *I worry about how LE is framed … There's educative work needed …what it means to employ people with lived experience into lived experience designated roles*. (P1)

P6 also pointed out that LE educator roles cannot be undertaken in isolation and that they need to be supported:

> *So, like every other role, you know we are meant to have supervision, we need to have support, we need to have training, we need training that is relevant. … there is lots of mainstream training that are really relevant for LE roles. So, it is not only identified LE training, although that is really important as well. But it is also some of the other mainstream things, that builds the skills for whatever role that person is doing*. (P6)

A recent study by Horgan et al. (2020) addresses the issues raised by these participants. Horgan et al. explored what organisational structures were needed to employ LE educators in MH nursing education. Support structures for LE educators were found to be crucial where they have access to general academic and LE specific support. For example; availability of support from their LE peers including professional supervision, the opportunity to develop their skills and advance their academic career, and they have equal partnership with other academics that builds confidence for themselves and their students.

Integration of LE into MHA curriculum could be assisted by the introduction of Mad Studies, a paradigm which is increasingly gaining acceptance globally. Mad Studies is an academic discipline that brings together empirical and experiential knowledge of mental distress and offers alternative ways of responding to mental distress other than traditional psychiatric interventions (Costa, 2014; International Mad Studies Journal, 2022; Newman et al., 2019). One organisational participant suggested that the LE paradigm that sees an individual in the context of a whole person and not just through the lens of mental illness closely aligns to the characteristics underpinning Mad Studies:

> *You know, the development of kind of Mad Studies and Mad research and development. … it would be good to see a lot more put into those and that would inform a lot of those education programmes.* (P6)

Mad Studies share similarities to critical disability studies that recognise the expertise of people who have a disability in understanding their own life, while acknowledging the experiences of people with disabilities are central to interpreting their place in the world (Reaume, 2014). Mad Studies, as with critical disability studies, exists as a growing discipline within academia and education and recognises the expertise of people's LE of mental distress and the process of recovery while at the same time advocating for social change in how mental distress is viewed (Armstrong & LeFrancois, 2021; Meekosha & Shuttleworth, 2009). Beresford (2016) contends Mad Studies in education offer an important alternative to traditional understandings of mental distress and that Mad Studies are most influential when they are led by people who have LE as survivors of the mental health system.

The subtheme "What is Needed to Integrate LE?" reflects the KMA strategic plan has the potential to drive the integration of LE content and in turn the employment of LE educators in MHA education. It is difficult for people with LE without a formal academic qualification to be recruited into LE educator roles within MHA education within Aotearoa. Appointments to LE educator roles need to be carefully considered as not all people with LE will be suitable. Education providers need to have support structures in place as with other academic staff. Mad Studies align to the LE paradigm and could offer empirical support to LE curriculum development.

What Stage Should LE be Integrated?

Participants were asked at what stage did they think LE should be integrated into MHA education? All strongly expressed the need for LE to be integrated across undergraduate and postgraduate MHA curriculum, and that people with LE be included at every stage of any curriculum development:

> *I think it should be integrated at all levels. They need to be listening to the people who use the services. To tell us what they think they need or how that might look like, what might be helpful for them. I'm jumping a little political here. But I feel quite strongly about it*. (P2)
>
> *I will say [at] all [levels]. Because the more people are exposed … it does become something that's business as usual. And so, it lifts up those experiences as being worthy, you know they have a value. [This] has a helpful effect back into our lived experience sector. Because it gives confidence and also gives their experiences a value that they hadn't had before*. (P6)

These participants are emphasising the importance of using the knowledge and expertise of people with LE to codesign curriculum, which in turn will allow the biomedical model and LE's recovery-oriented approach to sit alongside of each other as equal approaches in the treatment of mental distress and/or addiction. P2 describes their own perspective as being political which can be interpreted as sitting outside the current and prevailing biomedical model found in MHA curriculum, further highlighting the existing power imbalance discussed in the subtheme "Battle for Recognition". Happell et al. (2022b) believes if people with LE are not given the opportunity to have meaningful influence in the development of MH curriculum, then it continues to perpetuate the stigma and discrimination exhibited towards people with LE.

The subtheme “What Stage Should LE be Integrated?” reflects LE should be integrated across all stages of undergraduate and postgraduate MHA curriculum, using the knowledge and expertise of people with LE to codesign curriculum.

Chapter Summary

This chapter has presented the findings and discussion relevant to the final overarching theme “Integrating LE into Education”. Learnings from the discussion on integrating LE is that the current MHA education delivery system is unfocussed and under-resourced. From a planning perspective there is little strategy and policy to support integration. To achieve meaningful integration of LE there needs to be cooperation and collaboration between MHA education providers and the LE community. LE content needs to be included across all stages of undergraduate and postgraduate MHA curriculum, which will allow the biomedical model and LE paradigm to coexist. Mad Studies could offer empirical support to LE content and curriculum development. The current practice of MHA education providers is to recruit people with LE who also have formal qualifications. This practice could exclude people from the LE community who do not have formal qualifications and who could add value to the design, development and delivery of LE content. Integration should occur across all stages of student learning.

The following chapter will discuss the conclusions drawn from the findings and discussion chapters, the study’s limitations, and recommendations that will help integrate LE into the education of allied MHA health professionals.

Chapter Seven: Conclusion, Limitations and Recommendations

"Most of all, it takes generosity to turn our hard-won experiences into positive opportunities for people like us, and to support services and organisations to be most effective and responsive to the people they serve" (Te Pou, 2020, p3).

This study was designed to explore how can lived experience (LE) be integrated into and optimised in the education of allied mental health and addiction (MHA) health professionals. The study found there is value to student understanding of mental distress and/or addiction by integrating LE into MHA education and optimised when taught by people from the LE community. The conclusions from the study can be put into three categories drawn from the literature and participant interviews; planning, curriculum content, and attitudes towards LE.

Planning

The existing research on MHA education reveals that despite overseas and national recommendations there has been limited integration of LE across MHA curriculum in Aotearoa. Participant feedback in this study supports this finding and identifies some of the critical barriers causing this lack of integration.

In a recent initiative the Ministry of Health (MOH) has developed the Kai Manawanui Aotearoa: Long Term Pathway to Mental Wellbeing (KMA) strategy which recognises the need to strengthen relationships through opening up dialogue between the Ministries of Health and Education (Ministry of Health, 2021). An important element of the strategy is a call to review education curriculum to ensure MHA education reflects contemporary models of practice, including LE. With respect to LE content in MHA education, this review is needed as information on what LE content is currently being taught across MHA education in Aotearoa remains mainly undocumented. The lack of information is because only a small amount of research has been undertaken and this is not sufficient to give a consolidated view of LE curriculum content across Aotearoa. The KMA curriculum review presents an opportunity to introduce consistency in LE content across all MHA education providers and this will need a clear plan on how this content is to be introduced. The provision of an integration strategy and plan reflects the calls made by the participants for greater strategic approaches from government to underpin the development and integration of LE in MHA education nationwide.

Curriculum Content

This study found to achieve meaningful integration of LE there needs to be cooperation and collaboration between MHA education providers and the LE community. This involves MHA education providers having a clear understanding of what LE represents and recognise what value LE brings to student learning. The LE community hold the unique knowledge and expertise to develop and teach LE curriculum. MHA education providers who hold the authority to provide MHA education to allied health professionals need to provide the resources required so LE can sit alongside other educational approaches such as the biomedical model.

The literature (Happell et al., 2015b; Happell & Bennetts, 2016a; Jack, 2020) reviewed confirms that the predominant method for delivery of LE curriculum is storytelling, an important and distinguishing characteristic of LE. However, this has the risk of oversimplifying the knowledge that can be drawn from LE and a broader and deeper understanding of LE could be achieved by introducing LE principles into LE content. The value of LE principles for understanding LE was a critical component of feedback from participants in this study and emphasises the importance of integrating LE into MHA education. The inclusion of LE principles introduces a holistic approach which acknowledges a person’s unique strengths, values, opinions, and needs, compared to the biomedical model’s theory-heavy perspectives that emphasise a diagnostic approach for supporting people experiencing mental distress and/or addiction. A further value of having the LE principles in curriculum is they introduce the humanistic values of empathy and compassion, which in turn can reduce stigma and discrimination.

The value of teaching LE through storytelling and LE principles is that they complement each other and provide a way for students to connect theory with the reality of experiencing mental distress and/or addiction. To further enhance LE content, Mad Studies could be introduced. The integration of Mad Studies into LE content is not only appropriate it is entirely feasible. As a recognised academic discipline, the inclusion of Mad Studies would add value to student learning while at the same time contributing to the legitimacy of LE. The inclusion of storytelling, LE principles and Mad Studies can promote self-reflection about one's biases and assumptions towards people experiencing mental distress and/or addiction.

Where LE content currently exists in MHA education it is mostly delivered to students towards the end of their formal education (i.e., in the final year of training) or introduced at postgraduate level. In this respect, current LE content delivery means that it is seen not as a fundamental component of a health professionals' knowledge base which is taught from the initiation of training, instead it is viewed as an addition to core knowledge. If LE is to coexist within MHA education, then the teaching of both LE and the biomedical model needs to be in tandem and introduced early in students' formal education and continue throughout their training.

Attitudes Towards LE

The current study identifies there are differing attitudes held by MHA education providers towards LE which may be hindering its integration. The literature and some participants identified that discriminatory practices can often be hidden within education culture and policies. For example, this study highlighted that the selected entry practices of some MHA education providers, and the attitudes of selection staff, acted as a discriminatory barrier to some people with LE of addiction wanting to enrol in MHA education to become addiction practitioners.

Informed by their experiences in formal education and their workplace, participants in the current study voiced scepticism about MHA education providers’ commitment to integrate LE into MHA education. They suggested that if steps were taken to integrate LE then this would be merely tokenism. This is based on the participants’ wealth of experience in the MHA education and MHA sectors in which the design, development and delivery of programme curriculum, leadership, and selection for programme entry have largely excluded those with LE. To shift this perception there needs to be genuine commitment to change the current attitudes towards LE content in MHA education held by MHA education providers. This will involve collaboration between MHA education providers and the LE community to develop standardised LE curriculum that can be integrated into MHA education. A key factor in a change of attitudes in LE curriculum delivery is that it involves LE educators whose expertise or qualification is their LE.

The overall conclusion from this study is that if LE is to be integrated into and optimised in the education of allied MHA health professionals then LE needs to be recognised and accepted by Ministries, MHA education providers and the academic community as a legitimate health discipline within its own right. The LE community need to participate at all stages in the development and delivery of LE content and appropriate resourcing needs to be provided by the MHA education providers.

Limitations

This study is one of the first to reveal the factors underpinning barriers and facilitators for integrating LE into current MHA education programmes. While all efforts have been made to identify and engage with appropriate participants, using processes that are both ethical and ensure a bias-free voice with those with LE, there are still potential limitations to the study, that need to be highlighted.

The first limitation was at the outset in the research preparation stage. A reference group of three people with LE was established. The purpose was to discuss and give feedback on the aim and objectives of the research and input to the design of the information sheet and interview guides for the semi-structured interviews. Due to the COVID 19 pandemic two of the group members needed to withdraw from the reference group. The one remaining group member and the researcher both had extensive experience in the MHA sector and their combined knowledge meant that the preparation of the material for the research design was not compromised.

The method of the research was semi-structured interviews with face-to-face meetings with the participants. Due to the COVID 19 pandemic lockdowns and for the need to adhere to the research timeline the interviews were switched to Zoom and telephone interviews. In this respect, the researcher tried to maintain the validity of the interview process and provide ongoing voice to the participants, but it is possible that the trustworthiness of participants responses was in some form minimised by the loss of the primary face-to-face interview approach.

This study did not specifically reflect on the potential perspectives of LE provided by Māori and Pasifika people and educators. Māori and Pasifika communities are some of those most effected by MHA in Aotearoa. Consequently, government efforts at education and workforce development in the MHA sector increasingly focus on ensuring Māori and Pasifika world views are integrated within MHA education programmes. While the focus of this study was broadly on the integration of LE across MHA education programmes and did not specifically exclude Māori and Pasifika views and voice, nor did the study design explicitly focus on Māori and Pasifika insight which may be a factor in interpreting the validity of the current study results.

Recommendations

The recommendations made from this study align with the three categories drawn from the literature and participant interviews; planning, curriculum content, and attitudes towards LE.

1. A review is undertaken of LE content currently in the MHA curriculum of MHA education providers. This will provide an understanding of the current status of LE content being taught across Aotearoa. The information gathered could be; what resourcing is available and how much involvement do people with LE have in the design and delivery of LE content, what learning approaches are being used such as storytelling, and at what stage of student learning is LE content introduced.
2. The development of a plan to standardise LE content that is mandated to be integrated into MHA curriculum. The mandatory requirement would include; understanding LE principles and how they are applied in practice, the integrating of Mad Studies, and how these paradigms can coexist with traditional theories of mental distress and/or addiction such as the biomedical model. The plan will need to include a cultural perspective as it relates to Māori and Pasifika people.
3. MHA education providers review their policies and culture so that educators and students with LE are treated equally and discriminatory practices are removed. This review could cover areas such as; equal student enrolment criteria, and in the case of LE academic's availability of peer support, and equal opportunities to other academics who do not have LE.

The Ministries of Education and Health need to initially drive the first and second recommendations by providing support and resources. This would enable the LE community and MHA education providers to come together as equal partners and codesign a review of the current LE content which in turn will inform the development of standardised LE content. The third recommendation of a review of MHA education providers policies and culture has to be initiated by the individual MHA education providers working with the LE community as partners in the review.

If these recommendations are accepted and actioned, it would contribute to reducing the perception of scepticism and tokenism identified in this study, as it would be regarded as a genuine commitment on behalf of the MHA education providers and that they see the value LE brings to MHA education. The ultimate outcome of LE being integrated into and optimised in the education of allied MHA health professionals will be better outcomes for people who experience mental distress and/or addiction.

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Appendices

Appendix 1 Information Sheet

Information Sheet

Thank you for your interest in participating in this research study.

Study title.

Integrating and Optimising Lived Experience into the Education of Allied Mental Health and Addiction Health Professionals.

Purpose of the research.

It is recognised by the mental health and addiction sector that it is important to include people with lived experience in all levels of delivering mental health and addiction services. This has led to lived experience being written into mental health and addiction service development strategy and policy. For the sector to meet these strategy and policy expectations, it will require the development of a mental health and addiction workforce that has lived experience principles as the foundation of their practice.

Who is doing the research?

My name is Bronwyn Murdoch. I am a Masters’ student in the School of Health Sciences at Massey University in Palmerston North. My supervisors are Dr. Gretchen Good and Dr. Andy Towers. I work as a lecturer in the Bachelor of Social Health and Wellbeing Programme at the Open Polytechnic in Lower Hutt. I am also a dapaanz registered addiction practitioner and accredited supervisor. Until recently, I have worked in the mental health and addiction sector for 16 years. I am interested in learning how to integrate lived experience into the training of allied mental health and addiction health professionals.

What is the research about?

This research is about exploring how lived experience can be integrated and optimised into the education of allied mental health and addiction health professionals. The main aim of the study is to develop recommendations for how lived experience can be integrated into educating allied mental health and addiction professionals, so they have lived experience principles as the foundation of their practice. Three broad and inter-related areas will be covered.

- how lived experience is currently included in the education of allied mental health and addiction professionals
- what value is added when including lived experience in the training of allied mental health and addiction professionals
- how lived experience principles can be included in the training of allied mental health and addiction professionals

Why have you been invited to participate?

For the study to have a cross-sectional perspective I am inviting organisations to participate, who are involved in the development and/or training of allied mental health and addiction professionals. I am also inviting individuals to participate, who have experience of their own lived experience and have experience of working in the mental health and addiction sector.

What would I have to do as a participant of this study?

Each participant will be interviewed once by the researcher. The interview will last for one hour and be tape recorded. The interview will focus on the three areas mentioned above. The interviews will be transcribed by the researcher and each participant will have the opportunity to read their interview and amend and add to it as they wish. All participants will receive a summary of the research findings at the end of the study.

Confidentiality and anonymity

I will endeavour to protect your confidentiality and anonymity. All information gathered will be treated as confidential. Recording and notes taken from your interview will be given a code number and this will be used to identify you. This will help to keep all information anonymous. The researcher and her supervisors will have the only access to your interview, and this will be locked away securely. In the unlikely event of research assistants being hired to help input data, they will sign an agreement of confidentiality. None of your private information will be made available to anyone other than myself and my supervisors.

Your rights as a participant

You will be asked to complete a consent form before participating. It outlines your rights as a participant in this research.

- Your participation in this research is entirely voluntary. You have the right to decline any involvement
- You can ask any questions about the research at any stage
- You can refuse to answer any questions and withdraw from the research at any time
- Your participation will remain confidential to the researcher. That is your information will be used in a way that you will not be identified and is given on the understanding that your name will not be used under any circumstances, unless you give permission. As far as possible, I will assure your confidentiality and anonymity.

Research procedures

The purpose of the research is to gather an in-depth understanding of the topic. As mentioned above interviews will be used to collect this information. The interviews will be undertaken by Zoom meeting or telephone. As a participant you will choose the time of the interview that you feel is most comfortable.

Storage of the research

Your interview recordings and hard copy documentation will be stored in a locked cabinet in the researcher's home office. Electronic data will be stored on the researcher's computer which is password protected. Any identifiable data such as your consent form will be stored securely, separate from other data.

This study has received approval from the Massey University Human Ethics Committee.

If you have any further questions or queries regarding the study, please contact me or my supervisors.

Bronwyn Murdoch:

Phone: 0508 650200 Extn. 5344. Email bronwyn.murdoch@openpolytechnic.ac.nz

Supervisors:

Dr. Gretchen Good, Senior Lecturer, School of Health Sciences College of Humanities and Social Sciences. Phone: 64 6 9516510. Email: g.a.good@massey.ac.nz

Dr. Andy Towers, Co-Lead: Mental Health & Addiction Programme: Associate Dean of Learning & Teaching, College of Health School of Health Sciences, College of Health Massey University. Phone: 64 6 9516505. Email: A.J.Towers@massey.ac.nz

If you wish to participate, please sign the consent form, and return by email to bronwyn.murdoch@openpolytechnic.ac.nz

Appendix 2 Consent Form

Integrating and Optimising Lived Experience into the Education of Allied Mental Health and Addiction Health Professionals

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

I understand that the information will be used only for this research and publications arising from this research study.

I agree to participate in this study under the conditions set out in the information sheet.

Signed: ______________________

Name: _______________________

Date: _______________________

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A. Application 20/15. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicssoutha@massey.az.nz.

☐ **Tick here if you would like a summary of the research findings.**

Contact details:

Telephone ____

Email address ____

Postal address ____

____

Appendix 3 Interview Guide Organisational Participant

INTERVIEW GUIDE

Organisational Participant

Lived Experience Semi-Structured Interview

Study title:

Integrating and Optimising Lived Experience into the Education of Allied Mental Health and Addiction Health Professionals.

Demographic information:

Workforce Development Yes/No

Education Provider Yes/No

Region ____

Workforce development:

- How long has your organisation been involved in the development of the allied mental health and addiction workforce?

Educational Provider:

- How long has your training facility been involved in the training of allied mental health and addiction health professionals?

Interview introduction

Advise the interviewee, the main aim of the conversation is to see things from their organisations perspective on the topic being covered.

Verbal consent

Is it still okay for your organisation to participate in this study? Yes/No

Background information

The interviewee will be invited to briefly talk about the organisation's understanding, experiences, and involvement with the topic.

Lived experience and current allied mental health and addiction training

- Does your organisation see any trends within the mental health and addiction sector that are positive for lived experienced practitioners? Does the organisation see any unhelpful trends?
- Thinking about the formal education and ongoing professional development in the mental health and addiction sector, from your organisation's perspective, what has been/or is the most helpful for someone who has lived experience?
- Thinking about current training in the mental health and addiction sector, from your organisation's perspective is there anything the organisation would like added to the formal education and ongoing professional development of allied mental health and addiction health professionals?

What value is added if lived experience is added to allied mental health and addiction training

- What value does your organisation think can be added to professional practice if lived experienced educators are included in the education of allied mental health and addiction health professionals?
- Can you give your organisation's view on whether, including lived experience principles into professional practice can lesson stigma and discrimination?

How is lived experience included into allied mental health and addiction training

- How does your organisation see lived experience being integrated into mental health and addiction training?
- At what level of education does your organisation see lived experience being integrated?
- How does your organisation see, lived experience principles assisting in delivering positive outcomes for people who use mental health and addiction services?

Closing question

- What is one thing your organisation would want education programmes to include related to lived experience?

Appendix 4 Interview Guide Individual Participant

INTERVIEW GUIDE

Individual Participant

Lived Experience Semi-Structured Interview

Study title:

Integrating and Optimising Lived Experience into the Education of Allied Mental Health and Addiction Health Professionals.

Individual participant

Gender ____

Age ____

Ethnicity ____

Region ____

Are you currently working in the mental health and/or addiction sector? Yes/No

How long have you worked in the mental health and addiction sector? __________________

Interview introduction

Advise the interviewee, the main aim of the conversation is to see things as they see them, with a focus on their experience, opinions and what they think and feel about the topic being covered.

Verbal consent

Are you still okay to participate in this study? Yes/No

Background information

The interviewee will be invited to briefly talk about themselves. General information about their background experiences, and perspectives on the topic.

Opening Question

- Thinking about your own background, is there anything that helps you or has helped you to do your work?

Lived experience and current allied mental health and addiction training

- Do you see any trends within the mental health and addiction sector that are positive for you as a practitioner who also has lived experienced? Are there any unhelpful trends?
- Thinking about your formal education and ongoing professional development, can you tell me what has been the most helpful for you as someone who has lived experience?
- On reflection, is there anything that you would like to have seen added to your formal education and/or to your continuing professional development?

What value is added if lived experience is added to allied mental health and addiction training

- Generally what value do you think can be added to professional practice if lived experienced educators are included in the education of allied mental health and addiction health professionals?
- Can you give me your thoughts on whether, including lived experience principles into professional practice can lesson stigma and discrimination?

How is lived experience included into allied mental health and addiction training

- How do you see lived experience being integrated into mental health and addiction training?
- At what level of education do you see lived experience being integrated?
- Tell me about your thoughts on how, lived experience principles can assist in delivering positive outcomes for people who use mental health and addiction services.

Closing question

- What is one thing you would want education programmes to include related to lived experience?