Lived experience participation in mental health recovery teaching in university psychology courses

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Involvement of people with lived/living experience of mental distress in mental health workforce training has positive impacts on student learning and skill development, improves healthcare outcomes, and is mandated in international accreditation standards for clinical psychology training. However, there is limited research on the extent of lived experience involvement in psychology education more broadly. This research identified the extent of lived experience involvement in tertiary psychology education in New Zealand. All 77 teachers of 93 courses with mental health content at New Zealand universities were invited to complete an online survey about lived experience teaching in their course. Fifteen teachers provided data about 44 undergraduate, postgraduate, and applied training courses. Lived experience teaching was uncommon, especially in applied training courses. Lived experience involvement is underdeveloped in tertiary psychology education in New Zealand. It is time for psychology to recognise the importance of contact-based, lived experience-led, and recovery-focused teaching and learning in psychology education and training.

Keywords: *psychology; teaching; education; training; lived experience; expert by experience; recovery*

INTRODUCTION

Recovery-oriented practice is embedded in mental health policy around the world. An international review of mental health policy documents in 2006 found similarities in vision, values, and priorities for mental health, and focused on the concept of recovery, specifically defined to reflect the lived experience-informed conceptualisation of recovery (Compagni et al., 2006), which is:

> when people can live well in the presence or absence of their mental illness, and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them (Mental Health Commission, 1998, p.1).

Involvement of people with lived experience of mental distress, or experts by experience[1], is integral to practice that accords with this definition (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission, 2001). Increasingly, international policy reflects the expectation that people with lived experience actively participate in all aspects of mental health services, from design and planning to delivery and evaluation (Commonwealth of Australia, 2017; Health Services Executive, 2018; Mental Health Commission, 2012; Mental Health Commission of Canada, 2016; New Zealand Ministry of Health, 1995). Such expectations have been set out for mental health policy in Aotearoa. In 2018, the He Ara Oranga Mental Health Inquiry report recommended involving people accessing services in governance, policy, planning, and service development (Paterson et al., 2018). Kia Manawanui Aotearoa (Ministry of Health, 2021), the long-term plan for mental wellbeing, emphasises the need for lived experience involvement in mental health leadership, where people are "partners in their own care" (p.23).

Lived experience involvement and leadership is integral to systems and services being aligned with the lived experience conceptualisation of recovery. Collaboration and partnership with those with lived/living experience enables a shift in traditional power dynamics towards an approach where lived experience is valued (Felton & Stickley, 2004), which is critical to providing quality mental health care and improving healthcare outcomes (World Health Organisation, 2004). It is also critical to countering ongoing issues with health and mental health care provider stereotypes about and discrimination towards people who experience mental distress (Henderson et al., 2014). Valuing of lived experience is central to genuine

[1] There are many different terms used to describe people with lived or living experience of mental distress including service user, consumer, survivor, patient, client, person with lived experience, and expert by experience (Lyon & Mortimer-Jones, 2020). While there is considerable variability in preferred terms, 'people with lived experience' and 'expert by experience' are used in this paper, as these terms do not require service use and recognise the expertise that comes with lived experience.

mental health reform, enacting recovery-based care and empowerment of people with lived/living experience, which is a important shift against the background of institutionalisation and deinstitutionalisation (Gooding, 2016).

Recovery-oriented practice requires not only lived experience involvement in mental health systems and services at all levels, but also recovery-oriented education and training that includes lived experience involvement. As set out in the Australian National Practice Standards for the Mental Health Workforce (Commonwealth of Australia, 2002),

> "Of key importance is the premise that any health professional entering the mental health workforce, or completing undergraduate or postgraduate mental health courses, should have the opportunity to be educated by mental health consumers, their family members and carers about their 'lived' experiences of mental illness, requirements for adequate services and support, and ability to work in partnership with mental health professionals." (p.viii)

Lived experience involvement has potential positive impacts on student learning and skill development, including challenging stereotypes, learning from lived experience, and developing empathy and interpersonal skills, in a way that cannot be achieved by traditional teaching (Happell et al., 2020; Kang & Joung, 2020). It also has potential positive impacts for lived experience teachers in terms of empowerment and valuing of lived experience (Laging & Heidenreich, 2019). While some teachers have lived experience of mental distress, it is quite different to explicitly teaching from a lived experience perspective. Such explicit teaching is also important in terms of supporting people with lived experience to train as mental health professionals. It is increasingly recognised that the mental health workforce, including psychology, includes people with lived/living experience of mental distress, where people occupy dual spaces (although that is not frequently acknowledged: Gough, 2011; Smith & Ulus, 2020). Lived experience involvement in education would therefore also support initiatives to diversify the psychology workforce, along with the albeit slow developments in terms of sociodemographic diversity in psychology training in Aotearoa (Abbott & Durie, 1987; Nathan, 1999; Scarf et al., 2019; Skogstad et al., 2005).

Research on lived experience-led and recovery-focused education has increased rapidly in recent years, with studies conducted primarily in Australia and the UK in mental health nursing (Bingham & O'Brien, 2018; Foster et al., 2019; Happell et al., 2015, 2020; Stuhlmiller & Tolchard, 2019), occupational therapy (Arblaster et al., 2018, Logan et al., 2018; Scanlan et al., 2020), social work (Askheim et al., 2017; Driessens & Lyssens-Danneboom, 2022; Heule et al., 2017; Scanlan et al., 2020), and undergraduate medicine and psychiatry (Gordon et al., 2014; Newton-Howes et al., 2020). Research has typically examined expert by experience involvement in teaching but has recently extended to other aspects of education and training, such as placement and assessment. This is particularly important given the increasing requirements of professional bodies to involve people with lived experience in the design, delivery, and evaluation of education programmes, including in psychology. While there is no such requirement in accreditation standards for psychology training in Aotearoa (New Zealand Psychologists Board, 2018), the British Psychological Society has mandated lived experience involvement in its accreditation standards for postgraduate clinical psychology training (British Psychological Society, 2019). The American Psychological Association is also in the process of determining training standards for postdoctoral programmes specialising in serious mental illness, which are anticipated to include peer support and lived experience involvement (American Psychological Association [APA] & Jansen, 2014).

Given these mandates, it is important to know whether current education and training in psychology involves people with lived/living experience of mental distress. However, there is limited literature on this topic. Systematic reviews of expert by experience involvement in the tertiary education of mental health professionals across Europe, the UK, North America, Asia, and Australia have found that involvement was limited and variable across professions and institutions (Classen et al., 2021; Happell et al., 2013), although there are increasing developments to integrate lived experience participation in mental health nursing training to include curriculum development, teaching, assessment, and selection (Happell et al., 2015). In psychology, lived experience involvement in or leadership of teaching is less common (Townend et al., 2008). A study of undergraduate psychology programmes in the UK found that only two of the 66 programmes included people with lived experience as guest speakers (Cromby et al., 2008). Most of the research on lived experience teaching is in clinical psychology specifically, and describes the approaches used, provides qualitative analysis of different aspects of expert by experience involvement (e.g., teaching, assessment, selection), and/or reports on trainee, lived experience, or staff feedback (e.g., Clarke & Holttum, 2013; Holttum et al., 2011; Lea et al., 2019; Schreur et al., 2015; Vandrevala et al., 2007). Some studies have evaluated attitude change in students as a result of lived experience-led teaching (e.g., Taylor & Gordon, 2022), although none have examined whether such teaching translates to knowledge and behaviour change.

Apart from the UK studies by Cromby et al. (2008) and Townend et al. (2008), there is no research on the involvement of people with lived experience in undergraduate and postgraduate psychology education, despite such involvement being increasingly mandated in public mental health policy and training standards. The present study aimed to identify the extent of lived experience involvement in undergraduate and postgraduate psychology tertiary education in New Zealand.

METHOD

Participants

There were 77 coordinators of 93 relevant courses identified through information about psychology courses on each university's website. These 77 staff were

contacted through their university email address and asked to confirm the primary teacher/s of their course. Where the teaching and responsibility were shared equally among multiple staff, all teachers for that course were invited to participate. Courses at all levels and modes of study were included, specifically undergraduate, postgraduate, and applied training courses. Directors of applied training programmes were not included unless they were invited in their capacity as a teacher of a relevant course. Of the 77 teachers invited, 15 provided data about 44 of the 93 courses (47% of courses).

Materials

The online survey was developed for this study. Teachers identified whether they taught undergraduate (1st to 3rd year), postgraduate (Honours, general Master's, or general postgraduate diploma), and/or applied training courses (postgraduate diploma, Master's, doctorate, placement/internship, or advanced training). Teachers selected as many teaching levels that applied to them and stated the number of courses taught at each level. This determined the number of times the survey questions were repeated for each course the staff member taught.

Questions about lived experience participation and personal recovery teaching in mental health were adapted from Kent and Read's (1998) survey and Happell et al.'s (2002) Consumer Participation Questionnaire. Teachers reported the percentage of mental health content in the course and whether recovery was included in the course (*Yes*, *No*, or *I don't know*). If the course included recovery and mental health content, the participant completed the rest of the survey. Teachers reported whether there was lived experience involvement in teaching the course, either in the past or currently. Lived experience involvement was defined as teaching provided by a person with lived experience of mental distress, who may or may not have used mental health services. Survey respondents could have included themselves in their responses if they were teachers with lived experience, although this may or may not have equated to explicit teaching from lived experience and this distinction was not ascertained. If there was no current involvement, teachers indicated the reason from a list (*No scope in the curriculum*, *Funding issues*, *Not considered valuable*, *Hard to find qualified or experienced people*, *Other – please specify*).

If there was current involvement, teachers reported the number of experts by experience involved and, for up to three experts by experience, what aspects of the course they were involved in (*Curriculum development*, *Face to face teaching*, *Online teaching*, *Evaluation – marking and assessment*, *Other – please specify*; for those reporting on applied training courses, additional options were *Collaboration on research* and *Selection*), the total hours the expert by experience was involved in those activities, the nature of employment regarding those activities (*Unpaid guest lecture*, *Paid guest lecture*, *Sessional/casual*, *Part-time contract*, *Full-time contract*, *Fixed term contract*, *Staff member*), the content of expert by experience teaching (*Talk about their experiences only*, *Talk about their experiences in the context of broader aspects of the curriculum*, *Other – please specify*), to list the topics taught by experts by experience, and who the course content was developed by (*Lived experience teacher*, *Academic teacher*). The final three questions were about lived experience teaching in psychology courses in general. Teachers reported the extent to which increased lived experience involvement would change the course (*Improve a lot*, *Improve a little*, *No change*, *Worsen a little*, *Worsen a lot*), and to note their views about the value and pitfalls of lived experience participation in psychology course teaching.

Design and procedure

A cross-sectional online Qualtrics survey was used to determine the extent of lived experience involvement in undergraduate, postgraduate, and applied training psychology courses with mental health content at all eight New Zealand universities.

Primary teaching staff were contacted by email to provide information about the study and invite them to take part by clicking a link to the survey in the email message (which implied consent). Teachers could opt to receive a summary of findings, and in that instance provided their email address which was kept separate from their data. Teachers provided data about their course, and the number of courses was the primary unit of study. Data was anonymous to protect participant confidentiality. A total of 23 teachers started the survey. One teacher did not consent after reading the information sheet. Six others did not provide any information pertaining to the course/s they taught. One teacher identified that their course had no mental health content. Data from these eight teachers was excluded, leaving data on relevant courses from 15 teachers.

The study was low risk according to the university research ethics process. The study was included in an audit of the university's research ethics and was confirmed to meet the criteria for low risk research which does not require ethics committee review.

Data analysis

SPSS Version 26 was used to descriptively analyse the data for the courses that were reported on, which were grouped into undergraduate, postgraduate, and applied training courses. The main ideas from the small number of comments to the open-ended questions were presented and were not formally analysed.

RESULTS

Of the 77 teachers invited, 15 provided data about 44 of the 93 courses (47% of courses), of which 17 (39%) were undergraduate courses, 16 (36)% were postgraduate courses, and 11 (25%) were applied training courses. Two teachers taught undergraduate courses only, six taught a mix of undergraduate and postgraduate courses, three taught a mix of postgraduate and applied training courses, and the remaining four taught a mix of all courses. One postgraduate course had low mental health content (5%) but included lived experience participation so was included in the study.

Table 1. Percentage (*n*) of aspects of consumer teaching, based on the number of consumer teachers

	Undergraduate course teachers (n = 10)	Postgraduate course teachers (n = 6)	Applied training course teachers (n = 6)
Teaching activity			
Face-to-face teaching	90 (9)	83 (5)	33 (2)
Curriculum development	50 (5)	83 (5)	0 (0)
Marking and assessment	50 (5)	33 (2)	50 (3)
Online teaching	40 (4)	0 (0)	0 (0)
Research collaboration	N/A	N/A	33 (2)
Selection	N/A	N/A	17 (1)
Other	33 (3)	17 (1)	0 (0)
Teaching content			
Talk about lived experience only	40 (4)	50 (3)	67 (4)
Talk about lived experience in context of broader aspects of curriculum	80 (8)	67 (4)	67 (4)
Teaching content developed by			
Academic teacher	50 (5)	67 (4)	50 (3)
Consumer teacher	40 (4)	50 (3)	67 (4)

Note: There were 10 consumer teachers in 8 undergraduate courses, 6 consumer teachers in 6 postgraduate courses, and 6 consumer teachers in 3 applied training courses.

Personal recovery was taught in 13 of the 17 undergraduate courses (77%), 12 of the 16 postgraduate courses (75%), and nine of the 11 applied training courses (82%). The highest proportion of expert by experience involvement in both previous and current teaching occurred in undergraduate courses, where seven (41%) of the 17 courses had previous expert by experience teaching and eight (47%) had current such teaching. Six (38%) of the 16 postgraduate courses had previous or current lived experience teaching. Only two (27%) of the 11 applied training courses had current lived experience teaching, and 2 (18%) had previous such teaching. Of the eight undergraduate courses that included current lived experience teaching, six had one lived experience teacher and the remaining two had two such teachers (a total of ten lived experience teachers). Each of the six postgraduate courses had one expert by experience teacher, and the three applied training courses with lived experience teaching had two such teachers (six teachers). Most (60%) of the 10 lived experience teachers in undergraduate courses were employed on a full-time contract, with one each employed on a casual basis, fixed-term contract, or paid as a guest lecturer. Two of the six experts by experience involved in postgraduate courses were part-time, two were full-time, one was fixed-term, two were paid guest lecturers, and one was unpaid as a guest lecturer. Half of the six experts by experience in applied training courses were employed as paid guest lecturers, and the other 50% were employed in a full-time capacity.

Having no scope in the curriculum was the reason given for all eight remaining applied training courses not including lived experience teaching. The same reason was given for six postgraduate courses and two undergraduate courses. Funding issues were cited for four undergraduate and one postgraduate course, and for one other postgraduate course the reason was difficulty finding lived experience teachers. Other reasons for not including lived experience teaching were given for three undergraduate and two postgraduate courses, and were that lived experience teaching had not been considered, large workloads prevented meaningful inclusion of experts by experience, the lived experience teacher was not currently available, and lived experience teachers were not needed because students with lived experience were involved in course development.

Lived experience teaching activities across teaching level was mixed (see Table 1). Face-to-face teaching occurred in most (90%) of the undergraduate courses, with half of the lived experience teachers or fewer engaged in online teaching, curriculum development, and assessment. Face-to-face teaching was also prominent for lived experience teachers in postgraduate courses along with curriculum development (both 83%), with less involvement in assessment. Lived experience teachers in the small number of applied training courses were involved mostly in evaluation of students, face-to-face teaching, and research collaboration, with only one involved in selection. The number of hours of lived experience teacher time on all teaching activities ranged across the levels, although there was missing data on this variable. Lived experience teachers were involved for 1-20 hours each in six undergraduate courses, and two teachers spent 100-150 hours on all activities. Lived experience teachers in two postgraduate courses spent 4-10 hours each, while another two spent 100-150 hours on all activities. Experts by experience involved in the three applied training courses each spent 5-20 hours on all activities.

Teaching content was similar across teaching level (see Table 1). Expert by experience teaching focused on lived experience, especially as it related to broader aspects of the curriculum, and was developed by academic and lived experience teachers. The descriptions of topics taught by lived experience teachers were similar regardless of teaching level and were variously described as lived experiences, recovery and recovery paradigms, wellbeing, mental health and mental illness, issues with diagnosis, alternate approaches to mental distress, culture, and ways to support recovery.

Teachers reported the extent to which increased lived experience involvement would change the course. Six said the course would improve a lot, four said it would improve a little, and four believed no change would occur (there was missing data for one teacher). There were two key points in teachers' comments about the value of expert by experience involvement in psychology courses. One point was about the value of lived experience, in that expert by experience teachers "provide lived experience of many of the key issues taught in the course and an 'insider' view of how mental illness is experienced and understood", and "consumers who are openly teaching from the perspective of their lived experience provide an understanding of mental distress that is not possible when delivered by teachers without lived experience." The second point was about reducing stigma, as lived experience teachers "can have a much larger impact on student knowledge and attitudes about mental distress" and provide an "awareness of stigma…helps critical thinking on mental health dominant discourses". Some of the potential pitfalls of expert by experience participation in psychology courses that were described were to do with attitudes of staff ("staff attitudes"), students ("some students may not have the maturity or insight"), and the university ("lack of recognition of the value of consumer participation by university management"). Other comments focused on the role of the lived experience teacher ("stray from set course content and time constraints", "some consumers may not be great representatives, just vocal ones") or their welfare (could "be triggering for them", "exploiting the experiences of consumers", "risk of stereotyping consumers by emphasising their differences"), or the welfare of students (could be "triggering for the students").

DISCUSSION

The present study aimed to identify the extent of lived experience involvement in undergraduate and postgraduate psychology tertiary education in New Zealand. Of the 44 courses reported on by 15 teaching staff, 34 (77%) included teaching about personal recovery but only half of those (n = 17; 39% of all courses) involved lived experience teachers. Expert by experience teaching in psychology was proportionately higher in undergraduate courses (47%) than postgraduate courses (38%), and much higher than in applied training courses where only three of the 11 courses included lived experience teaching (27%). Although there were relatively small numbers of courses across these levels of study, especially at the level of applied training, the proportion of lived experience involvement in teaching was generally low, particularly in applied training courses which typically have the most mental health content (e.g., clinical psychology). Previous studies and reviews have identified a lack of lived experience involvement in teaching (Cromby et al., 2006) as an "underdeveloped area within contemporary psychological educational practice" (Townend et al., 2008, p.65), and the present study suggests that this remains the case more than a decade later.

Where lived experience teachers were involved in psychology courses, they mostly engaged in direct teaching about their lived experience, and to a lesser extent curriculum development, although not in applied training courses. As well as direct teaching, some lived experience teachers in applied training were involved in evaluation and only one in selection. There were low levels of involvement in broader aspects of teaching activity. Teaching content was developed by academic and lived experience teachers. Many other studies describe expert by experience involvement in providing guest teaching on lived experience, although research in applied training such as clinical psychology reports on variable roles for lived experience teachers, from informal mentoring, role-play, and small presentations (Holttum et al., 2011) to assessment of trainees (Lea et al., 2019) and selection (Vandrevala et al., 2007), much of which does not involve direct teaching and content development (Vandrevala et al., 2007).

The limited involvement of experts by experience in psychology teaching, particularly at the level of applied training, is problematic given the benefits and value of lived experience to training, practice, and improved mental healthcare outcomes, all of which inform current policy expectations for lived experience involvement at all levels of mental health service provision (Commonwealth of Australia, 2017; Health Services Executive, 2018; Mental Health Commission, 2012; Mental Health Commission of Canada, 2016; New Zealand Ministry of Health, 1995). In terms of policy specifically related to the practice of psychology in New Zealand, the core competencies for psychologists set out by the New Zealand Psychologists Board state that psychologists should understand and integrate the concepts of stigma, discrimination, and social exclusion into assessment and treatment processes (New Zealand Psychologists Board, 2018). However, in the Board's accreditation standards, there is no requirement for lived experience involvement in training programmes leading to registration as a psychologist (New Zealand Psychologists Board, 2016), including Māori as lived experience teachers. This is in stark contrast with the mandate of professional bodies in other countries, such as the British Psychological Society, which requires postgraduate clinical psychology programmes to evidence lived experience involvement (British Psychological Society, 2019), or the developments occurring in the American Psychological Association to require peer support and lived experience involvement in training programmes specialising in serious mental illness (APA & Jansen, 2014). More than 10 years ago, the British Psychological Society's Division of Clinical Psychology (2008) produced practice guidelines for lived experience and carer involvement in clinical psychology training, setting out a criterion that "Programmes must work collaboratively with service users, carers and community representatives to identify and implement strategies for the active participation of these stakeholders within the programme" (p. 8). Practice guides have also been prepared for mental health education and training (e.g., Tew et al., 2004). More recently, there has been recognition of lived experience within the clinical psychology profession, in terms of supporting and valuing lived experience in clinical psychologists and trainees (Division of Clinical

Psychology, 2020a, 2020b). The guidance for training involves stakeholders contributing to "creating training and clinical environments that are compassionate and that seek to destigmatise lived experience" (Division of Clinical Psychology, 2020a, p.8), such as courses including seminars and workshops from lived experience teachers.

Clearly, international research as well as policy requirements are setting the standard for lived experience involvement in psychology teaching and training. Tertiary institutions and training programmes, including course staff and external supervisors, have a responsibility to respond accordingly, in terms of creating a course and/or training culture that recognises the importance and value of lived experience teachers and teaching (Division of Clinical Psychology, 2020a). Accreditation standards in New Zealand also need to reflect the evidence base about the benefits of recovery-oriented and lived experience-led education that informs national mental health policy about lived experience involvement in all aspects of mental health services, and explicitly address what that means for education and training in psychology. While accreditation standards may not always lead to tertiary providers delivering on these mandates (e.g., mātauranga Māori; Levy, 2018), they are an important part of the response, and are consistent with international developments (APA & Jansen, 2014; British Psychological Society, 2019). They may also provide an important support for initiatives by tertiary providers to enact lived experience-led education in psychology teaching and training, given that a main reason for courses having no expert by experience involvement was that there was no support from universities to fund such teaching and that university management did not recognise the value of expert by experience teaching.

However, challenges to implementing lived experience teaching may not only exist at the level of the institution. In the present study, other main reasons for no expert by experience involvement in courses were that it had not been considered by teaching staff and there was no scope in the existing curriculum for such teaching. Participants also noted potential issues with the attitudes of staff and students. Research in the UK indicates that psychology students value lived experience participation in their education and training (Khoo et al., 2004; Norwood et al., 2019; Vandrevala et al., 2007). As in the present study, academic staff recognise the benefits of lived experience in terms of student knowledge, practice, and critical thinking about current clinical systems (Campbell & Wilson, 2017; Holttum et al., 2011; Norwood et al., 2019). However, negative views of involvement have been demonstrated by staff and students, including assumptions about representativeness, bias, and emotional distress in lived experience teachers, and these attitudes are not shared by experts by experience (Cooper & Spencer-Dawe, 2006; Garwood & Hassett, 2019; Happell et al., 2019b). There were some such views expressed in the present study, such as views about lived experience teachers being vocal but "not...great representatives" who veer away from set course content. If some teaching staff consider that lived experience participation in psychology teaching would not add value to courses, or hold attitudes that invalidate lived experience, as was the case in the present study, there is additional work to do in addressing this as a barrier. Future research is needed to better understand the range of views psychology teaching staff have about lived experience involvement, especially where involvement is not valued. We know that health professionals hold stigmatising attitudes and engage in discriminatory behaviour towards those who experience mental distress (Henderson et al., 2014), and that the most effective anti-stigma programmes are those with multiple forms of social contact and an emphasis on recovery (Corrigan et al., 2012; Knaak et al., 2014). Student attitudes towards experts by experience are less negative and more flexible following contact with people with lived experience in an educational environment (Happell et al., 2020; Newton-Howes et al., 2018). Such approaches may also be needed for some psychology teaching staff. Research is also needed pertaining to Māori lived experience teachers in psychology. Increasingly, research has demonstrated the importance of allyship in supporting the development, implementation, and sustainability of expert by experience roles in mental health academia (Happell et al., 2022).

There were limitations of the present study, particularly that only 15 of the 77 teaching staff approached provided data on their courses. However, the number of potential teachers may have been overinclusive, as data was provided for 44 of the 93 relevant psychology courses available at the time (47%), and courses were the unit of study rather than the teachers providing data on the courses. However, factors pertaining to the teachers may have impacted on the study. For example, the survey invitation was sent once in October and again in November, and study recruitment of university teachers at this time of year may have led to lower response rates. Teachers who knew their course had lived experience involvement may have been more motivated to take part while teachers who were aware of no such involvement could be more likely to choose not to take part in the study. Therefore, the study might overestimate the extent of lived experience involvement. While the present study is therefore not a representative survey of tertiary psychology courses in New Zealand with mental health content, it is apparent that further research is needed to clarify whether the findings apply to the broader suite of courses, particularly in terms of the extent of lived experience involvement in teaching. A more systematic approach to data collection would improve the response rate and accuracy of data. One such method could be the use of Official Information Act requests, although that could present its own challenges, especially if teachers were reluctant to disclose their own lived experience or lived experience information was not known or collected (e.g., King et al., 2021). International studies are also needed to better understand the current state of psychology teaching in terms of expert by experience participation. This could involve not just course teachers, but lived experience teachers, as well as students, to triangulate data on mental health teaching in psychology

and the extent of lived experience involvement in this teaching.

Another limitation was that the survey did not take into account that some academic teachers may have had lived experience. This should be identified more clearly in future studies, although being an academic with lived experience and taking the position of explicitly teaching from a lived experience perspective are not one and the same. Teaching openly from a position of lived experience and teaching with lived experience but not acknowledging that in the teaching are quite different approaches, and the critical component for contact-based and recovery-focused education is explicit identification of a lived experience position. Future research is needed to specifically seek the perspectives of lived experience teachers about their teaching in psychology courses.

In conclusion, personal recovery teaching in these 47% of relevant psychology courses in New Zealand was common, but the rates of expert by experience involvement in such teaching were low, especially at the level of applied training. These findings are at odds with international research on the improved attitudes, knowledge, skills, and mental healthcare outcomes from lived experience teaching. Stigmatising attitudes of mental health professionals and educators exist that maintain limited lived experience participation in psychology education (Happell et al., 2019a; Kent & Read, 1998; Taylor & Gordon, 2022). It is critical that psychology enacts recovery-oriented and lived experience-led education as is evidence-based and mandated in policy around the world, to recognise the importance of contact-based and recovery-focused learning in psychology education and training.

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