FEATURE ARTICLE

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Co-design and evaluation of a multidisciplinary teaching resource on mental health recovery involving people with lived experience

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Abstract

Background: Students from a range of health disciplines need to learn from people with lived experience of mental distress and recovery to develop recovery capabilities for mental health practice.

Aims: The aims of this study are to describe the co-design of a teaching resource, to explore the experience of people with lived experience during the resource development, and to evaluate the outcome of the resource on student recovery capabilities.

Method: Using a sequential mixed method, a project group consisting of six people with lived experience and 10 academics from five health disciplines was convened to co-develop teaching resources. People with lived experience met independently without researchers on several occasions to decide on the key topics and met with the research team monthly. The teaching resource was used in mental health subjects for two health professional programmes, and the Capabilities for Recovery-Oriented Practice Questionnaire (CROP-Q) was used before and after to measure any change in student recovery capabilities. Scores were compared using the Wilcoxon signed rank test. The people with lived experience were also interviewed about their experience of being involved in constructing the teaching resources. Interviews were audiotaped, transcribed, and analysed thematically.

Results: The finished resource consisted of 28 short videos and suggested teaching plans. Occupational therapy and nursing student scores on the CROP-Q prior to using the educational resource ($n = 33$) were 68 (median) and post scores ($n = 28$) were 74 (median), indicating a statistically significant improvement in recovery capability ($P = 0.04$). Lived experience interview themes were

(i) the importance of lived experience in education; (ii) personal benefits of participating; (iii) co-design experience; and (iv) creating the resource.

Conclusion: Co-design of teaching resources with people with lived experience was pivotal to the success and quality of the final product, and people with lived experience described personal benefits of participating in resource development. More evidence to demonstrate the use of the CROP-Q in teaching and practice is needed.

KEYWORDS
capability, consumers, co-production, health professional students, video

1 | INTRODUCTION

To enable health professional graduates to deliver recovery-oriented mental health services, health-care students need exposure to authentic learning experiences during their professional preparation programmes. Real-world interactions with people with lived experience of mental distress and recovery and health service use are particularly powerful. Mental illness-related stigma occurs among health-care providers and is a barrier to accessing treatment and recovery for people with lived experience of mental illnesses. Such stigma may arise from negative attitudes, a lack of awareness, therapeutic pessimism, a lack of skills, and workplace culture (Knaak et al., 2017). Therefore, health professional students need to understand the lived experience of recovery by participating in educational activities that present the issues, to be prepared to work effectively in mental health services during placements and upon graduation.

University education has an important role to play in equipping students with an understanding of mental health recovery (Happell et al., 2014), and learning from people with lived experience is considered critical for this understanding (Brand et al., 2021; Chester et al., 2016; Horgan et al., 2020). This is consistent with current health and industry policy directing the contribution of people with lived experience at all levels of health science curricula, including co-designing learning experiences and assessment, teaching in person, and curriculum review. Programme accreditation standards now require involvement of people with lived experience of health conditions and using health services in entry-level occupational therapy education (Occupational Therapy Council [Australia and New Zealand] Ltd, 2018). This is consistent with other disciplines (Australian Association of Social Workers, 2012 [revised January 2015]; Australian Nursing and Midwifery Accreditation Council, 2019). This involvement should go beyond 'telling one's story' to initiatives which embed a lived

Key Points for Occupational Therapy

- Co-design principles were fundamental to the success of a teaching video resource for a multidisciplinary student audience.
- People with lived experience of mental distress and recovery considered that their experience of creating the resource was beneficial to them.
- Occupational therapy and nursing students demonstrated an improvement in recovery capabilities after using the teaching resource.

experience perspective in all aspects of the programme (O'Reilly et al., 2012). A survey of occupational therapy programmes in Australia and New Zealand found that although involvement of people with lived experience of mental distress and ill health was valued, it remained limited (Scanlan et al., 2020). For most programmes, involvement was restricted to a single session in which a person told their story (Scanlan et al., 2020). These findings are consistent with a survey of lived experience involvement in nursing programmes in Australia (Happell et al., 2015). Although most nursing programmes reported lived experience involvement, the most common approach was a single person with lived experience telling their personal story. A minority of universities involved people with lived experience in developing curriculum content, in subject or programme committees, or in paid academic roles. A review by Arblaster et al. (2015) identified no studies related to consumer involvement in the recovery components of occupational therapy programmes and no studies that evaluated the efficacy of consumer elements in changing behaviours or attitudes of students in practice contexts.

Recovery-oriented interventions are the gold standard for mental health clinical practice (Arblaster et al., 2015). The Australian National Framework for Recovery-Oriented Mental Health Services defines recovery as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Australian Health Ministers Advisory Council, 2013, p. 2). This definition was developed through extensive consultation with Australian mental health consumers. Recovery emphasises the right of people to choose what constitutes a meaningful life and does not require absence of symptoms of mental distress and ill health for recovery to be achieved. This means enabling people with lived experience to generate hope; understand their abilities; be engaged in an active life; enjoy personal autonomy, social identity, meaning, and purpose in life; and a positive sense of self (Australian Health Ministers Advisory Council, 2013; Leamy et al., 2011). Therefore, recovery-oriented practice requires a transformed understanding of mental distress and recovery and of approaches to treatment and care. It challenges the traditional biomedical frame of reference and values the knowledge offered by lived experience (Le Boutillier et al., 2011).

Co-design adopts a participatory approach to educational projects where academics work in partnership with people with lived experience, and attention is paid to power sharing and positioning lived experience expertise as equal to professional expertise in contrast with some clinical encounters (Brand et al., 2021; Sangill et al., 2019). This approach is also aligned with the social constructivist learning paradigm where learners construct their knowledge through social interaction with people with lived experience (van Bommel et al., 2012). People with lived experience have indicated that inclusion in nursing education enhances students' understanding of recovery by seeing the strengths of a person beyond their diagnosis and supported students to explore their own thoughts and feelings about mental distress in the context of people with lived experience (Horgan et al., 2018). By developing a teaching resource co-designed with people with lived experience, it is anticipated that students will gain insight about the process of recovery and reduce potential negative attitudes.

Co-design using the expertise of people with lived experience is valuable because it can lead to a high-quality programme outcome, allows for relationships to be built, and thus validates the strengths of consumers (Gordon & O'Brien, 2018; Hickey, 2018). Several principles of co-design have been identified, including equity of participation across one or more aspects of a project; power sharing within the project team; reciprocal and mutually beneficial relationships; and links to broader lived experience networks (Brand et al., 2021; Heaton et al., 2016). One study investigating the views of people with lived experience about participating in co-design activities found that the key ingredients were developing a safe space for participation, being aware of group dynamics, and developing partnerships with stakeholders (Bell et al., 2021). Co-design is associated with improvements in the delivery of outcomes of education (Heaton et al., 2016).

This study aimed to (i) co-design a teaching resource that could be embedded in health professional degree programmes, (ii) evaluate the application of the resource according to the acquisition of recovery-oriented capabilities by students using the Capabilities for Recovery-Oriented Practice Questionnaire (CROP-Q), and (iii) explore the experience of the co-design process from the perspective of people with lived experience.

2 | METHOD

The study was a mixed method sequential design (Creswell, 2014), including qualitative and quantitative evaluations. Ethics approval was gained from the University of Sydney Human Research Ethics Committee (2018/387).

2.1 | Process of co-design of the teaching resource

A project group was convened consisting of 10 academics (four from occupational therapy, three from nursing, two from pharmacy, and one from nutrition and dietetics) and six people with lived experience who were members of a Lived Experience Expert Reference Group and agreed to participate in this project and produce a teaching resource. People with lived experience were paid for their time for contributing to project meetings and activities. Regular face-to-face meetings were held for all team members (pre-COVID) to determine the need for the resource, the goals of designing the resource, and what form the teaching resource should take. Consistent with co-design principles, the lived experience experts decided on the topics for the videos in their own separate meetings, and the academics on the project arranged the video technology for the filming of the videos. The videos were largely unscripted to allow participants freedom to share their experiences. One academic was present during filming with the video producer to provide support to participants who were sharing very personal stories. Filming took place in a small private studio at the University. Draft videos were made available to each participant to enable them to decide on editing, prior to final production.

2.2 | Experience of the co-design process from the perspective of people with lived experience

Using an exploratory qualitative description approach (Bradshaw et al., 2017; Neergaard et al., 2009), people with lived experience who were engaged in the co-design process were invited to participate in telephone interviews to explore how the co-design process was perceived. Semi-structured interviews were used to allow flexibility for participants to describe their experience of the project (Green & Thorogood, 2014). The interview guide was deliberately broad for exploratory purposes, and interviews were conversational to maximise the opportunity of gaining in-depth information from the participants (Doody & Noonan, 2013). Topics explored included why the person with lived experience decided to be part of the project; how the lived experience group decided on the topics to be covered; what they thought students needed to know about; how they felt when doing the video recordings and being part of the project; what they thought they had personally got out of working on this project; and any challenges in being involved with the project. All interviews were conducted by L. M. and ranged from 25 to 70 minutes. Interviews were audio recorded and transcribed verbatim. A thematic analysis process was utilised to generate codes and to search, review, and define themes (Braun & Clarke, 2006). Categories of codes were identified and organised into themes and subthemes. Data saturation was reflected in repeated reference to similar issues from the dataset. As the people with lived experience who were interviewed are also authors of this article, pseudonyms were used in the analysis to preserve anonymity. Lived experience participants were invited to review the findings in order to ensure their views had been captured accurately.

2.3 | Evaluation of student recovery-oriented capabilities using the CROP-Q

To determine how the teaching resource was received by students, an evaluation was made of student development of recovery-orientated capabilities needed for practice following the use of the resource using the CROP-Q. The development and piloting of the CROP-Q has been described elsewhere (Arblaster, 2020). The CROP-Q was informed by previous studies where people with lived experience identified curriculum priorities and preferred modes of involvement in occupational therapy education using an eDelphi (Arblaster et al., 2018). The CROP-Q instrument consists of one of three vignettes representing scenarios that students might encounter while on placements. Students were asked 20 questions about a vignette which emphasised their behavioural choices in response to the vignette and the values, attitudes, knowledge, and skills that underpin and enable these choices. The CROP-Q is scored out of 100 (see Table 1)

A pre-post study method was used to evaluate student outcomes of interacting with the resource using the CROP-Q. A convenience sample of occupational therapy and nursing students at the University of Sydney were recruited. All students had undertaken mental health units using the developed teaching resource and were invited to participate in the study. Invitations were posted on the relevant unit of study sites on the university's Learning Management System and in class announcements about the study were made. Reminders were also posted on the Learning Management System. The teaching staff had no access to the data and were unaware of which students participated. Students were informed that participation was optional and would not contribute to their grades. The teaching resource was embedded in the occupational therapy unit of study during teaching sessions, and a link was provided to the resource for students to access at any time. However, the nursing unit of study approached this differently, by only making the resource available to students with links to their Learning Management System site for students to supplement in class learning about mental health and recovery if they wished.

Data were collected and managed using REDCap electronic data capture tools (Harris et al., 2009). Students accessed the CROP-Q questionnaire using a link provided in the invitations posted on the Learning Management System. Prior to scoring, all negatively worded items were reverse scored, and the total score for each participant was calculated by summing the item scores. Descriptive statistics (median and range) were calculated and were entered into SPSS (IBM Corp., Released, 2017). The Wilcoxon signed rank test was used to examine whether there was a significant difference in CROP-Q scores between pre- and post-tests. This non-parametric test was selected as the samples were small, data were ordinal and not normally distributed, and matched pairs for pre- and post-testing were available (Brace et al., 2006; De Vet et al., 2011; Knapp, 2017; Scott & Mazhindu, 2014).

3 | RESULTS

3.1 | The completed teaching resource

The final teaching resource consisted of nine online modules with 28 video recordings lasting from 1- to

TABLE 1 Sample of Capabilities for Recovery-Oriented Practice Questionnaire survey items related to a vignette

For me to understand XXXX's mental health needs and intervene appropriately:

1. I should prioritise exploring issues of risk.
2. I must explore XXXX's understanding of his concerns and the reasons he is talking about suicide.
3. I must offer XXXX the opportunity to connect with a peer worker.
4. Acknowledging past trauma is not important in understanding XXXX.
5. I need to arrange a psychiatrist appointment as soon as possible to get a clear diagnosis, as this will be important for determining treatment and prognosis.
6. I must take time to listen, show concern, and validate XXXX's experiences, rather than educate XXXX about his diagnosis.
7. I will look for opportunities to provide choice of treatment for XXXX.
8. I should create a safe and open environment for discussion of XXXX's beliefs, hopes, and dreams.
9. XXXX's previous experiences of mental health treatment are not important considerations.
10. I will use language that is consistent with XXXX's own way of understanding his problems.
11. Knowledge of local community resources that XXXX can choose to access for his recovery is essential.
12. I will explore XXXX's strengths with him and help him to utilise these as part of treatment.
13. I should not ask XXXX who in his life he might like to have involved in his care.
14. I should not invite XXXX to participate in mental health service improvement initiatives, even when he is feeling better.
15. At this point in time, I do not need to inform XXXX of any actions I plan to take in relation to his mental health care.
16. Empathy and respect are secondary considerations in this consultation.
17. I should consider how XXXX's needs might change over time when referring him to a service provider.
18. A working knowledge of recovery principles is not required to decide what to do next.
19. I must gain an understanding of XXXX's current level of function.
20. Cultural understandings are not a relevant consideration for me in supporting XXXX at this time.

Note: Scoring per item: *strongly disagree* = 1; *disagree* = 2; *don't know* = 3; *agree* = 4; *strongly agree* = 5. Some item scores were reversed.

6.5-minute interviews with six people with lived experience (five women and one man). Module topics were stories of recovery; the importance of knowledge for people with lived experience of mental distress; being a recovery-oriented health professional; experiences of stigma and self-stigma; peer work; the issues of involuntary treatment; the impact of trauma; advanced directives; and open dialogue. The resource has its own site on the university's Learning Management System and is available for any health professional programme to use as part of their teaching. The participants with lived experience did not have face-to-face contact with any of the students during class sessions.

3.2 | Experience of the co-design process from the perspective of people with lived experience

Four themes were identified from the interviews: (i) the importance of lived experience in education; (ii) personal benefits of participating; (iii) co-design experience; and (iv) creating the resource (see Table 2).

3.2.1 | The importance of lived experience in education

Participants emphasised the human aspects of students learning from lived experience as the basis for their involvement, both in terms of learning from people's human experience and exploring students' own humanity. For instance:

> I wanted people to connect on a human level with our experiences .... It was in order to find some humanity in people working with people with mental distress. (Lucy)

> I thought that giving the human experience, the lived experience to students studying, would be a really good way for them to get in touch with that ... and relate to their basic human experience. (Elaine)

Linked to the humanity subtheme was the need for health professional students to develop respect for people with lived experience through their involvement and contribution:

> Respect for people as people, rather than as patients or as a particular diagnosis ... that is the main thing I wanted .... (Lucy)

TABLE 2 Themes and subthemes of interviews

Themes	Subthemes
The importance of lived experience in education	Human aspects of learning
	Respect for people with lived experience
	Countering stigma and stereotypes
	The long-term nature of recovery
Personal benefits of participating	Positive personal feedback about their recovery
	Positive effect on their mental health
	Sense of pride in the finished product
Co-design experience	Familiarity with other members of the project team
	Valued and supported to participate
	Adequate space to develop own ideas
	Some struggles
Creating the resource	Use of actors
	Videotaping experience
	Confronting nature of videotaping
	Satisfaction with the product

> I think that the main thing is just that people who experience mental health issues need to be trusted and listened to and respected .... I think it's more of like a sense of understanding ... you have to sort of learn to trust and believe other people's experiences and ... I think that's kind of the most important thing, from my perspective. (Pamela)

In contrast, the stereotypes and stigma experienced by people with lived experience from service providers worked against this notion of respect, and people with lived experience hoped that the education resource would counter this:

> I find some models can be a little bit harsh .... There's still this old school mentality of, oh, well, just get yourself a full time job and you'll be all right, sort of thing ... I think a lot of people fall through the cracks as they're

not fully functioning enough to be operating fully in society. (Brenda)

> For health professionals ... the culture of the health system is very stigmatised for people with mental health problems. (Lucy)

One participant focussed on the reality of the long-term nature of recovery within the health system and that health professionals needed to be aware of this:

> [Intervention] is not sort of something that a clinician will do to the person. The person has to be actively involved in their recovery and it's not ... just going to magically happen. (Hayley)

3.2.2 | Personal benefits of participating

All lived experience participants expressed the personal benefits they experienced from participating in the project, such as positive personal feedback about their recovery, a positive effect on their mental health, and a sense of pride in the finished product, while acknowledging that involvement in the project would not be useful to every person with lived experience in the same way:

> I felt that I've got a story to tell and it's actually a really powerful thing to do, and I think it's a gift for the students to hear that. And it's a gift for me, because it makes me feel good about where I'm at and what I've experienced, and good that I'm in a place that I can share it and feel good about that ... I'm a vocal advocate ... so I know some of my friends might not feel comfortable in doing that, which is fair enough, but for me, I really like it. (Elaine)

> I guess just that I was really grateful to be able to be involved actually. And I think even though sort of the outcome was not necessarily perfect, I think that it was still really interesting. (Pamela)

> Personally, I felt good about contributing to something important and I was pretty happy with the end product. I think it flowed really well. I think it covered really a lot of really important areas and I think it'll be a great learning tool. (Elaine)

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3.2.3 | The co-design experience

This theme deals with the social experience of co-design. Some of the people with lived experience were known to each other and the academics through various networks, including consumer organisations and previous research and teaching activities. This assisted with assembling the project team and contributed to creating a cohesive and supportive working environment:

> I was introduced to the project by [another person with lived experience] and she's somebody that I've worked with before, so when she mentioned it to me, I sort of thought that if it was something that she was bringing up as something that I might be interested in, I sort of trusted her to be involved with the project. It was sort of appealing on every front. (Pamela)

Overall, people with lived experience felt that they were valued partners in co-design process and were supported to participate:

> I think it's a great thing that all those different people in different areas came together and recognised that they need to work on these things together. I think the people that I've met throughout the process had really good vision and commitment to the issues, and I think they were really authentic about trying to make the consumers lead it and decide what to talk about. I really love co-design projects, because lived experience consumers have great knowledge and great expertise, but the workers do too, and the experience by training and by working is really important too, and we can learn from each other. (Elaine)

> Oh look, I felt very supported .... Look, I have to say the staff of the university, the academics, were wonderful to work with. There was never a sense that we were being told what to do. I think it really was a consumer led project. Although it was done in the auspices of a university, but within that context, I thought that we, as consumers, had a great deal of control. (David)

Lived experience participants also felt they were given adequate space to develop their own ideas for the project:

> It took extra time and it was good that we had those other meetings just with consumers, and that we had that space, because often people say, I want you to be on this committee or I want you to do this project or whatever, but there's a six week timeframe, which is really tokenistic, but to be able to say, Hey, you guys, take this space, take this time and do it how you see that it should be done. And I think that was really good. (Elaine)

> I think we had a couple of lived experience group meetings and discussions. So it was sort of decided on as a group-based thing, but I think we're all pretty much in agreement around what should be covered It was fine. I mean, I thought it was all good. We felt respected. It was safe to share, lived experience. I mean, I've had other situations where it hasn't been safe to disclose lived experience and it backfired, and there's been consequences. (Hayley)

> I really, really appreciated being kind of trusted, and along with all the other consumers, being allowed to, or being able to, or encouraged to genuinely contribute and being treated an equal part of the project. (Pamela)

However, one of the participants did struggle with the process:

> Working with the team was great. I think when it came to pulling my own weight within the team, I did struggle a little bit. I think, because I had so much going on at that time. I felt that the group worked really well together. But I think on an individual level, I did find it a bit overwhelming. (Brenda)

3.2.4 | Creating the resource

This theme covers the mechanics of creating the resource and the pragmatic considerations about how the resource was created and how the people with lived experience participated in this phase of the project. People with lived experience in the project were given the option to have an actor take on their role for the filming of the resource

in case they did not want to be identified on film. One person with lived experience elected to use an actor and this created its own issues:

> I think from my perspective that there may have been like a little bit of a misunderstanding about how much of my story the actor would be portraying versus how much she would kind of be putting her own spin on things. (Pamela)

Pamela had met with the actor first and went through the content of an interview and created a script to work from.

Other lived experience participants described their feelings when doing the video recording and for some the editing process later:

> The taping itself was good. I felt that I gave the depth that I needed to without exposing myself too much and very relaxed and it was good to chat about those things. I felt I had a free rein to say whatever I wanted to say. I didn't feel in any way edited. (Lucy)

> Because it was on a video and it's me talking, and I feel like you're telling this to the world. I'm quite shy as it is anyway, so to go on video and talk about it was even more confronting. (Brenda)

> I took some Valium for my nerves. So that mitigated some of the difficulty of doing an interview. I've talked about my experiences before, so it wasn't a completely new challenge for me. (David)

Overall, people with lived experience in the project group were satisfied with the end result and felt that it gave students a unique insight into the process and experience of recovery for them:

> I just think [the videos] are so poignant and they capture people's vulnerabilities in ways that are safe, and yet really communicate something very special that you wouldn't get in a lecture. I don't think you'd even get it if someone stood out the front of a class, because ... it allowed an intimacy that wouldn't otherwise have been gained (Lucy).

> A lot of people say they learn more from the lived experience than they do from textbooks. I think [students] really need to be speaking to people who've been through the system to find out what helps and what doesn't help. The textbook stuff is really quite sterile and doesn't really give you that insight. (Hayley)

3.3 | Evaluation of student recovery-oriented capabilities using the CROP-Q

In all, 56 students completed the pre-test and 28 students completed the post-test of the CROP-Q. Participant characteristics are outlined in Table 3.

Student response rates ranged from 28% (nursing) to 35% (occupational therapy). The CROP-Q was scored out of 100, meaning that students demonstrated all of the recovery capabilities measured by the CROP-Q (beliefs, hopes, and dreams; communication style; consumer participation; distress; family context; human rights; mental health knowledge; professional practice; promoting personal recovery; therapeutic relationship; and understanding the person). The median score for the pre-test was 69 (range = 17) and for the post test was 74 (range = 16). Both scores indicate a moderate to high level of recovery capabilities demonstrated by students. There was a significant difference between pre- and post-test medians ($P = 0.04$). The minimum sample size of 50 recommended for non-parametric tests comparing before and after scores (De Vet et al., 2011) was met.

4 | DISCUSSION

This study sought to create and evaluate a teaching resource that was co-designed with people with lived experience and could be evaluated with students to determine their learning once they interacted with the resource. The content of the resource was directed by people with lived experience who agreed what aspects that health professional students needed to know about mental health recovery. The resource took the form of a range of curated video recording around key topics that could be embedded along with teaching plans with an eLearning site (Brand et al., 2021). An outcome measure, the CROP-Q, was piloted and applied with some health professional students before and after their exposure to the resource and indicated that students had developed their understanding of their role in recovery. The resource provided a flexible and collaborative learning environment for students to learn from people with lived experience and engage with a model for their future practice in the mental health context (Happell et al., 2014). It

TABLE 3   Characteristics of students who completed the Capabilities for Recovery-Oriented Practice Questionnaire

	Pre-test (*n* = 56)		Post-test (*n* = 28)	
Age	*n*	%	*n*	%
<20	5	8.9	0	
20–29	41	73.3	25	89.3
30–39	9	16.0	2	7.2
40–49	1	1.8	1	3.5
Gender	*n*	%	*n*	%
Male	7	12.5	2	7.2
Female	49	87.5	26	92.8
Other				
Discipline	*n*	%	*n*	%
Occupational therapy	28	50.0	26	92.8
Nursing	28	50.0	2	7.2
Past experience in mental health	*n*	%	*n*	%
Yes	35	62.5	7	25.0

directly addressed the development of graduate qualities for students, especially excellence in applying disciplinary expertise in the mental health context. Broader qualities such as meaningful communication with people with lived experience, thinking critically about how to adapt interventions to promote a recovery approach, and to respond creatively to the needs of service users were also enabled. It is hoped that students will develop their skills and confidence in working with people with lived experience which may reduce the potential of students at risk during placements. The resource may also reduce the potential of people with lived experience being 'at risk' of interpersonal and communication issues, psychosocial challenges or reduced safety, and dignity from students as a result of stigmatising behaviours and attitudes. Other potential benefits are a reduction in stigma by students and development of values and attitudes to underpin professional behaviours in practice (Morgan et al., 2021).

Co-design of the resource with people with lived experience was pivotal to the success, and quality of the final product and lived experience interviews confirmed that they had appreciated an equal relationship and a safe environment for them to decide on the content of the resource and participate in producing the videos (Bell et al., 2021). The study has confirmed that people with lived experience have valuable expertise to share with health professional students in prioritising topics that need to be included in the teaching resource. The co-design approach empowered people with lived experience to participate as they saw fit so that their expertise could be privileged in the process, and their contribution was meaningful (Gordon & O'Brien, 2018). The project met

the principles of co-design (Bell et al., 2021; Brand et al., 2021; Heaton et al., 2016) as confirmed by the qualitative data from people with lived experience who participated. People with lived experience were active agents in the development of the teaching resource and felt they were equal members of the project team. The project team worked together and supported each other so that the needs of consumers were met, especially in the filming and editing phases of the project. People with lived experience stated that they felt safe participating in the project, and this facilitated them to be comfortable sharing their experiences. For some, their participation contributed to their sense of well-being. People with lived experience who expressed some anxiety about the filming process felt supported by the team who provided encouragement and an opportunity to debrief about the experience. People with lived experience also felt included in the decision making about editing the videos and organising these into the teaching resource.

There are examples of similar projects in the literature that focus on health professional student learning and curricula. Taylor and Gordon (2021) evaluated a lived experience-led 2-hour tutorial for clinical psychology students and evaluated changes in attitudes before and after the tutorial and 2 months later using the Recovery Attitudes Questionnaire and the Opening Minds Scale for Health Providers. These both focussed on attitudes and stigma and may not capture recovery capabilities for practice. However, results showed improved attitudes towards recovery and reductions in stigma after the teaching. The Valuing Lived Experience Project embedded lived experience into a social work curriculum

(Dorozenko et al., 2016) and produced four video recordings of people with mental health lived experience, addressing the lived experience of 'mental illness', service delivery experiences, recovery journeys, and best practice approaches. However, outcomes measures were not reported. The 'Talk to Me' Massive Open Online Course (Bell et al., 2021) focussed on supporting university students with mental health issues and was delivered online. The 'Co-production of Mental Health Nursing Education' (Horgan et al., 2018) used focus group findings to identify priorities for curriculum content. One of the key findings from the Horgan et al.'s (2018) study was to respect the human behind the label of being a person with lived experience, and this was also expressed by consumers in our study. A review of Australian programmes to reduce stigma towards people with lived experience did not locate any programmes conducted by occupational therapists (Morgan et al., 2021). However, these programmes were not all focussed on the development of recovery capabilities for students. A survey of the integration of people with lived experience in occupational therapy curricula in Australia and New Zealand indicated that the range of activities that consumers were involved in was limited (Scanlan et al., 2020). Therefore, this study has contributed to ongoing developments supporting authentic collaboration in curriculum design, delivery, and evaluation.

Another outcome of our study was the application of a new outcome measure: the CROP-Q. As there was not an equivalent measure to use, the development of the CROP-Q was informed by the core capability framework from a qualitative interview study with people with lived experience (Arblaster et al., 2019) and the 12 capability domains from an eDelphi study with consumers (Arblaster et al., 2018). This development was needed as many of the outcomes used in published programmes did not address these recovery capabilities (Arblaster et al., 2015). The lived experience focus was invaluable in ensuring that the vignettes and items within the measure were expressed in recovery-oriented language and reflected recovery-oriented practice capabilities. The findings of our study suggest that the CROP-Q may be an appropriate instrument that can measure change after exposure of students to the teaching resource and now requires formal psychometric validation. However, there were fewer nursing students in the post-test sample using the CROP-Q. Therefore, the higher scores post-test may have been affected by the educational intervention or fewer nursing students in the database.

5 | STUDY LIMITATIONS

As with any co-design project, it is possible that lived experience participants may have experienced a power imbalance when interacting with the academic team for the project, although the qualitative data indicated this was managed well. The student component of the study was limited by the reporting of one pre- and post-evaluation of the teaching resource with only two health professional programmes. Issues of scheduling of mental health content across health professional programmes made a larger study more difficult to achieve, and the low response rate of students to completing the CROP-Q voluntarily further limited the comprehensiveness of the results. However, the strengths of the study were the co-design principles that were incorporated into the design of the teaching resource and the creation of the video interviews and the response of the consumers to their involvement in the project. Using mixed methods helped to expand and strengthen the conclusions of the study related to the development and utility of the educational resource. However, integrating data from the qualitative findings and the CROP-Q data was challenging. Despite all ethical processes put into place to reduce any perceptions by students of a power imbalance when taking part in the CROP-Q study, there may have been a potential perception of coercion or social desirability bias in data collection.

6 | CONCLUSION

In this study, we have presented the process of co-designing a teaching resource with people with lived experience expertise and evaluated it from the perspective of lived experience involvement in the co-design process and developing student capabilities for recovery-oriented practice. Findings indicate that the co-design process was effective for the lived experience participants, and the completed videos met the goals of the project. Initial findings suggest that students improved their recovery capabilities following exposure to the teaching resource using a new evaluation tool (the CROP-Q). Further work needs to be done to validate the CROP-Q, and more evidence is required to evaluate a broad range of recovery-oriented learning activities in health professional curricula.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTION

All authors contributed to the grant application, developing the methods, and approved the manuscript. K. Arblaster, L. Mackenzie and K. Gill, developed the CROP-Q and collected and analysed data for this component. L. Mackenzie, K. Gill, L. Gomez, D. Hamilton, Y. Quinn, R. Schweizer and K. Wells developed the video scripts and resources. L.Mackenzie drafted the manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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