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Lived experience and clinical co-facilitation of a mental health literacy programme: qualitative exploration of satisfaction and factors supporting effective delivery

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ABSTRACT

Purpose: Mental health literacy programmes can help reduce stigma towards people who experience mental health challenges. Co-facilitated mental health literacy programmes, delivered by a person with lived experience of mental health challenges in partnership with a person with clinical experience in mental health services, may further reduce stigma. This qualitative study explores participants' satisfaction with a co-facilitated mental health literacy programme and facilitator characteristics influencing satisfaction.

Design: We used deidentified post-workshop evaluation data from 762 community mental health literacy programme participants (86% response rate). Thematic analysis of qualitative data used a general inductive approach.

Findings: Findings indicate high satisfaction with the co-facilitation model used to deliver a mental health literacy programme. Three key themes related to co-facilitation satisfaction: how participants perceived the co-facilitation model overall; the impact of having two facilitators that offered different knowledge and perspectives about mental health challenges; and the impact of personal stories shared. The personal stories shared by facilitators were perceived as bringing the workshop content to life and providing insights into people's experiences and wellbeing journey. Key themes influencing co-facilitation satisfaction related to facilitator knowledge, skills, values and attitudes.

Originality: To our knowledge, this is the first large study examining satisfaction with a co-facilitated mental health literacy programme for the general public.

Practical implications: Findings indicate the positive impact of incorporating people's lived experience into the design and delivery of mental health literacy programmes. Findings highlight key facilitator characteristics and support needs when recruiting facilitators to deliver programmes. This includes good facilitation skills alongside personal experiences.

INTRODUCTION

Stigma and discrimination towards people with experience of mental health challenges is common and negatively impacts people's lives (Government Inquiry into Mental Health and Addiction, 2018; McBride, 2015). Stigma reflects negative attitudes towards people recognised as "different" from common norms and behaviours, often stemming from a lack of understanding or fear (American Psychiatric Association, 2020). Discrimination is the action or behaviour resulting from stigma, such as labelling or treating others differently or unfairly (American Psychiatric Association, 2020).

BACKGROUND

Education is a key approach that can be used to reduce stigma. Educational anti-stigma strategies present factual information with the goal of correcting misinformation or contradicting negative attitudes and beliefs (National Academies of Sciences, Engineering, and Medicine, 2016). Mental health literacy programmes are a common educational strategy for reducing stigma.

Evidence suggests mental health literacy programmes are an effective way of changing knowledge and attitudes toward people who experience mental health challenges (Kitchener and Jorm, 2006; Morgan *et al*., 2018; Caulfield *et al*., 2019). Increasing mental health literacy can assist communities to support people experiencing mental distress through appropriate knowledge of mental health challenges and supporting people's help seeking efficacy (Kutcher *et al.,* 2016). Stigma is a core domain of mental health literacy, which recognises that a lack of knowledge can drive negative attitudes and influence behaviour (Kutcher *et al.*, 2016).

Contact with people who experience mental health challenges may also be important in reducing stigma and discrimination. Based on Allport's 1954 contact hypothesis, contact

or interaction between members of different groups reduces negative feelings or attitudes if the interaction involves common goals, equal status, and support from relevant authorities. The theory is that negative feelings or attitudes often result from false beliefs or misconceptions, so interactions that demonstrate these are not correct help shift people's perspectives (Allport, 1954). A meta-analysis demonstrated that while both education and contact reduce stigma, contact may be even better than education at reducing stigma among adults (Corrigan *et al*., 2012).

Carefully structured contact with people who experience mental health challenges in an adult education setting may therefore help reduce stigma (Corrigan *et al*., 2001; McBride, 2015; Pettigrew and Tropp, 2006). A recent systematic review and meta-analysis supports this view among healthcare professionals and students, finding education combined with contact is a more effective anti-stigma intervention compared to either alone (Lien *et al.*, 2020).

For contact to be most effective, people with lived experience should be involved in the design, delivery, and evaluation of programmes aimed at reducing mental health stigma and discrimination alongside others to balance the content from different perspectives (Slay and Stephens, 2013). This is a shift away from the historic positioning of professionals as experts who steer the content and agenda (Roper *et al*., 2018). Any contribution by people with lived experience should be distributed throughout the whole programme rather than confined to a single session or portion (Happell *et al*., 2014).

In New Zealand, a unique aspect of the Mental Health 101 (MH101) 1-day mental health literacy programme aimed at the general public is use of a co-facilitation model. Based on the contact hypothesis described above, this involves facilitation by a person with lived experience of mental health challenges in partnership with a facilitator with clinical experience supporting people in mental health services. The two facilitators work together to equally deliver the programme content. Each facilitator builds on the other's content, and the

person with lived experience adds real life examples where appropriate and relevant. This co-facilitation model is a point of difference with other commonly delivered mental health literacy programmes. The MH101 mental health literacy programme aims to increase knowledge about mental health challenges, including recognising signs of mental health challenges, and increasing confidence in relating and responding to people needing support.

This study aims to inform the design and delivery of a mental health literacy programme aimed at the general public, and identify opportunities for improvement. This qualitative study examines participants' perceptions of the co-facilitation model used to deliver the mental health literacy programme. Specific research questions are a) does the co-facilitation model of delivery influence satisfaction of a mental health literacy programme? and b) what facilitator characteristics influence co-facilitation model satisfaction? To our knowledge these questions have not been previously explored in a large sample of people attending a mental health literacy programme for the general public.

METHOD

Study design

This observational study used deidentified MH101 post-workshop evaluation data. All people who participated in a MH101 workshop during 2019 were invited to complete a brief online anonymous survey administered using Survey Monkey Inc (San Mateo, California, USA). A participant information sheet explaining confidentiality and use of the data was provided.

The Health and Disability Ethics Committee in New Zealand (HDEC) confirmed that full ethical approval for the study was not required based on a scope of review. Facilitator names in open-ended data were replaced with CF for the clinical facilitator and LEF for the lived experience facilitator to ensure anonymity.

Setting and participants

This study includes data from all Ministry of Health funded MH101 workshops in 2019. Adults attended one of 46 in-person workshops delivered in multiple locations across New Zealand by Blueprint for Learning, a private training establishment. Participants worked in health, social, and other services.

Measures

Participants provided open-ended feedback about what they found particularly interesting, workshop delivery, and areas for improvement. Comments about co-facilitation satisfaction were extracted from the data. The overall workshop was also rated on a 5-point Likert-type scale ranging from 1 (*poor*) to 5 (*excellent*).

Demographic variables used to describe the sample included gender, age group, and ethnicity (Māori and non-Māori). Organisation type included health and social services (non-government organisations or social agencies, Kaupapa Māori, Pacific, youth, health, or primary care services); and other services (government organisations, rural professionals/farmers or agricultural workers, education, industrial, or other private businesses or organisations).

Bias

People may view data differently through their own lenses. Four people (TP, RR, AJ, HKT) reviewed and coded the data. TP is a researcher of European ethnicity. RR is a principal advisor - lived experience and peer project lead addiction, and identifies as New Zealand European and Māori. She has links to consumer groups and networks spanning over 20 years. AJ is a researcher of New Zealand European ethnicity. HKT is an evaluator of European ethnicity.

We chose to use “people who experience mental health challenges” as strengths-based language instead of mental illness or disorder.

Analysis

This qualitative study used a general inductive approach, which is appropriate when there are specific research aims and objectives (Thomas, 2006). In this approach, raw data are examined in the context of being guided by objectives, but findings are based on raw data not on a-priori expectations based on the objectives.

Thematic analysis was undertaken according to the six steps recommended by Braun and Clarke (2006). The process was not linear as some steps were revisited as we refined the coding framework. Four people participated in data coding. The data were first reviewed by TP to develop an initial framework which was refined further by AJ, RR and HK. We then identified and agreed the key themes and sub-themes. Multiple, regular reflective conversations were had as a group. Observations and discrepancies were discussed, and consensus reached. Where possible, data related specifically to lived experience stories were identified by TP and RR**.** The coding framework was then finalised.

Organisation of themes and sub-themes were determined by importance to the research question, rather than by frequency. We used a latent approach whereby themes and sub-themes were not based simply on words but underlying ideas of statements (Braun and Clarke., 2006).

Nowell et al (2017) outlines five domains of trustworthiness for thematic analysis: credibility, transferability, dependability, confirmability, and audit trail. For credibility, two of our authors have family lived experience of mental health challenges. A person with lived experience of mental health challenges and a MH101 facilitator with lived experience also reviewed our work.

For transferability, we describe the participant sample. For dependability, we followed an established procedure for analysis. This was Braun and Clarke's (2006) method which includes six phases of analysis (1) familiarization with data including transcribing, reading, and re-reading transcripts; (2) generating initial codes (on the basis of aims rather than

research questions); (3) searching for themes by collating codes into potential themes; (4) reviewing themes and generating a thematic map of the analysis; (5) defining and naming themes; and (6) producing the report. We have multiple versions of our codebook and coded segments recorded.

For confirmability, we listed the methods used – an inductive approach to thematic analysis. We also used code memos or definitions to define each theme and sub-theme. Finally, we recorded all the raw data, themed data, codebooks and coded segments as the project developed. Revisions in coding were documented and we had regular meetings to discuss and agree on coding changes.

Qualitative analyses were undertaken using MAXQDA (VERBI Software, 2019) and Stata Version 15 (StataCorp, College Station, Texas, US) for quantitative data describing the sample and satisfaction ratings.

RESULTS

In total, 762 people participated in the survey (86% response rate). Nearly all participants were female (93%, 7% male, <1% another gender); about half were aged 50+ (47%, 30-49 years 39%, under 30 14%), and 1 in 5 identified as Māori (80% non-Māori).

Nearly all participants rated the workshop facilitation as very good (30%) or excellent (65%; 5% good and <1% poor or satisfactory). Older people (aged 50+) were more likely to rate the facilitation as very good or excellent than those aged under 30 (97% and 89% respectively).

Does the co-facilitation model of delivery influence satisfaction of a mental health literacy programme?

Table I summarises the three key themes and relevant sub-themes from qualitative data related to satisfaction with co-facilitation. The themes include (1) how satisfied participants were with the co-facilitation model overall, (2) what impact having two facilitators

with different knowledge and perspectives had on satisfaction, and (3) what impact the sharing of personal stories by facilitators had on satisfaction. Unless specified, the data underpinning the themes appears to refer to both facilitators equally.

Table I. *Themes and Sub-themes About if The Co-facilitation Model of Delivery Influences Satisfaction of a Mental Health Literacy Programme*

(1) How satisfied participants were with the co-facilitation model overall
Participants thought the workshop was well facilitated
Participants thought the two co-facilitators worked well together
Participants thought co-facilitation made the programme interesting and engaging
(2) What impact having two facilitators with different knowledge and perspectives had on satisfaction
Participants were satisfied by the complementary knowledge and expertise of the two facilitators
The complementary lived experience and clinical perspectives were valued
Participants valued having two facilitators of different cultures
Participants valued having two facilitators of different age and gender
Participants valued having a balance and mix of facilitators
Participants valued the different delivery styles of the two facilitators
(3) What impact the sharing of personal stories by facilitators had on satisfaction with the co-facilitation model
The shared stories brought the content to life and made the content real
The shared stories were interesting and informative
The shared stories were enjoyed and appreciated

The shared stories were impactful or powerful
The shared stories supported connection with facilitators
The shared stories were inspiring and participants recognised the courage and bravery required to share these stories
The shared stories challenged current beliefs and language used to describe people
The shared stories supported people to perceive an ability to make a difference and provided hope

The first theme describes perceptions of the co-facilitation model as being positive overall and helping to make the workshop interesting and engaging. Most data described the workshops as well facilitated and the facilitators working well together: "*Excellent delivery with a mixture of presentations delivered by 2 people*" (#43) and "*Excellent co-facilitation*" (#711). Participants said this made the workshop interesting and engaging: "*Both presenters were engaging and real – good to have 2 people to share the workshop as it kept interest up*" (#126).

The second theme describes the benefit of the co-facilitation model that includes two facilitators with different and complementary knowledge and perspectives and how this provided a good mix or balance to workshop delivery.

Participants acknowledged and appreciated the different perspectives offered by having one clinical facilitator and one lived experience facilitator, as well as different cultural and gender perspectives: "*Really good to have both male and female presenters, Māori aspect and lived experience regarding mental health*" (#525) and "*Excellent approach with having a clinician and also a person that has experienced mental [health challenges]*" (#694).

People described the balanced or mixed delivery approach offered by the co-facilitation model: "*Very good balance with the presenters alternating according to their expertise*" (#412) and liked the different delivery styles: "*Both of the facilitators were very knowledgeable and brought different experiences and delivery styles. I appreciate both of them and it made a strong team"* (#689).

The third theme describes how the sharing of personal stories as part of the co-facilitation model largely had a positive impact on participants. There was a strong sense that participants experienced the stories as interesting and informative. The data indicated that for some participants the sharing of stories was the most interesting or informative part of the workshop. Participants enjoyed and appreciated the stories: "*So appreciated the honesty of a personal story shared"* (#197) and "*Particularly liked the personal stories shared by [LEF] that gave a very human side to some of this*" (#521). To a large extent the personal stories described appear to be those shared by the lived experience facilitator.

The sharing of personal stories was highlighted as impactful and powerful. To a large extent the personal stories described were those shared by the lived experience facilitator: "*I really enjoyed [LEF's] story, this is very powerful"* (#541). Participants described how the sharing of stories enabled connection to the facilitators: "*It is always of value when the facilitators have lived through such events themselves and can facilitate from a position of personal experience. Facilitators were able to relate easily with the course participants"* (#611).

The data indicated the personal stories contributed to satisfaction by bringing the workshop content to life and making the learning experience seem more real: "*[CF and LEF] delivered the workshop in a way that made the information come 'alive'; they connected it to real life experiences that absolutely clarified the contents*" (#141) and "*I think the personal stories of the demonstrators added more value to what we were learning…it makes everything more real and relatable*" (#116).

Some participants said they had better insight into people's experiences of mental health challenges due to the personal stories shared. To a large extent the personal stories described were those shared by the lived experience facilitator: "*It was fantastic because [LEF] was speaking from the heart as a service user which gave me very good insight…*" (#76). The data showed that lived experience stories helped to challenge people's beliefs and use of language. Participants also described the courage and bravery required to share lived experience stories: "*I thought it was very courageous that [LEF] shared their own personal experiences with mental health issues"* (#320).

Participants perceived an ability to make a difference and hope: "*…also challenged misconceptions about who mental health effects, and the capacity to move on from this*" (#129) and "*I found the personal experiences that [LEF] shared were invaluable. It was very moving and also gave me hope that people can get better"* (#712).

What facilitator characteristics influence satisfaction with the co-facilitation model?

Table II summarises the themes and sub-themes emerging from qualitative data about factors influencing satisfaction with the co-facilitation model. Key themes include how the facilitators': (1) knowledge and experience, (2) skills, and (3) values and attitudes impacted satisfaction.

Table II. *Themes and Sub-themes Related to What Facilitator Characteristics Influence Satisfaction with the Co-facilitation Model*

(1) How the facilitators' knowledge and experience impacted satisfaction
Participants were satisfied by the level of facilitator knowledge
Participants were satisfied by the facilitators' good understanding of content

Participants were satisfied by the facilitators' level of experience

Participants were satisfied with the facilitators' ability to answer questions

(2) How the facilitator's varied facilitation skills impacted satisfaction

The co-facilitation model worked well due to good facilitation skills

The co-facilitation model worked well due to the facilitators' ability to balance content and group work well

The co-facilitation model worked well as the facilitators created a good and safe environment to learn about mental health

The co-facilitation model worked well due to good group facilitation skills

Participants were satisfied with the facilitators' ability to encourage questions and participation

Participants were satisfied with the facilitators' ability to make people feel included and valued

Participants were satisfied with the facilitators' ability to deliver difficult content in a safe way

Participants were satisfied with the facilitators' taking the time to learn about participants

The co-facilitation model worked well as both facilitators clearly communicated and delivered the content

Participants thought the facilitators had good communication and presentation skills

The facilitators conveyed information simply which impacted their understanding

The facilitators provided practical examples which helped understanding of the content

Participants were satisfied with the facilitators' ability to engage participants

The facilitators were engaging which positively impacted satisfaction

The facilitators were interesting which positively impacted satisfaction

The facilitators were interactive which positively impacted satisfaction

Participants appreciated that each facilitator managed the delivery dynamics with their co-facilitator

The co-facilitation model worked well as the facilitators flowed well (both delivery and content)

The co-facilitation model worked well as the facilitators kept up a good pace

The co-facilitation model worked well as the facilitators made a good tag team

The co-facilitation model worked well due to good time management

(3) How the facilitators' values and attitudes impacted satisfaction

Values and attitudes appreciated by participants include being genuine, honest, optimistic, compassionate, respectful, and open-minded

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The first theme of facilitator knowledge and experience recognised the level of knowledge and understanding of the facilitators and the impact combining their knowledge had on satisfaction with the co-facilitation model: "*Thought you both came across as very knowledgeable and familiar with most aspects…"* (#26), "*It was good to have two presenters, who worked very well together and each one of them brought their own experience and knowledge for us to take away" (*#445*).* The data highlighted how facilitator experience impacted satisfaction with the co-facilitation model. Participants recognised the experience and expertise required to deliver workshops and identified some facilitators who were newer or less experienced: *"Facilitators very skilled and experienced"* (#679)*.* Having knowledge

and the ability to answer questions was also recognised as important: *“Answered all questions in good depth*” (#372).

The second theme to emerge from the data indicated the varied facilitator skills that impacted on satisfaction with the co-facilitation model. This included an ability to clearly communicate and deliver the programme content, manage delivery with the co-facilitator, balance content and group work, engage participants, create a safe and good learning environment, and support effective groupwork.

Clear communication and delivery of the content were highlighted as being aided by avoiding the use of jargon or clinical terminology so people could easily relate and understand concepts: *“It was delivered in plain language that was easy to understand”* (#616). Participants liked the inclusion of practical examples: *“Good use of practical examples”* (#629). Opportunities for improvement included not talking too fast or quietly and pronouncing te reo Māori words correctly.

The management of delivery with the co-facilitator emerged as an important aspect of satisfaction in terms of the flow of topics, pace, transition between facilitators, and time management: *“The two presenters switched well and kept the program bouncing along”* (#583). Participants felt the two facilitators were a good tag team: “*I enjoyed [LEF] and [CF] tag team approach”* (#7). Data highlighted the importance of not rushing through the programme content.

Having facilitators who are engaging and interesting emerged as a key factor influencing satisfaction: *“The facilitators did a great job of keeping the sessions interesting and engaging”* (#296). Participants liked the opportunities to interact with others: *“Really liked how it was interactive and we worked in groups”* (#253). The interaction between the facilitators was also shown to influence participants’ enjoyment of the workshop: *“Both facilitators delivered well, interacted great and helped build a fun and engaging atmosphere”* (#575).

Participants valued the ability of facilitators to create a safe space and good learning environment where people could contribute and ask questions: *"Two amazing presenters that created a safe environment for us to all become involved"* (#81). This includes delivering the content in a safe manner: *"They provided a really safe learning environment for dealing with hard topics and made sure everyone knew they were available if there was something people needed to talk to them about privately"* (#404). The data showed the importance of feeling valued and included: *"The facilitators made me feel comfortable and I found that what I contributed was valued"* (#572). Participants also appreciated how facilitators took time to learn their names and where they came from: "*Impressed with how quickly both facilitators learned all our names*" (#219).

The data indicated that good facilitation and group facilitation skills were evident and impacted on people's satisfaction: *"I found both presenters to be credible, professional and they could read the group and let people talk and understand without disrupting the flow of the day"* (#717).

Facilitator skills included the ability to share their personal story in an appropriate way: *"Clear delivery – not too fast or too many stories"* (#399). Feedback highlighted the need for stories to be the right length to avoid losing connection with the audience: "*I did find myself disengaging with some of the lengthier personal stories"* (#399).

The data revealed facilitator values and attitudes impacted satisfaction. This included being genuine and honest, approachable and professional, compassionate, open-minded, and respectful: *"Both presenters displayed kindness, thoughtfulness and empathy"* (#379) and *"…I appreciated the respect they gave to each other and also those of us attending the course"* (#327).

DISCUSSION

This study explored satisfaction with a co-facilitation model used to deliver a mental health literacy programme aimed at the general public by a clinical and a lived experience facilitator, and factors influencing this.

Overall, findings indicate high satisfaction with the co-facilitation model used to deliver a mental health literacy programme. The three key themes include: (1) how satisfied participants were with the co-facilitation model overall, (2) what impact having two facilitators with different knowledge and perspectives had on satisfaction, and (3) what impact the sharing of personal stories by facilitators had on satisfaction.

Exploration of facilitator characteristics influencing satisfaction with the co-facilitation model also revealed three key themes. This includes facilitators' (1) knowledge of the content and respective areas of expertise, (2) varied facilitation skills, and (3) values and attitudes.

Does the co-facilitation model of delivery influence satisfaction of a mental health literacy programme?

Much of the data suggests that the co-facilitation model used as part of a mental health literacy programme contributes to good facilitation of the programme generally.

Based on what people liked about the co-facilitation model, it is important that co-facilitators work well together and have good transitions between them. Delivery is viewed favourably when facilitators have a good relationship including mutual trust, share the content well, and bounce off each other. Having two facilitators can help make the workshop interesting for participants and supports their engagement. Engagement is important for learning, retention, and connection to information and experience (Ziegler and Durant, 2001; Mandernach, 2015; Mcallister *et al*, 2018).

There is value in having two facilitators with different knowledge and perspectives. In addition to clinical and lived experience perspectives, different cultural, age, and gender perspectives are viewed positively. This is seen as offering a good mix and balance of delivery. The sharing of both clinical and lived experience perspectives within workshops may help learners gain a better understanding of the value of difference and highlight the multiple pathways to wellbeing (Happell *et al.*, 2014).

Data indicates the inclusion of people with lived experience helps provide a different perspective. Findings suggest co-facilitation adds value by helping to bring the programme content to life and provides real life examples, particularly when the stories are relevant, timely, and appropriate to the content. People say this helps solidify their learning and makes the content seem more real. Previous research identifies the delivery of content in a meaningful way with relevant examples as important (Salas *et al.*, 2012).

Findings indicate participants were positively impacted by the stories shared. Highly emotional experiences tend to be well remembered, particularly those eliciting positive emotions (McConnell and Eva, 2012), like hearing about people's resilience.

The sharing of lived experience stories is a unique addition to this community mental health literacy programme which previous research indicates can positively impact perceptions and attitudes towards people with mental health challenges (Pettigrew, 1998; Corrigan *et al.*, 2001; Pettigrew and Tropp, 2006; McBride, 2015; Lien *et al.*, 2020). The lived experience stories shared were often described as impactful or powerful, as increasing people's perceived ability to make a difference, and providing hope. The stories helped challenge people's beliefs and use of stigmatising language. The stories also provided insight into peoples' experiences of mental health challenges, which participants described as requiring courage and bravery to share.

What facilitator characteristics influence satisfaction with the co-facilitation model?

Our findings suggest facilitators' knowledge, skills, values and attitudes are important components influencing satisfaction with co-facilitation of a mental health literacy programme. Being a good facilitator is key and appears important regardless of the delivery model used. As identified in the wider mental health education literature, facilitator knowledge or experience alone is not enough; good facilitation skills are also important (Mcallister *et al.*, 2018; Higgins *et al.*, 2020). Key facilitator skills include the ability to balance the content and group work and not overload people with too much information, clearly communicate and deliver the content, and keep participants engaged and interested (Mcallister *et al.*, 2018; Higgins *et al.*, 2020).

Mental health, mental illness, or distress can be sensitive topics that may be difficult for many people to openly discuss (Sawrikar *et al*., 2011; National Mental Health Commission, 2012; Hamilton *et al.*, 2014). It is vital facilitators create a safe space which encourages participants to share and contribute (Salas *et al.*, 2012). Safe learning environments in which people feel valued supports connection between people's hearts and minds, exploration of different perspectives, and safeguards people's wellbeing (Hall, 2005; Morrissette and Doty-Sweetnam, 2010).

Facilitators' honesty and genuineness are among the key values and attitudes people identify as important. Many of the values and attitudes described reflect those outlined in core capability and competency frameworks for working with people with mental health and addiction needs across health settings (Te Pou o te Whakaaro Nui and Ministry of Health, 2018; NHS Health Education England, 2020; UK Government, 2021). These values and attitudes have been identified as contributing to positive experiences and outcomes for people.

Limitations

It was not always possible to determine if the data related to stories shared by the lived experience or clinical facilitator. We therefore likely underestimate the extent to which data refers to lived experience stories. It was also not always possible to determine if the lived experience facilitator shared a personal experience or a story related to another person.

To minimise recall bias and encourage participation, people were invited to complete the survey soon after programme completion. However, not everyone took part and those that did may have viewed the programme more favourably. Further, even though the questionnaire was anonymous to encourage honest feedback, it is noted that workshop ratings are often positively skewed and may reflect a tendency for people to respond in a socially desirable way. Programme participants were also largely females, non-Māori and about half were aged over 50.

While contact with people with lived experience of mental health challenges as part of a co-facilitated mental health literacy programme likely reduces stigma, people did not directly discuss this in their comments, and we did not measure stigma specifically. Future research should explore this further, through open-ended feedback and specific validated stigma and discrimination measures, alongside more targeted facilitation measures.

Implications of our findings for mental health literacy programmes

Co-facilitation

Co-facilitation by a clinical and lived experience facilitator may enhance learning outcomes in mental health literacy and other training programmes. Facilitators with lived experience can help people connect with the content and provide greater insight into real life experiences. A systematic review of lived experience involvement in education indicates medical students gain insight into what life is like for people with experience of mental health challenges, and their individual experience of and treatment within services (Happell *et al.*,

2014). This may help health professionals see people more holistically and value all their experiences.

Facilitator backgrounds should reflect the target audience of mental health literacy programmes. For example, those programmes aimed at family members supporting a person with experience of mental health challenges should be facilitated by someone with this experience. As the MH101 programme targets people in the general public, many of whom may have lived experience of mental distress or know of someone experiencing mental health challenges, it is appropriate that one of the facilitators has lived experience of using mental health services to support their own challenges.

Design, delivery, and evaluation

Mental health literacy programmes provide an opportunity to implement co-facilitation models. These need to be well designed and provide equal opportunities for both facilitators to contribute. Evidence suggests equal status between facilitators helps reduce stigmatising beliefs and attitudes (Allport, 1954; Mann and Himelein, 2008). It is important that both facilitators are also involved in programme review and evaluation. MH101 involves people with lived experience in the design, delivery, and evaluation of the programme.

Findings suggest some tailoring of programmes may be important for different audiences like younger people.

Stigma and discrimination

The co-facilitation model allows participants to see people with lived experience and clinical facilitators as equals, more than their experience of mental health challenges, and to value their different perspectives. Meeting people with lived experience and hearing their stories of wellbeing can reduce discrimination and helps show that wellbeing is possible (Byrne *et al.*, 2019; Changing Minds, 2019). This may help challenge individual beliefs. Our data suggests

that hearing the personal stories of facilitators challenges beliefs and gives better insight into people's experiences.

Facilitators can help challenge stigma and discrimination through modelling the use of strengths-based language. This reduces stigma by focusing on people and their experiences rather than emphasising sickness, illness, and disease (Changing Minds, 2019).

Recruitment

In recruiting facilitators for mental health literacy programmes a range of characteristics and skills appear to be important including good facilitation skills alongside people's own personal experiences.

To increase lived experience facilitation of mental health literacy programmes there may be a need to grow this workforce. While many health professionals may have their own experience of mental health challenges, lived experience roles often make up only a small proportion of the overall mental health workforce and a number of countries are committed to growing this workforce (Peer Work Hub, 2019; Te Pou, 2020; White *et al.*, 2020). In line with wider workforce needs, diversity in terms of age, gender, and culture is also required among facilitators. Recruitment practices which support and encourage diversity and lived experience may be important.

Professional development and supervision

Both lived experience and clinical facilitators need access to opportunities for professional development and supervision. Previous research with people with lived experience (Horgan *et al.*, 2020) indicates key areas for development may include building emotional intelligence, an understanding of adult learning principles and techniques, and ensuring access to appropriate support when required. Supervision helps support facilitators' wellbeing and the effective sharing of lived experience stories (King *et al.*, 2020). Training on

how to best share personal stories is also recommended (Marino *et al.*, 2016), which may include the observation of others facilitating programmes. Facilitators should feel comfortable sharing their stories and communicate these appropriately to build on the training content. Resources have been developed to support lived experience facilitators in sharing their stories as part of MH101 programme delivery.

Facilitators need to be aware of the potential impact that sharing their story may have on themselves (Marino *et al.*, 2016), and how this may differ over time depending on current circumstances. There may be certain situations or triggers that make sharing stories more challenging (Marino *et al.*, 2016). Support for the lived experience facilitator is an important consideration during and after training to minimise any negative impacts on their wellbeing. Potential impacts may include, but are not limited to, discrimination, disapproval or judgement, and burdening others (Marino *et al.*, 2016). Formalised processes for self-reflection and reflection with the co-facilitator are important. Debriefing with other lived experience facilitators may be useful, along with ensuring facilitators are aware of local community supports available. Programme scheduling that includes breaks between delivery may support time for reflection and enhance facilitators' wellbeing.

CONCLUSION

Our data reveals high satisfaction with a co-facilitated mental health literacy programme for the general public. Having two facilitators, one with lived experience and one with clinical experience, is viewed positively. Findings suggest the inclusion of people with lived experience of mental health challenges in the delivery of mental health literacy programmes is beneficial. The sharing of personal stories brings the training content to life and makes it more meaningful for participants. A range of factors appear to support satisfaction with a co-facilitation model, including facilitator knowledge, skills, values and attitudes. Findings have

implications for the design and delivery of mental health literacy programmes, and workforce development.

Added value of this study

To our knowledge this is the first large study examining satisfaction with a community co-facilitated mental health literacy programme involving facilitation by a person with lived experience of mental health challenges in partnership with a facilitator with clinical experience in mental health services. Our qualitative approach allowed insight into more than 700 participants' thoughts about the co-facilitation model and integral facilitator characteristics.

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