Available on: https://jsshrs.ep-journals.org/ E-ISSN: 3051-3561, P-ISSN: 3051-3553

Journal of Social Science and Human Research Studies

Volume : 02 Issue : 08 August-2026

Beyond Institutional Care: Why Lived Experience Should Inform Mental Health Professional Education

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Published Date: August 25, 2026 **Article DOI: 10.65150/EP-jsshrs/V2E8/2026-23**

ABSTRACT : The transition from institutional to community-based mental health care represents more than a change in the location of services; it requires a fundamental reconsideration of how mental health professionals understand care, autonomy, recovery, and expertise. Although contemporary professional education increasingly emphasizes person-centred and recovery-oriented approaches, people with lived experience often remain positioned primarily as recipients of care rather than contributors to professional knowledge. This Perspective argues that lived experience should occupy a meaningful role in the education of psychologists, social workers, nurses, and other mental health professionals. Narratives of institutionalization, recovery, stigma, coercion, community reintegration, and encounters with mental health services can illuminate dimensions of care that cannot be fully captured through textbooks, diagnostic frameworks, or professional guidelines. Meaningful involvement of people with lived experience may strengthen reflective practice, challenge stigmatizing assumptions, increase awareness of professional power and human rights, and support the development of more person-centred professional identities. However, such involvement must move beyond tokenistic participation and be grounded in ethical engagement, appropriate preparation, recognition of experiential expertise, and psychological safety. Integrating lived experience into mental health professional education should therefore be understood not merely as educational enrichment, but as an important component of contemporary, rights-based mental health training.

KEYWORDS: lived experience, mental health education, deinstitutionalization, professional education, recovery, human rights, social work, nursing

INTRODUCTION

The history of mental health care has been profoundly shaped by institutionalization. For many decades, people experiencing severe mental health difficulties were frequently separated from their communities and placed within large psychiatric institutions, where professional and institutional authority could determine everyday life, treatment, mobility, relationships, and opportunities for social participation. The international transition toward deinstitutionalization and community-based mental health services has challenged this model and contributed to growing recognition of autonomy, social inclusion, recovery, person-centred care, and human rights as central principles of contemporary mental health practice [1,2].

Yet closing institutions or relocating services to community settings does not automatically eliminate institutional ways of thinking. Paternalism, stigma, unequal professional–service user relationships, and assumptions regarding the capacities of people experiencing mental health difficulties may persist even within community-based systems. Contemporary rights-based approaches therefore require not only organizational reform but also transformation in professional culture and in the relationships between professionals and the people they support [1,2].

Education has a critical role in this transformation. Psychologists, social workers, nurses, psychiatrists, occupational therapists, and other professionals acquire more than clinical knowledge and intervention techniques during their training. They also develop beliefs about professional authority, vulnerability, autonomy, risk, recovery, and what constitutes legitimate knowledge. If mental health education is predominantly constructed through professional and academic perspectives, an essential source of knowledge may remain underrepresented: knowledge developed through lived experience [3-5].

From Being the Subject of Care to Being a Source of Knowledge

People who have experienced psychiatric hospitalization, institutional care, community mental health services, stigma, recovery, or social reintegration possess experiential knowledge that differs from, but can complement, traditional clinical and academic expertise. Increasingly, lived experience is being recognized not simply as personal testimony but as a legitimate source of expertise capable of informing mental health education, research, and professional practice [3-5].

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A textbook can describe institutionalization. A professional guideline can define person-centred practice. A lecture can explain stigma or shared decision-making. However, lived experience can reveal how mental health practices are experienced from the other side of the professional relationship: what it means to have decisions made on one's behalf, to feel unheard, to encounter a professional who restores dignity, to experience stigma after leaving a service, or to reconstruct one's social identity and everyday life.

This distinction is important. Mental health professionals require evidence-based knowledge, but evidence alone does not determine how care is experienced. The quality of a therapeutic encounter is also shaped by language, interpersonal relationships, respect, power, communication, and opportunities for meaningful participation. Critical reflections on the involvement of people with lived experience in mental health organizations similarly emphasize the importance of recognizing experiential knowledge alongside conventional forms of academic and professional expertise [4].

For this reason, professional education should move beyond simply teaching students about people who use mental health services toward creating opportunities to learn with and from people with lived experience. Evidence from mental health and health professional education suggests that expert-by-experience roles and lived-experience narratives can provide meaningful educational opportunities and challenge traditional hierarchies regarding who is considered an educator and knowledge holder [3,5].

What Can Lived Experience Add to Professional Education?

Meaningful incorporation of lived experience can contribute to professional education in several interconnected ways.

First, it can humanize theoretical and clinical knowledge. Students frequently encounter mental health difficulties through diagnostic criteria, clinical cases, assessment instruments, and intervention protocols. These are essential components of training, but when presented in isolation they may distance students from the complex social and personal realities behind diagnoses. First-person perspectives can restore the individual, relational, and social dimensions of mental health and care [3,5].

Second, lived experience can help students recognize power within professional relationships. Mental health professionals possess substantial institutional and symbolic authority. Decisions that may appear routine from a professional perspective can have profound implications for the autonomy and dignity of the person receiving care. Listening to people who have experienced these relationships can encourage future professionals to critically examine how professional power is exercised and how participation in decision-making can be strengthened.

Third, experiential knowledge can contribute to challenging stigma and assumptions about incapacity. People with lived experience who participate as educators, advocates, researchers, or collaborators disrupt the assumption that individuals experiencing mental health difficulties should be positioned exclusively as passive recipients of professional expertise. Recent work has also demonstrated the relevance of lived-experience advocacy to broader educational and employment engagement, reinforcing its relationship with social inclusion and participation [6].

Fourth, lived experience can strengthen reflective practice. Instead of asking only, “What intervention should be provided?”, students can be encouraged to ask additional questions: “How might this intervention be experienced?”, “Whose priorities are guiding this decision?”, “Was the person genuinely heard?”, and “Could professional practice unintentionally reproduce exclusion or loss of autonomy?”

Finally, lived-experience education can contribute to understanding recovery as a process involving more than clinical outcomes. Identity, relationships, meaningful activity, social participation, autonomy, hope, and belonging are central dimensions of people's lives that may become particularly visible when individuals are given opportunities to describe recovery and mental health care in their own terms. Such an approach is consistent with the broader international movement toward person-centred and rights-based mental health systems [1,2].

From Deinstitutionalization to Human-Rights-Based Education

The lessons of institutional mental health care have contemporary relevance. Historical institutional practices demonstrate the consequences that may arise when professional authority becomes disconnected from autonomy, participation, dignity, and human rights.

Lived experience can therefore provide a bridge between the history of institutionalization and contemporary human-rights-based practice. Narratives from people who have experienced institutional or long-term psychiatric care can encourage future professionals to consider fundamental questions: What does dignity mean in everyday care? When does protection become excessive control? How can professionals respond to vulnerability while supporting autonomy? What does meaningful participation in treatment decisions actually look like?

These are not exclusively historical questions. They remain relevant wherever individuals experience coercion, stigma, exclusion from decision-making, or limited opportunities to influence their own care. WHO guidance explicitly emphasizes person-centred and rights-based community mental health services and the need to move away from models characterized by institutionalization and insufficient respect for autonomy and human rights [1].

Mental health education should therefore connect the history of deinstitutionalization with current professional responsibilities. The objective is not simply to teach students that institutional models belonged to an earlier period, but to enable them to recognize and challenge institutional attitudes and practices wherever these may continue to appear.

Avoiding Tokenism: From Personal Testimony to Meaningful Participation

Including lived experience in education is not automatically empowering. Inviting an individual to recount a difficult personal history to a classroom while professionals retain complete control over how that story is selected, interpreted, and incorporated into teaching can reproduce rather than challenge existing inequalities.

Meaningful involvement therefore requires more than personal testimony. Tokenism can operate at a structural level, whereby visible inclusion may coexist with persistent inequalities in participation, authority, and influence [7]. Although evidence on tokenism extends beyond mental health settings, this broader concern is highly relevant when considering how experiential expertise is incorporated into professional education. Within mental health academic environments specifically, critical reflections have emphasized the importance of addressing power, organizational structures, and the conditions required for meaningful lived-experience involvement [4].

People with lived experience can contribute not only as guest speakers but as educators, co-designers of teaching activities, contributors to case-based learning, participants in curriculum development, and partners in evaluating professional education. Their contribution should be recognized

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as expertise rather than treated merely as an emotionally powerful addition to conventional teaching. Recent discussion of interprofessional mental health teams similarly argues for moving beyond narrowly defined "peer worker" roles toward greater recognition of experiential expertise [8].

Ethical safeguards are equally important. Individuals should determine what they wish to disclose and should never be pressured to reveal traumatic experiences for educational impact. Preparation, informed consent, appropriate recognition or remuneration where possible, confidentiality, psychological safety, and opportunities to withdraw should form part of responsible lived-experience involvement.

Students also require preparation. Lived-experience teaching should be accompanied by structured reflection so that narratives are not reduced to exceptional or emotionally compelling personal stories but become opportunities to examine professional values, systems of care, social inequalities, power, and ethical responsibilities.

Implications for Nursing, Social Work, Psychology, and Interprofessional Education

The relevance of lived-experience education extends across mental health professions.

For nursing, experiential knowledge can deepen understanding of dignity, communication, everyday care, therapeutic relationships, and the experience of receiving care within healthcare environments. Research on expert-by-experience roles in mental health education supports the potential educational value of incorporating such perspectives into professional training [3].

For social work, lived-experience education aligns particularly strongly with commitments to social justice, empowerment, self-determination, anti-oppressive practice, and the person-in-environment perspective. First-person accounts can help future social workers understand how mental health difficulties interact with stigma, family relationships, housing, employment, poverty, social exclusion, and access to community resources. The relevance of lived-experience advocacy to education and employment engagement further demonstrates how mental health recovery is inseparable from opportunities for social participation [6].

For psychology, lived-experience perspectives can complement diagnostic and therapeutic knowledge by emphasizing personal meaning, identity, therapeutic relationships, autonomy, and individuals' own understandings of recovery.

The implications extend beyond individual disciplines. Interprofessional learning may be particularly valuable. Bringing students from nursing, social work, psychology, medicine, occupational therapy, and related disciplines together around lived-experience narratives may shift discussion away from professional boundaries and toward a shared question: What does good mental health care look and feel like from the perspective of the person receiving it?

Such a question is simple, but it can fundamentally alter the educational perspective. Rather than positioning the professional as the sole interpreter of care, it recognizes the person receiving services as someone whose knowledge is essential to understanding the quality, meaning, and consequences of professional practice.

CONCLUSION

The transition beyond institutional mental health care remains incomplete if professional education continues to privilege knowledge about service users while giving limited space to knowledge from service users.

People with lived experience should not be understood solely as patients, clients, research participants, or recipients of professional interventions. They can also be educators, collaborators, advocates, and knowledge holders. Evidence from contemporary health professional education and mental health research increasingly supports recognition of experiential expertise as a meaningful contribution to education, research, and interprofessional practice [3-5,8].

Integrating lived experience into mental health professional education can help future practitioners understand the consequences of institutionalization, recognize power within professional relationships, challenge stigma, strengthen reflective practice, and develop more person-centred and human-rights-based approaches to care.

Moving beyond institutional care therefore requires more than changing where mental health services are delivered. It requires reconsidering how professionals are educated, who participates in that education, and whose knowledge is considered valuable

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