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**To Disclose or not to Disclose? Peer Workers Impact on a Culture of Safe Disclosure for
Mental Health Professionals with Lived Experience**

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Abstract

The presence of peer workers in multi-disciplinary environments has rapidly increased in recent years, yet the impact of peer work on other mental health roles is largely unknown. This paper explores the presence of peer workers within multi-disciplinary environments, with specific focus on the possible impact of this presence on the culture of disclosure for mental health professionals with lived experiences of mental health challenges. Semi-structured focus groups and interviews were conducted with 132 participants at five organizations across the United States. Participants self-identified as being employed in a range of roles including management, mental health professionals, designated peer workers and designated peer leadership positions. Findings suggest intentionally employing peers and using peer values to address stigma towards mental health professionals improves the culture of disclosure. In work environments where peer-led initiatives were featured, mental health professionals felt safer to disclose their own lived experience to their colleagues and supervisors. Recommendations include the use of parallel strategies to promote the perceived value of peers and to implement peer-led training for both supervisors and professionals to model a workplace culture that promotes and supports self-disclosure in the organization.

Impact statement

Mental health stigma impacts people employed as mental health professionals. Fear of disclosing lived experience of mental health challenges to colleagues or supervisors poses a risk to mental health professionals seeking help when needed. Peer roles can be used to facilitate the creation of safe spaces for mental health professionals to disclose their own lived experiences; and in turn may also increase the perceived value of peer workers to mental health professionals. These strategies may contribute to decreasing stigma, contributing to safer workplaces for mental health professionals and ultimately, more effective, appropriate services for users.

Keywords: self-disclosure, disclosure, mental health professionals, peer work, stigma, organizational culture, systems transformation

To Disclose or not to Disclose? Peer Workers Impact on the Culture of Disclosure for Mental Health Professionals with Lived Experience

While disclosure of relevant lived experience by professionals in the field of substance use has a long history, disclosure by mental health professionals has generally been more fraught, influenced by the ‘blank slate’ idea in psychoanalysis as well as by the continuing prevalence of mental health stigma (Byrne, Roper, et al., 2019; Frese & Davis, 1997; Nemec et al., 2015). Yet, this issue of disclosure, particularly to colleagues and supervisors, is significant given that mental health professionals are no less likely to experience mental health challenges (Edwards & Crisp, 2017) and evidence suggests that it is often these experiences of mental health challenges that draw professionals to work in this field (Barnett, 2007; Farooq et al., 2014). In contrast, the growing peer workforce in mental health, for whom disclosure and the use of personal experience is an explicit part of their role, (Mead et al., 2013), draws the issue of disclosure by people working in mental health into high relief.

Frese and colleagues discuss experiences working in the mental health field and also carrying a diagnosis of mental illness (Frese et al., 2009). Similarly, here are well known figures (e.g., Deegan, Fisher, Bassman, Linehan) who have shared their experiences in the mental health system and developed, particularly in Deegan’s case, a career creating tools to promote better access to recovery-oriented services (Deegan & Affa, 1995; Deegan et al., 2017). However, their openness and use of personal experience is the exception rather than the rule.

Much has been written about self-disclosure by therapists within the therapeutic relationship (Hill et al., 2018; Knox et al., 1997). Here, self-disclosure is defined as the sharing of personal information by the therapist and is distinguished from immediacy statements; reactions or feelings in the moment, which are considered a more common and

simpler use of disclosure (Knox & Hill, 2003). Therapist self-disclosure is viewed as a facilitating factor in some instances, making the relationship feel more mutual, and a hindering factor in others, especially when there is role confusion generated by personal disclosure (Audet, 2011).

These experiences are also dependent on the extent of and perceived intention behind the disclosure (Farber, 2006; McCormic et al., 2018). Although a high percentage of psychotherapists acknowledge using self-disclosure with their clients, few openly talk about the practice with colleagues (Harris et al., 2016; Henretty & Levitt, 2010). This has been described as a culture of “don’t ask, don’t tell” (Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). Subsequently, the disclosure of mental health professionals’ ‘lived experience’ to colleagues and supervisors is a much less commonly discussed, researched or written about topic.

Mental health professionals have been shown to be reluctant to disclose their mental health experiences to colleagues (Gras et al., 2015; Harris et al., 2016). The “culture of non-disclosure” characterized by one survey study of Veterans Health Administration (VHA) providers, described fear of discrimination on the part of providers if they disclosed lived experience (Harris et al., 2016). Another survey of 77 providers with lived experience in the VHA found 36% endorsed “be cautious about disclosure” when asked, and about a third of the sample reported that none of their colleagues were aware of their lived experience (Boyd, Zeiss, et al., 2016).

The gatekeeping function of psychologists’ ethics code, which requires psychologists to report on other psychologists and identify ‘impaired professionals’, creates a significant barrier to disclosure (Boyd, Graunke, et al., 2016; Zerubavel & Wright, 2012). Many state statutes require contact with the mental health system by mental health professionals to be documented and reported to the licensing board (Boyd, Graunke, et al., 2016; Virginia State,

n.d.). This is similarly identified by an Australian cohort of mental health professionals, who indicated legally mandated reporting requirements as a barrier to accessing mental health care for themselves (Edwards & Crisp, 2017). These kinds of statutes, that make self-disclosure a potential threat to one's livelihood, stand as a deterrent to self-disclosure by mental health professionals in mental health and a potential barrier to help-seeking by contributing to stigma (Sandhu et al., 2019; White et al., 2006).

While limited research has been conducted into mental health professionals with lived experience disclosing to colleagues, the concept of the "wounded healer" (Zerubavel & Wright, 2012) has been more thoroughly explored. One study looking at the wounded healer found therapists with unprocessed or unacknowledged wounds were likely to engender relationships in which their stance was more pathologizing of the person accessing services and promoted a more 'us-them' stance (Gelso & Hayes, 2007) with the therapist regarded as being "healed" and the service user in need of healing (Zerubavel & Wright, 2012). This is very different from peer support, which promotes mutuality as a key tenet (Mead et al., 2013).

While therapists with undisclosed lived experience did draw upon the experience to inform their work (without actually disclosing), they were unable to use this experience in a way to educate others or advocate via role modeling (Zerubavel & Wright, 2012). By extension, mental health professionals are not provided with guidance on how to use their experience appropriately or effectively for the benefit of service users. The idea of having come to terms with one's own experience enough to draw upon it without it interfering in the therapeutic work is something that is seemingly a "know it when you see it" phenomenon and deserving of further consideration (D'Aniello & Nguyen, 2017; McCormic et al., 2018).

Although readying an organization to be open to peer work is more well-documented than creating a culture of safe disclosure for providers, Welder & Salzer (2016) identify

several steps for encouraging agencies to become more accepting and welcoming to mental health professionals who are not in designated peer roles. These include identifying policies, confronting the issue directly, and educating staff and supervisors. Specific strategies include enhancing employee wellness programs, ensuring health insurance parity, training supervisors in how to respond to and support the person, and other steps specifically geared to creating a welcoming culture in the institution (Welder & Salzer, 2016).

Research specifically exploring the influence of peer roles in creating a culture of disclosure has been absent from the literature. The aim of this study was to better understand the employment of peer workers in multi-disciplinary environments. Due to the accepted role of peers in reducing stigma for mental health service users and the prevalence of peers within participating organizations, it was hypothesized that mental health professionals with a lived experience would feel enhanced confidence to disclose their experiences. This paper explores the impact of a peer workforce on the disclosure of lived experience by mental health professionals and strategies that assist in encouraging disclosure.

In the context of this paper, the term ‘multi-disciplinary environments’ is used to denote organizations in which people from a variety of disciplines are employed, including both peer-designated and non-peer designated roles (e.g., psychologists, mental health nurses, psychiatrists). The term ‘mental health professionals’ is used to describe people employed in non-peer designated mental health roles. This language choice does not suggest that peer support is not a discipline in its own right, but simply uses common parlance for broad identifiability. The term ‘peer leadership positions’ is used to describe people in designated roles that utilize their lived experience as core to their role and are part of the management structure of the organization. People in peer leadership positions would be expected to disclose their lived experience as a central qualification of the role. Finally, participants’

experiences of ‘safety’ or feeling ‘safe’ describe being supported rather than discriminated against when/if they disclose having a lived experience of mental illness.

Method

Participants

The study included five diverse multi-disciplinary organizations within five states of the United States. Location of states included two in the northeast, one in the south, and two in the west. Organizational types included: one county-run behavioral health division, one behavioral health within a managed care fund, one privately owned behavioral health organization, and two non-profit organizations. Included were a range of organizations who worked predominantly with people from metropolitan, regional, or rural and remote locations. Participant numbers across the five sites were distributed as follows: 31 at organization one, 27 at organization two, 31 at organization three, 23 at organization four and 20 at organization five.

To ensure no inadvertent identification of organizations, the order in which organizations are described in reporting does not correspond with the order of organizational types preceding. The states in which organizations are based are also not mentioned in reporting.

A total of 132 people from different work roles participated, including: 32 people employed as mental health professionals, 47 in management positions (not peer designated), 7 in peer-designated leadership positions, 38 in peer designated positions (not management), and 8 other or unspecified.

People were given the option to identify as male, female, transgender or ‘don’t wish to identify’. Of the 129 people opting to fill in the demographic, the majority of people

identified as Female ($n=84$) with around half that number identifying as Male ($n=41$), and a small percentage selecting 'Don't wish to identify' ($n=3$) and Transgender ($n=1$).

Race and ethnicity were separate on the demographic, with the question regarding race appearing first on the form. However, all the people identifying as Hispanic added 'Hispanic' to 'other' under the question of race. To reflect participants understanding and way of viewing, race and ethnicity have been reported together. The vast majority of participants ($n=88$) identified as Caucasian American/White. Additionally, 15 people identified as African American/Black One, 10 as multiracial, seven as Asian, six as Hispanic, two as Native American and one person identified as a Native Hawaiian/Pacific Islander.

Materials

Broad initial questions were developed for the focus groups and interviews, relating to the functions of the peer role, individual worker experience and organizational culture. The broad initial questions were: what defines peer work, how are peer workers employed at your organization, what in your opinion allows peer workers to be effective in their roles, what organizational/practical strategies do you think aids employment of peers?

Procedure

An expert advisory group ($n=12$) was convened and consulted to identify appropriate multi-disciplinary organizations to better understand the employment of peer workers in multi-disciplinary environments. The advisory group included both peers and 'allies': people in non-designated positions who understand and champion peer work. Advisory group members were selected to represent a range of relevant perspectives and included researchers as well as industry representatives and funders. Advisory group members were well known nationally for their commitment to and expertise in peer workforce development and came from diverse states across the United States. The advisory group included people from diverse cultural backgrounds and identifications.

Advisory group members nominated numerous multi-disciplinary organizations employing peers. Organizations nominated most frequently were approached to be invited to participate in the study. Letters confirming participation were signed by the executive management of each organization prior to commencement. Initial questions were also determined in consultation with the advisory group. In line with grounded theory methods, the list of questions was expanded and refined as concepts were frequently raised by participants. The study utilized a qualitative approach, conducting focus groups and individual interviews, and employed grounded theory methods to allow for exploration of an area about which little is known (Corbin & Strauss, 2014). Grounded theory methods were also employed to best represent the experiences of those who have had limited ‘voice’ (Charmaz, 2014), in the case of this study, peer workers and mental health professionals with lived experience. Both interviews and focus groups were semi-structured. In line with grounded theory methods, questions were deliberately broad to allow participants to raise issues they saw as important, and the same initial questions were asked at the beginning of each focus group and interview (Birks & Mills, 2015).

Separate focus groups were organized and conducted at each site for participants in the different categories of mental health professionals, management, and peer designated roles. Most interviews were face to face, with one interview conducted via video call. All but one focus group was face to face, with one conducted via video conference using the same procedures. Staff participants in each of the selected organizations were given the option to attend an individual interview and/or focus group. From the five organizations participating in the study, eight people chose to participate in an individual interview and 124 participants attended focus groups. A total of 14 focus groups were conducted.

IRB approval was granted by Yale University. No compensation was offered for participation; all participants provided written informed consent prior to participation,

including the right to withdraw without penalty at any stage. To preserve confidentiality, participants were offered private, one on one interviews in addition to focus groups. Focus groups and interviews were audio recorded. There were no pre-existing relationships between the research team and participants, and no relationships of unequal power such as client/patient, student, or subordinate.

Analysis

To protect against identification of participants or organizations in reporting, all transcripts from audio recordings were de-identified and coded before analysis began. All potentially identifiable data was substituted by codes. The coded information was stored separately from identifiable material and kept in locked, password protected files. The data remain stored in locked, password protected files until five years after the last date of publication. The data was stored and managed using QSR International's NVivo 12 software, 2018.

However, all coding was manual. Transcripts were coded by a member of the research team who had not participated in the data collection. In line with grounded theory methods, 'open' line by line coding was first conducted. Codes were then compared relationally and clustered to identify key concepts (Corbin & Strauss, 2014). Once coding was complete, key concepts were compared with detailed researcher memos from the site visits. The two sources were used to refine and confirm key concepts and themes.

Results

Three main categories emerged from the results in relation to disclosure of mental health professionals: Lived experience within work roles, Workplace Culture, and Role Clarity. Each category included several themes as detailed in Table 1. Table 1 also provides some explanation of the themes as well as a breakdown of in how many of the sites themes

emerged and the number of endorsements of each theme per organization. Table 1 includes the abbreviations: LE to denote lived experience and MHP for mental health professionals.

[Insert Table 1 about here]

Clarity on the role of peers and the perceived value of peer roles was variable across the organizations. Two of the organizations expressed consistent understanding and high perceived value for peers across all cohorts of management, mental health professionals, and designated peer positions. Three of the organizations were more varied across these cohorts in terms of understanding the functions of peer roles and the value they attached to the roles.

Of interest, mental health professionals at organizations possessing the highest, unanimous perceived value for peers predominantly still reported not feeling confident or safe to disclose their own lived experience in the workplace. Conversely, mental health professionals at two of the organizations with inconsistent views on the perceived value of peers felt actively empowered to share and even utilize their lived experience. The fifth and final organization held inconsistent views across cohorts, but mental health professionals reported not feeling confident to disclose. In this instance, the priority placed on hiring and integrating peers was considered by some mental health professionals to have hindered creating a culture in which they might feel safe to disclose.

Table 2. provides a comparison of the different organizations in relation to understanding and perceived value of lived experience broadly; designated peer roles; and disclosure of lived experience by mental health professionals.

[Insert Table 2 about here]

In the following section the results have been grouped specific to each organization to assist in describing the unique culture and priorities within each organization. The descriptions of the results are drawn directly from and describe or paraphrase the interview and focus group responses. At times, direct quotes are included to illustrate the themes and provide an example of the participants' experiences in their own words.

Organization One

Of the five organizations, Organization One had the strongest consensus from all cohorts as to the role, function and definition of peer support work. This organization held the highest perceived value for peer workers across all the categories of respondents, as well as across demographics such as race and gender. The organization also had the highest level of satisfaction with peer work from all job roles. There were a multitude of ways in which peers were employed within this service, with more expansion planned.

This organization had significant peer leadership, with people in designated peer roles at various levels throughout the organizational hierarchy. Executive management was personally and professionally committed to the continued development of the peer workforce. This organization had thoroughly resourced peer work, making a significant financial and philosophical commitment. This organization also had peers employed over the largest variety of programs.

However, people in mental health professional roles often still felt unwilling to disclose or use their lived experience. Some of this reluctance was attributed to adverse reactions from people accessing services, when disclosure by the therapist had been made after the relationship had existed for some time. There were reports of people accessing services feeling 'betrayed' that the lived experience of the mental health professional had not been shared earlier. Further, mental health professionals shared the opinion that people

accessing services preferred different types of relationships, and in the context of non-designated roles, preferred the stronger boundaries with people in ‘traditional’ roles:

I think someone with lived experience in a traditional [mental health professional] role is extremely valuable but it doesn’t mean that they should cross outside of the same kind of bounds or job description... There’s a reason those were developed, there’s a healthy model for the person that you’re engaging with. If as the clinical person, I keep within this box and you can expect that of me and that’s a professional safe relationship and then when you have a peer relationship it is modelling the more natural support in a person’s life... if they came to the professional support and got the personal [peer] support it would be really confusing... it’s different, it’s just a strange setup versus the more natural role that a peer can provide (Organization 1. Focus Group: Mental Health Professionals).

For other mental health professionals, a fear of stigma meant they did not disclose to colleagues or access help when needed:

I’m not gonna tell you because I’m afraid to tell you, because I’m wearing this clinical hat and really what I’m doing is really struggling to survive and I’m not willing to say that out loud to anyone because of the stigma around it (Organization 1. Focus Group: Mental Health Professionals).

This was partially explained by inadequate or unhelpful organizational responses that actively discouraged mental health professionals from disclosing, with at times tragic consequences:

I’ve known more traditional providers who have had mental health breakdowns because of the lack of support and their fear of reaching out. I’ve known two over the years who have completed suicide because they didn’t have anywhere to get the support. Because even using their employment assistance program, or their own

health insurance...they don't want to go and get help in that community because of fear of people knowing (Organization 1. Focus Group: Mental Health Professionals).

Organization Two

Organization Two had the least consensus on understanding the role of peers. There were the fewest peer participants in the research and the need for peers was variously interpreted by different individuals and cohorts. Traditional management participants at this organization expressed the least understanding of designated peer roles. There was also some confusion for traditional management and mental health professionals as to how 'peer employment' was defined. While it was more difficult to gain data on peer work in this organization, there was a strong commitment to lived experience more broadly. This site emphasized extremely long retention of management, which may or may not have played a role in the priority on lived experience of mental health professionals, as opposed to peer roles. Despite mixed views on the value of designated peer roles, expansion of peer roles was progressing with new roles commencing soon.

This organization was described by all cohorts (management, mental health professionals, and peers) as a 'family culture'. It was designed to be open, welcoming and accepting of difference. Executive management at this organization played a visible role in contributing to a culture of safe disclosure.

...we have in our lives and our family folks with lived experience, why would it be any different in our company culture? ... Culture is very important; a healthy culture is very important to the work we do. And part of my job that I see here is I'm a keeper of the culture (Organization 2. Interview: Traditional management).

Many non-peer participants including mental health professionals and corporate staff spoke enthusiastically about how they felt safe to discuss their own lived/living experience and to use it in their roles:

It says a lot about a company when you feel open enough to come to your supervisor and just be completely and blatantly open with what's going on with you in your life (Organization 2. Focus Group: Mental Health Professionals).

These participants expressed gratitude that they could be open about their lived experience, gain support, and even be valued more highly because of their lived experience. This was a consistent message across focus groups and interviews. However, it was also acknowledged that lived experience was still not valued the way formal education was valued, which may have been related to the lack of peer workforce development at this organization.

Overall, peers did not appear to have as strong a presence within this organization; however, two of the prominent strategies to encourage the workplace culture of disclosure were peer-led. Peer leadership roles had been employed for some years and assisted in reducing stigma by providing training acknowledging that everyone has a lived experience and how to use this lived experience in relationships with people accessing services. This organization had also provided external peer-run training on identifying lived experience, which participants felt had challenged the idea of 'them and us' between professionals and service users. Some mental health professionals were passionately in support of peer work because of participating in the training:

I'd always seen the peer as something that ... there's a client and then there's us. You know, there's the staff and the client. But after going through that class and putting myself in their shoes and trying to find my story, and listening to the stories, I find that we all have a lived experience and we all have a recovery story within us (Organization 2. Focus Group: Mental Health Professionals).

Organization Three

Organization Three, despite being a long-term employer of peers, had varied views on peer work from mental health professionals, management and peers. Managers viewed the

peer presence as strong and positive, and largely defined peer work in a way that is consistent with the literature. However, there were diverse views from people in non-designated roles, management, and peers as to the need for designated roles and the value of peer work to the organization.

Management spoke about the desire to decrease stigma by encouraging people in non-designated roles to disclose their lived experience. Many mental health professionals felt comfortable not only to disclose in the workplace, but also to use their lived experience in relationships with service users. While most expressed the value of still having designated peer roles, some shared a belief their own use of lived experience made designated peer roles less needed:

...it doesn't necessarily have to be peer designated in order to be something that's part of the job and part of what makes somebody a good worker, regardless of the designation of whether it's peer... I don't see people running around saying like "hey I'm peer designated and hey I'm not peer designated" (Organization 3. Focus Group: Mental Health Professionals).

Similarly, several traditional management participants were unclear on how necessary designated roles were, but also acknowledged potential challenges with professionals sharing their lived experience with people accessing services:

I think sometimes too if you're not in a peer designated role and you do disclose things; that can cause tension between you and the person [accessing the service] (Organization 3. Focus Group: Management).

Mental health professionals mirrored these concerns and described both positive experiences disclosing their lived experience, and times when the person accessing the service felt some betrayal that the provider had been 'hiding' their lived experience.

Despite the strong emphasis on lived experience within this organization, for some participants in non-designated roles there were still experiences of being stigmatized because of disclosure:

I very recently had someone be like “well you’re sick and you can’t do this and I don’t know why you thought you could do any of this, like you’re mentally ill” ... and then you feel less confident in the services you’re providing... It’s always kind of a gamble (Organization 3. Focus Group: Management).

While the value of peer work was promoted by traditional management and mental health professionals, peers were vocal about feeling unsure of their place in the organization. Peers were not always confident that use of lived experience by mental health professionals was effective and questioned the efficacy of combatting stigma with disclosure that could be ‘turned on and off’. Other peers were supportive of mental health professionals using their lived experience but held concerns when this was not guided by peers.

Like Organization Two, new peer roles were still being developed, with many new roles commencing soon. Also, like Organization Two (the only other site where lived experience seemed to be prioritized above peer work), Organization Three boasted particularly long retention of executive management, which was highlighted in both focus groups and interviews. Although the mental health professionals at this site felt confident and supported to disclose and utilize their lived experience in work roles, unlike the management participants, they reported high turn-over and low retention.

Organization Three did have strong peer involvement from inception of the organization and strong peer influence in earlier decades. Reportedly peers were involved within the organization before peer credibility had developed, at a time when the emphasis on lived experience rather than designated peer roles was seen to ‘protect’ people from the potential stigma of being identified publicly. Some participants felt this belief had persisted

and encouraged the emphasis on lived experience generally, rather than designated peer roles specifically. As with Organization Two, stigma reduction involved peer-led training focused on acknowledging that everyone has a lived experience and how to identify and use lived experience to create connection with people accessing services.

Organization Four

This site corresponded most to Organization One. The basic premise of what peers do, and their perceived value was consistent across the three cohorts – significantly more so than Organizations Two, Three and Five. Mental health professionals here were enthusiastic about the benefits of peers both to people accessing services and themselves. Professionals at this site defined peer work accurately and with passion. They were vocal in defence of peer work and the benefits to organizations, people accessing services and themselves as a result of peer employment.

Of interest, like people employed in non-designated roles at Organization One, there was little disclosure of lived experience from mental health professionals at Organization Four. Here though, the reasons focused more on the continuing prevalence of stigma and discrimination and less on the needs and preferences of people accessing services. Mental health professionals at Organization Four largely felt that being able to disclose and even use their lived experience would benefit people accessing services but stated there was a long way to go before they would feel safe to do so.

The role of supervisors in encouraging disclosure in the workplace was strongly emphasized by mental health professionals at this organization.

It depends on who your supervisor is. I had one I would not tell him any sort of anything. Not even like if I'm dying sick, I will show up but not tell him I'm dying sick, versus the new one that I have, I can be open and it's okay. But it all depends on

who is at the end of the rope (Organization 4. Focus Group: Mental Health Professionals).

I have to just say this. And, people in my team will relate. We have like one of the best supervisors ever. Because she... not only does she empathize, she empowers us. I mean, she listens. If you say you need two hours, take it. You know, she wants you to take care of yourself... And it's wonderful. You don't have that every day so when you do, you say hallelujah, thank you Jesus (Organization 4. Focus Group: Mental Health Professionals).

Organization Five

Management and peers at this organization had strong consensus and high levels of satisfaction. People in non-designated roles were not as unreservedly enthusiastic and offered both positives and negatives in their views about the impact of peer designated roles. This organization had made a significant commitment to peers, arguably at the expense of mental health professionals. One mental health professional described a program that had existed some years ago, before the wide-scale employment of peers, in which people in non-designated roles were offered a safe space to explore their own lived experience and encouraged via other methods to discuss and gain support. There was a perception this initiative had disappeared around the time peers became embedded in the organization.

...people were always encouraged which I thought was great, if they had struggles, if they had lived experience, to be able to talk about that and I think there were actually opportunities for people to get together and talk about struggles that they'd had (Organization 5. Focus Group: Mental Health Professionals).

Much like Organization One, Organization Five employed significant peer leadership, with peers at various levels throughout the hierarchy of this organization. Commitment to peer work was a 'given' and further expansion of peers was cited. Mental health

professionals at this organization felt the peers had significantly more freedom than they did. Mental health professionals felt they were discouraged from disagreeing with organizational policy and approach, while peers were encouraged to provide a critical view. Although there was some dissatisfaction about their own positions, mental health professionals did describe benefits of peers both to themselves as professionals and to people accessing services. These participants discussed peers contributing to stigma reduction within services and the wider community, as well as the self-stigma of people accessing services, but not in reducing the stigma they felt as professionals within the organization.

Mental health professionals at Organization Five concurred with participants at other sites that there were risks in disclosing lived experience to service users and similarly raised the potential for service users to feel betrayal at what was viewed as a lack of ‘transparency’. Some participants held concerns about how they would be viewed as professionals if they were to self-disclose.

Would their opinion or view of me change if I share too much... would they take me as serious? I don't know (Organization 5. Focus Group: Mental Health Professionals).

Mental health professionals at this site also viewed the attitude of the direct supervisor as essential to feeling safe to disclose. People in non-designated roles expressed trepidation in disclosing and were more likely to test the waters and see how the supervisor responded to less significant sharing of personal/life struggles. The supervisor expressing empathy and understanding would lead to further sharing. Where a supervisor was willing to talk openly about their own challenges, participants were much more willing to share. Supervisors sharing their own lived experience was identified by these participants as the most effective strategy in building trust.

Discussion

It was hypothesized that mental health professionals with a lived experience would feel enhanced confidence in disclosing their experiences to colleagues and supervisors in agencies where peer work and peer leadership were valued. Although the assumption had been that employment of peer workers would automatically contribute to a culture of disclosure for mental health professionals, based on the participants' statements, this did not seem to be the case. Further, peer work was not uniformly valued or promoted within these organizations. Instead, according to the participants' experiences and views it appeared organizations had taken an 'either/or' approach to the promotion of lived experience: either strongly committing to the employment and support of peer workers or developing a workplace culture in which mental health professionals were encouraged to disclose. In the organizations where disclosure for mental health professionals was reportedly promoted, peer work was seen to be less understood, embedded or struggling to gain credibility.

In terms of the apparent preference for some organizations to focus on the lived experience of people in mental health roles at the expense of peer development, the data was not clear. The role of peer as 'change agent' is reported in previous research as challenging for organizations (Kent, 2018). Some mental health professionals expressed a belief that everyone should have opportunity to be a 'dissenting voice' but they did not feel mental health professionals had this opportunity, whereas peers did. It is possible that non-designated roles, bound by greater restriction and mandated activity, produce a workforce that is more likely to conform than contest (Grendar et al., 2018; Levett-Jones & Lathlean, 2009). Further research could provide a more understanding of whether people in non-designated roles provide a less disruptive way for organizations to include lived experience perspectives and the reasons behind preferences.

With regards to disclosure by mental health professionals, we propose a distinction be made between mental health professionals using lived experience in relationship with people

accessing services and the right as employees to feel safe to disclose and seek support within the workplace from supervisors and colleagues. We acknowledge that the former is contested and as participants described, complicated by numerous factors including the preference of the person accessing services. Further, mental health professionals' willingness to disclose lived experience may be significantly affected by historical prohibitions of self-disclosure to service users (Jancin, 1999; Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001).

Prevailing stigma may prevent mental health professionals from receiving the care they need (White et al., 2006). However, the right to discuss health issues, including mental health, and to not be discriminated against, is enshrined in anti-discrimination policy (Americans with Disabilities Act, 1990). Recent studies reveal that only six out of 69 participants were aware of these rights under the disability discrimination legislation and only three had asked for reasonable accommodations (Kottsieper, 2017). Clear distinctions in the context of disclosure and anti-discrimination policy support the suggestion that mental health professional disclosure to colleagues and supervisors should be considered separately from disclosure to people accessing services. In relation to mental health professionals disclosing their lived experience to people accessing services, some participant views correspond with literature arguing for maintaining professional boundaries (Audet, 2011) and included concerns about how appropriate the disclosure and sharing might be without appropriate training or guidance.

However, other participants, predominantly mental health professionals, were of the belief that sharing their lived experience with service users was beneficial. This sentiment is reflected in a few preliminary studies that suggest possible positive impact on social inclusion and recovery for people accessing services when mental health professionals are 'out' with their own lived experience (Holttum, 2017). Further, research that explores the differences

between peer and clinical roles and the diverse considerations for each role when considering disclosure, may provide guidance on what is appropriate in relation to disclosure for the distinct roles.

While promotion of lived experience disclosure for mental health professionals has not automatically occurred in these organizations as a result of peer employment, strategies identified as encouraging an environment in which people feel safe to disclose did include peer designed and delivered training. Use of peer-led training on identifying lived experience and how to use it was considered to challenge the ‘them /us’ thinking of some mental health professionals and contribute to more effective therapeutic interactions. Previous research on reducing stigma in mental health services similarly found the them/us divide, or disidentification, was challenged by education that emphasized people across diverse positions and social roles having a lived experience (Harris et al., 2019).

Considering the contentious nature of provider disclosure to service users, as indicated by participants, there may be further potential for peers to guide mental health professionals in the appropriate use of lived experience. The acknowledged expertise of peer workers in use of personal story supports this notion (Byrne, Roennfeldt, et al., 2019; Miyamoto & Sono, 2012). Similarly, supervisors sharing their own challenges to engender trust was raised as a positive factor in facilitating disclosure. By extension, it may be feasible to utilize peers to create or co-create training for supervisors in how to disclose and use their personal story effectively and provide support for others in the process of disclosure.

Findings in relation to the loss of dedicated strategies for mental health professionals at some organizations when peers were introduced, may indicate usefulness in taking a whole-of-workplace approach to stigma reduction and the perceived value of lived experience. Similarly, parallel processes promoting disclosure of mental health professionals and encouraging understanding of the role and value of peer work may benefit both cohorts.

As previous research has identified, peer work is supported and successful when the organization demonstrates commitment to peer roles and principles (Ibrahim et al., 2019). This commitment includes: addressing workplace culture and the preparedness of the organization to accept and value peer work (Jones et al., 2019), the employment of peers in ‘leadership’ roles including management positions (Byrne, Roennfeldt, et al., 2019), and human resources policies and processes, including recruitment and role descriptions (Byrne et al., 2018). We propose attention to these issues to improve integration of peers while simultaneously providing initiatives to create spaces where disclosure by mental health professionals is supported.

Use of peers in reducing stigma faced by mental health professionals is supported by the significant body of research on the value of people being ‘out’ of the proverbial closet as having lived experience (Corrigan & Al-Khouja, 2018; Rüsch et al., 2014). Participants of this study align with previous research suggesting mental health professionals first seek what they define as ‘safe’ spaces before disclosing and seeking support within their organization (Infranco, 2012). Peer support being used to facilitate the creation of safe spaces for mental health professionals to disclose and gain support may also serve to increase the perceived value of peer workers to mental health professionals.

Ultimately, it is worth considering: how effective and ‘safe’ are services for users, if discriminatory beliefs about people with lived experience are still so prevalent that members of the mental health workforce continue to fear disclosure? Implications for the effectiveness of service delivery and the well-being of both service users and mental health workers suggest the usefulness of research to better understand these issues. Several suggestions for future research have been proposed. Further, it is recommended that future research should consider a more contextualized, intersectional analysis that examines ways in which lived and learned identities and experiences of oppression intersect and thus influence or impact the

culture of disclosure. Disclosure or non-disclosure could also be considered in the context of both individual and collective disclosure and the results of either collective empowerment or increased stigmatization of lived experience in the workplace.

While this study has a large sample size in terms of the key participants (n=132) it is limited by a relatively small number of organizations, and to only five states in one English-speaking country – the United States. Transferability and cultural representation are therefore limited. Further exploration of the experiences of mental health professionals across a broader range of countries and organizations, including how disclosure is handled or received, is needed to deepen understanding of the issues and guide effective strategies for decreasing stigma.

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Table 1.*Themes and number of endorsements across sites*

Category	Theme	Description	Sites that endorsed themes	Endorsements per site
Lived experience (LE) within work roles	Use of LE by mental health professionals (MHP)	MHP discussed the strengths of using LE in their roles as well as limitations	5	Site 1=3 Site2=7 Site 3=10 Site 4=1 Site 5=5
	Value of Peer Work	Peer work was described as having benefits for peer workers, traditional staff and people accessing services.	5	Site 1=22 Site 2=17 Site 3=11 Site 4=15 Site 5=19
	Universality of lived experience	Lived experience was considered in a broader context, not defined by mental health experience or designated roles	4	Site 1=3 Site 2=11 Site 3=4 Site 5=2
	Stigma	The impact of identifying as having a ‘mental illness’ was discussed and the associated negative perception. Experiences of discrimination and perception of stigmatised identities.	5	Site 1=3 Site 2=3 Site 3=7 Site 4=6 Site 5=5
	Peer Leadership	Peer leadership was described as leaders who were respected in high profile positions within the organization, also links with well-known and prominent peers outside the organization	4	Site 1=4 Site 2=2 Site 3=1 Site 4=1 Site 5=2
Workplace Culture	Safe to disclose	Culture described as feeling ‘safe’, comfortable and there is acceptance of lived experience as valued, and disclosure is supported.	5	Site 1=8 Site 2=19 Site 3=7 Site 4=2 Site 5=10
	Openness and transparency	Organizations were described in terms of openness in sharing experiences and transparency by employees and management.	5	Site 1=2 Site 2= 5 Site 3 =2 Site 4=1 Site 5=4
	Whole of organization education and training	Whole of organization training where staff are exposed to LE delivered training and LE concepts was helpful in building trust, collaborative relationships and greater understanding.	5	Site 1=5 Site 2=4 Site3= 5 Site4= 3 Site5= 2
	Management	Commitment, championing and vision of management was critical to	5	Site 1=8 Site 2=3

		establish a positive and inclusive culture for peer roles, involves understanding peer concepts.		Site 3=5 Site 4=4 Site 5=4
Role clarity	Understand- ing of Peer Role	The importance of a clear understanding of the role of peer workers by traditional staff and management was discussed. Lack of clarity was raised as a barrier in effective relationships	5	Site 1=9 Site 2=6 Site 3=4 Site 4=6 Site 5=5
	Unique Role	Peer work described as distinct from MHP roles. Peer work also seen as complimentary to traditional roles. Peer work identified as having a distinct focus, distinct use of language, defining features of practice and unique skill set	5	Site 1=18 Site 2=6 Site 3=15 Site 4=5 Site 5=4
	Job satisfaction	Job satisfaction was described as feeling respected and involved understanding of both peer and MHP roles that led to an appreciation of both roles and effective collaboration	4	Site 1= 6 Site 3=2 Site 4=6 Site 5=5

Table 2.*Comparison of Organizations*

Table 2. Organization/Site	Understanding/Value of lived Experience	Understanding/Value of peer work	Understanding/Value of disclosure by mental health professionals
1	High	High	Low
2	High	Low	High
3	High	Medium	High
4	High	High	Low
5	High	High	Low

Note: General interview questions one and three: ‘defining peer work’, and ‘what makes peer workers effective’, led to discussion of, and ultimately sub-questions about the topics of valuing lived experience, valuing peer work, and understanding disclosure.

The ratings in Table 2. were determined by comparing the overall understanding of different categories or groups of workers at each organization (i.e. people employed as mental health professionals, management, or in peer designated roles) with the degree to which group

understanding correlated with definitions in the existing literature. Further, the degree of consensus across the worker groups at each organization were also compared e.g.: for the item ‘understanding/value of peer work’, an organization with strong correlation to existing definitions and strong consensus across all three worker groups were rated as having a ‘high’ overall understanding. Those organizations with strong correlation to existing literature and consensus across two of the worker groups were rated as ‘medium’, and those organizations where only one worker group confirmed the definitions in existing literature were rated as having a ‘low’ collective understanding.