FINAL PROJECT REPORT

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FINAL PROJECT REPORT
26 November 2022

Supporting the sharing of lived and living experience in the mental health workplace

Findings from research conducted at two Victorian mental health services

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Table of contents

Glossary of terms

The language used in this report is intended to be consistent with current conversations around lived experience in the mental health field and convey clearly the topics being discussed, with the understanding that this language will continue to evolve with our understanding over time.

Lived experience (le)
"…mental health challenges that have caused life as we knew it to change so significantly we have to reimagine and redefine ourselves, our place in the world and our future plans. . . . The lived experience perspective is not about individual illness or specific diagnoses, but rather universal experiences, such as marginalisation, loss of power, status/ citizenship, employment, a stable home and relationships. It's not just about loss but also about regaining hope and understanding hope is essential in the context of recovery or healing" (Byrne & Wykes, 2020, p. 1). In this research, lived experience refers exclusively to personal rather than supporter lived experience (see below).

Living experience
Mental health challenges currently impacting the daily activities or wellbeing of someone with lived experience.

Lived Expertise (LE)
The skilled use of individual experiential knowledge and the collective wisdom of the consumer/survivor/ex-patient movement to support others directly (e.g., peer support) or through contributions to service innovation and structural change.

Mental health challenges
Experiences of distress and extreme states causing disruption to one's participation in daily activities and personally valued roles, or pursuit of chosen goals.

Mental health professionals (or professionals)
Staff employed by mental health services in direct service delivery roles (e.g., key clinicians, mental health support workers) or roles influencing service delivery (e.g., training, service managers), for whom training in a mental health related disciplines (e.g., nursing, social work, psychology, occupational therapy, community services) may or may not be a requirement of their role.

Mental health professionals with lived experience (MHPle)
Mental health professionals, who identify publicly or privately with lived experience of personal mental health challenges.

Peer workers
Staff employed in designated Lived Experience roles (e.g., peer support workers, consumer consultants).

Registered professionals
Staff for whom registration with the Australian Health Practitioner Regulation Agency (AHPRA) or the Australian Association of Social Workers (AASW) is a requirement of their role (e.g., registered nurses, clinical psychologists, occupational therapists, psychiatrists, social workers).

Supervisors
Professionals or peer workers employed in line management roles (e.g., team leaders, service managers) or providing spaces for reflection and growth for staff related to their work role (e.g., supervision, clinical supervision, co-reflection).

Supporter lived experience
Experience of supporting a loved one (e.g., family member, partner, close friend) through mental health challenges.

Executive Summary

The experiences of mental health service staff with their own mental health challenges have historically been a taboo topic for discussion in their workplaces. Growth in designated Lived Experience roles, however, has caused some to question why staff in other roles (e.g., clinicians, support workers) don't share these experiences. Is it that staff outside of Lived Experience roles don't experience mental health challenges? Or are there barriers to the safe sharing of lived experience? This research aimed to find out by exploring the perspectives and experiences of mental health service staff at two Victorian mental health services.

Interviews with staff from a range of positions and roles, and relevant organisational policies and procedures, were compared. Similarities and differences between individuals, groups and organisations identified key factors that encouraged and discouraged staff from sharing with colleagues and supervisors. Perceived organisational and supervisor support, and an individual preference for openness, supported staff with lived experience to share, privately or openly. Staff were more likely to share openly when their team leader and colleagues cultivated spaces for sharing, by seeking and reflecting upon lived experience perspectives. Conversely, defensive responses to sharing 'shut down' opportunities for reflection and growth. Sharing in supportive relationships and teams 'lifted the burden' of secrecy from staff with lived experience and created opportunities for mutual emotional and practical support with colleagues. Those who felt supported to share openly in the workplace, described satisfaction associated with 'bringing their whole selves' to their work. Documents reviewed suggest opportunities for organisational change to maximise the benefits of sharing in the workplace.

These findings suggest several areas of reflection for organisations, supervisors, teams, and individuals who wish to support the sharing of lived experience in their workplace:

AREAS OF REFLECTION…

…for organisations

- Valuing lived experience across the workforce
- Understanding the value and purpose of sharing lived experience
- Supporting the Lived Experience workforce

…for supervisors

- Improving consistency in supervisor support
- Supporting inclusion of staff with living experience
- Transparency and choice in information sharing

…for teams

- Understanding and supporting psychological safety
- Prioritising opportunities for team reflection & mutual support
- Addressing microaggressions in the workplace

…for individuals

- Access to and use of reflective spaces
- Negotiating one's own boundaries around sharing
- 'Being a part of the culture you want'

Why focus on sharing lived experience by professionals?

This section of the report describes previous research conducted with mental health professionals with lived experience (MHPIe) and their colleagues that have informed this research.

LIVED EXPERIENCE IN THE MENTAL HEALTH WORKFORCE

The number of professionals within the mental health workforce who identify with lived experience is not currently known. However, findings from studies in Australia, Canada, the United Kingdom, and the United States suggest mental health professionals experience mental health difficulties at similar rates to the general population (Godfredsen, 2005; Hassan et al., 2013; Tay, Alcock, & Scior, 2018; White, Shiralkar, Hassan, Galbraith, & Callaghan, 2006). In a survey of Australian mental health professionals, 40% of participants reported having experienced a "mental illness" at some point in their life and 59% had received treatment for mental health issues (Edwards & Crisp, 2017). It seems likely, then, that more professionals have experience with mental health challenges than are speaking about them in the workplace.

STIGMA IN THE MENTAL HEALTH WORKFORCE

A commonly proposed reason for professionals not sharing with colleagues and supervisors is stigma. Stigma describes our tendency to fear and exclude those we perceive as different to ourselves. Stigma beliefs are the assumptions that we make about people based on stereotypes associated with the category we or others have put them in (e.g., 'consumer,' 'schizophrenic,' 'borderline'). Common stigma beliefs associated with people with lived experience are that they are incompetent, to blame or dangerous (Corrigan & Wassel, 2008). These beliefs cause harm to people with lived experience through the processes of: labelling, stereotyping, separation, status loss, and discrimination (Link, Yang, Phelan, & Collins, 2004).

The prevalence of stigma beliefs held by professionals varies across settings and countries (Henderson et al., 2014). However, studies have found some mental health professionals hold stigma beliefs towards the people they work with. Most often this is reported as a desire for social distance (Hansson, Jormfeldt, Svedburg, & Svensson, 2013; Hori, Richards, Kawamoto, & Kunugi, 2011), which has been described as creating a 'fortress mentality' in some mental health services (Slade, 2010). Stigma beliefs have also been found to contribute to the limiting of treatment options for service users (Sercu & Bracke, 2016).

The presence of stigma beliefs within the mental health workforce have been found to prevent professionals seeking help when they experience their own mental health difficulties (Edwards & Crisp, 2017; Hassan et al., 2016; Tay et al., 2018) and to encourage them to conceal their experiences in the workplace (Tay et al., 2018; Waugh, Lethem, Sherring, & Henderson, 2017).

> *"I'm scared to death that I would be outed, and the next thing you know, my career would be over" (Elliott & Ragsdale, 2020, p. 6).*

HOW DOES LIVED EXPERIENCE IMPACT MENTAL HEALTH PROFESSIONALS?

Lived experience is thought to offer both benefits and challenges to mental health professionals. MHPIe have been found to identify more with service users than their colleagues without lived experience (Harris, Leskela, & Hoffman-Konn, 2016). Identification is described by MHPIe as giving them a greater sense of empathy and compassion which assists them in developing collaborative working relationships with service users (Adame, Morsey, Bassman, & Yates, 2017; Infranco, 2013; Richards, Holttum, & Springham, 2016).

> *"All of this somehow has influenced my practice in a good way. I think that I learned to be very sensitive, warm and empathic towards others. I have an open mind, flexible approach and a deep sense of the other, I can be empathetic, and people can feel that I feel with them" (Taylor, 2008, p. 305).*

Lived experience has been described as both a risk (Cain, 2000) and a protective (Turnbull & Rhodes, 2019) factor for burnout, depending on the personal (e.g., use of self-care) and workplace (e.g., flexibility and spaces for reflection) resources available to MHPIe (Zerubavel & Wright, 2012).

HOW CAN SHARING LIVED EXPERIENCE IMPROVE MENTAL HEALTH SERVICES?

Approaches to mental health service delivery informed by Lived Expertise, such as recovery-oriented and trauma informed approaches, are a growing influence in the mental health landscape in Australian and internationally. Growth in the Lived Experience workforce, as recommended by the Royal Commission into Victoria's Mental Health System, is intended to further support these approaches. However, recent Australian research has found that staff in Lived Experience roles are often 'employed but not included' and do not always feel supported in sharing their lived experience.

> *"They don't consider you an equal, they considered you as like a token, you're just put there because they have to have a consumer–worker on their team, and they don't consider you as part of their team (Edan et al., 2021, p. 17).*

MHPIe may be a valuable resource in the inclusion staff in Lived Experience roles. Existing research supports stigma reduction approaches are more effective when they involve contact with people with lived experience who belong to the target population (e.g., health care professionals) (Corrigan, Rusch, & Scior, 2018; Moll, Patten, Stuart, MacDermid, & Kirsh, 2018). Research in the United States found that stigma beliefs were reduced, and 'disclosure' increased, in mental health service staff that were involved in a contact-based education program delivered in multiple sessions within a year by a service user advocate and a MHPIe (Harris et al., 2019). Lived Experience researchers have also recommended that organisations take action to support sharing across the workforce (Byrne, Roennfeldt, Davidson, Miller, & Bellamy, 2022).

> *It is possible that we need to look no further than the next office to find individuals who can act as role models to change the culture of nondisclosure. (Harris et al., 2019, p. 2)*

WHAT HAS OTHER RESEARCH FOUND ABOUT SHARING BY PROFESSIONALS?

A scoping review of research with MHPIe and their colleagues found 23 studies that reported findings related to sharing with colleagues and supervisors. The studies included mostly focussed on sharing for help-seeking (e.g., professional help, reasonable adjustments, leave) and reflective practice (e.g., supervision). However, MHPIe also reported wishing to share to reduce stigma and share their knowledge with colleagues.

Some key themes were noted across studies which are pictured in the diagram below.

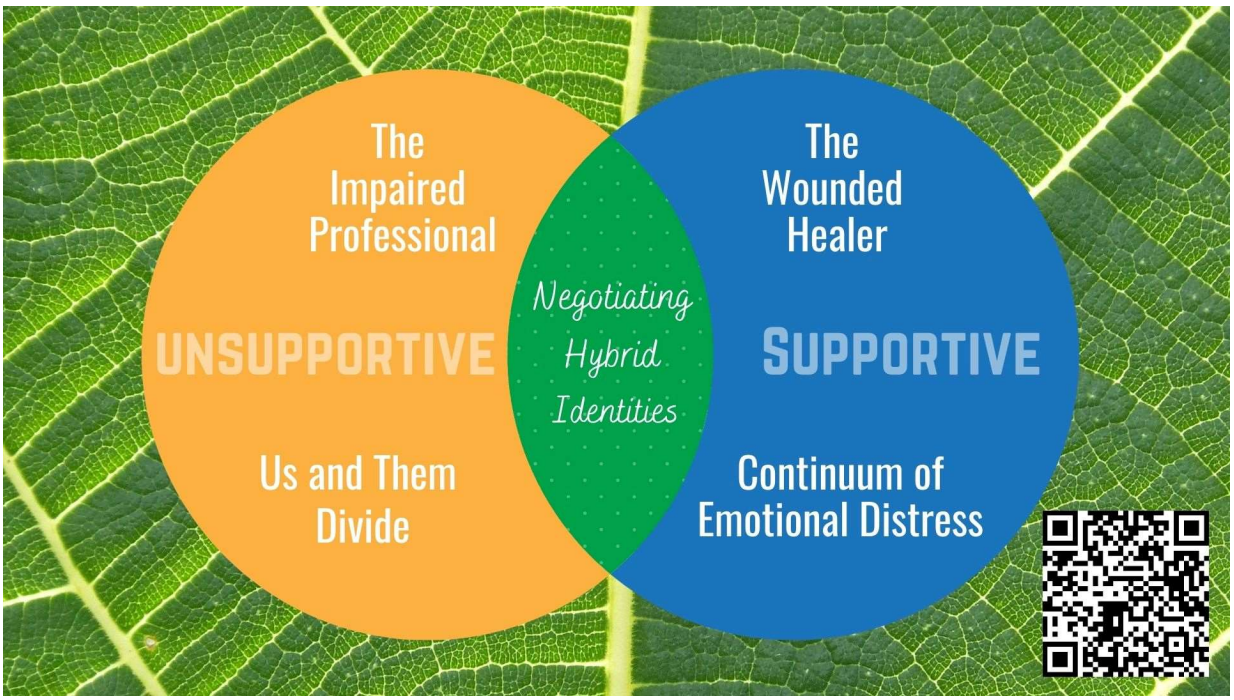

Figure 1. Themes supporting and constraining the sharing of lived experience by mental health professionals

The paper describing these findings (King, Brophy, Fortune, & Byrne, 2020) is available by scanning the QR code in Figure 1 or at this link: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900606

Themes that were unsupportive of MHPIe sharing were:

The impaired professional
Fears related to having one's competence as a professional questioned (i.e., prejudice) and affecting one's employment or future career progression (i.e., discrimination).

The us and them divide
The false belief that professionals don't experience mental health challenges, use mental health services, or have lived experience.

Themes that supported MHPIe to share were:

The wounded healer
Belief in the value of lived experience in relationships with service users and perspectives on recovery.

Continuum of emotional distress

The belief that we all have experiences of emotional distress that can be drawn upon in connecting and working with service users.

Conflict between these perspectives made it difficult for MHPIe to share, even when they personally valued their lived experience and wanted to share it with in the workplace.

Overall, the review found that sharing is complex and specific factors that support it poorly defined.

How was this research conducted?

To explore the topic in more depth, this research used interviews with mental health service staff, and review of relevant policies and procedures, from two Victorian mental health services. Organisation A is a specialist mental health service that employs mostly registered professionals delivering services in community clinics and inpatient units. Staff at Organisation A have the authority to detain and treat people involuntarily under the Mental Health Act 2014. Organisation B is a community mental health support service that employs staff, with and without vocational and tertiary training in mental health related disciplines, to deliver psychosocial disability support in community and residential settings.

The following sections provide further details of the staff who participated in interviews and the documents that were reviewed.

INTERVIEWS

Interviews of 30-57 minutes (mean = 44 minutes) duration were conducted via Zoom with 33 participants across the two organisations. Participants had worked in mental health services on average 8.23 years (range = 0.5 to 25 years) and for their current employer on average 5.09 years (range = 0.5 to 15 years). Participants were more commonly women (*n*=26), than men (*n*=5) or non-binary persons (*n*=2).

Participants included MHPIe, professionals not identifying with lived experience (mental health professionals) and peer workers. Each of these groups included staff in supervisory roles, of which ten were responsible for the supervision of other staff (e.g., clinical education, co-reflection, reflective supervision) and nine were responsible the line management of other staff (e.g., recruitment, pay and leave, performance review). **Table 1** provides further breakdown of the number of participants interviewed from each of these groups.

Table 1. Interview participants by informant group (n=33)

INFORMANT GROUP	ORGANISATION A	ORGANISATION B	TOTAL
Mental health professionals with lived experience	10	11	21
Mental health professionals	1	4	5
Peer workers	4	3	7
Supervisors*	8*	6*	14*
TOTAL	15	18	33

* from any of the above groups

Please note…

As the focus of this research was the sharing of personal lived experience, professionals with solely supporter (e.g., family member, partner, friend, or unpaid carer) lived experience were allocated to the *Mental Health Professional* group. Peer workers in Lived Experience roles designated for those with supporter lived experience (i.e., carer peer support workers, carer consultants) were eligible to participate, however, analysis focussed on the sharing of *personal* lived experience. Of the seven peer workers who participated, only one was in role designated for those with supporter lived experience. This participant also identified with personal lived experience.

Participants were also asked whether they identified with personal lived experience, supporter lived experience, or both. **Table 2** shows that all but two participants identified with some form of lived experience. Of the 28 participants identifying with personal lived experience, more had experience supporting someone close to them with mental health challenges than did not.

Table 2. Identification with lived experience reported by interview participants on screening (n=33)

IDENTIFICATION WITH LIVED EXPERIENCE	NUMBER OF PARTICIPANTS
Both personal and supporter lived experience	16
Personal lived experience only	12
Supporter lived experience only	3
TOTAL	31

Table 3 shows the types of education in mental health related disciplines participants had completed, started and did not complete, or were currently undertaking.

Table 3. No. of participants by training in mental health related disciplines (n=33)

DISCIPLINE	NUMBER OF PARTICIPANTS
Social Work	10
Non-clinical, MH related*	9
Nursing	5
Psychology	5
Other clinical**	5
Peer Support	5
Occupational Therapy	2
Psychiatry	2

*E.g., Community Services, Counselling.
**E.g., Family therapy, Narrative therapy.

DOCUMENT ANALYSIS

A list of documents of interest was supplied to the research sponsors at each site via e-mail and documents suitable for inclusion were discussed at individual meetings with both. Organisation A supplied their documents from October 2020 to June 2021. Organisation B supplied their documents during October to December 2020. All documents were up to date at the time of provision. Document types, and numbers analysed are provided in **Table 4.**

Table 4. Document types and numbers analysed.

DOCUMENT TYPE	DESCRIPTIONS OF DOCUMENTS ANALYSED	ORGANISATION A	ORGANISATION B
Staff health and well-being	Occupational health and safety policies and procedures Staff diversity and inclusion policies and guidelines Human resource policies Enterprise bargaining agreements Employee assistance program policies Tools to manage staff wellbeing	6	7
Supervision and mentoring	Supervision policies and procedures Performance development and review procedures and guidelines Disciplinary procedures	9	4
Lived Experience workforce	Service user participation policies and procedures Lived Experience workforce guidelines	2	1
Position description	Manager position descriptions Clinician position descriptions Peer support worker position descriptions	3	4
Training	Mandatory training procedures Descriptions of training modules Staff training guidelines	1	5
Vision and mission statements	Mission statement Strategic plan	0	2
Practice guidelines	Code of ethics Professional conduct guideline Service user diversity and inclusion guidelines Carer inclusive practice guidelines	1	3
TOTAL DOCUMENTS ANALYSED		22	26

Analysis of interview and document data used the descriptive, comparative and relational data analysis methods recommended for qualitative research as described by Bazeley (2013) and Miles, Huberman, and Saldaña (2020).

FOCUS GROUP

In January 2022, an e-mail was sent directly to MHPIe from both sites, who had participated in a research interview. Due to insufficient numbers at Organisation A, only the Organisation B focus group went ahead. Four participants were available to participate. All participants in the focus group identified openly with lived experience in their current workplace. Their reflections on the findings supported the development of the recommendations in this report and are used to illustrate key recommendations.

RESEARCH ADVISORY GROUP

The design and conduct of this research were guided by a research advisory group of eight members, chosen for their personal experiences with the topic, knowledge of the mental health service system, and experience as researchers in the field. Amongst the eight members: four had worked in designated Lived Experience roles; six had professional backgrounds; three were employed by participant organisations; and six had experience in conducting research.

ETHICS AND GOVERNANCE APPROVAL

The project had ethical approval of the research review committees of both organisations and La Trobe University, and governance approval of senior executives of both organisations.

What did this research find?

INTERVIEW FINDINGS

This section of the report shares the findings from 33 participant interviews with staff from a range of perspectives and roles. Factors that encouraged and discouraged staff from sharing their lived experience with colleagues and supervisors are described. A model explaining the influence of these factors on the way staff with lived experience share is also proposed. Finally, some of the key impacts of sharing reported by participants are described.

Factors supporting sharing

Comparison of individual participants' perspectives and experiences with sharing identified the following factors that supported staff to share their lived (or living) experience in the workplace.

Perceived organisational support

Organisational support for sharing lived experience was generally perceived as inconsistent by staff across both organisations. "Messaging" from senior organisational leadership that lived experience was valuable, including actions to seek and include these perspectives, were described by participants as supportive of sharing.

The number, position, and remuneration of staff in Lived Experience roles was seen by participants in this research as an indication of the value the organisation placed on lived experience. Specifically, peer workers considered their role valued in workplaces where there was:

- Parity in pay between peer support worker and staff in non-designated roles (e.g., support workers).
- Similar numbers of staff in Lived Experience and professional roles (e.g., in small teams).
- Senior Lived Experience roles.

In contrast, peer workers considered themselves to be undervalued by their employing organisation where they were:

- Conducting similar duties (e.g., intake assessments) for less pay than clinically qualified staff.
- Funding their own external discipline-specific supervision.
- Not engaged by senior organisational staff.

Perceived supervisor support

Most participants described their current supervisors as privately supportive, particularly when their mental health challenges impacted work (e.g., taking personal leave) or when providing support 'behind closed doors.' Fewer participants reported having the opportunity to discuss the impact of their lived experience on their work or how they might share their lived experience in team meetings or with service users.

Individual preference for being open

Participants who shared more openly in the workplace spoke about the value of authenticity and being 'vulnerable' in 'cultivating' spaces for sharing. This included acknowledging personal weaknesses (and strengths) and discussing work-related challenges with colleagues and supervisors. This contrasted with more traditional ideas of professionalism where speaking about oneself was considered inappropriate or irrelevant.

Psychological safety in teams

Participants felt more comfortable sharing in teams that explicitly encouraged team members to voice their opinions and ideas, including those informed by lived experience, and responded positively. In these teams, staff felt equally valued within the team, regardless of their discipline or seniority. In contrast, teams in which staff felt unsafe in sharing were described as 'hierarchical' and defensive in response to sharing.

Examples of how participants described these factors are provided in **Table 4**.

Table 5. Participant descriptions of supportive and unsupportive factors for sharing

FACTOR INFLUENCING SHARING	SUPPORTIVE EXAMPLES	UNSUPPORTIVE EXAMPLES
Perceived organisational support	*I think [Organisation B] . . . on the whole have had the right approach. . . . I think [Organisation B] do continually reflect and develop and grow. . . So, I think, organisationally, they do things pretty well.* (Adhiarja, MHPIe, Organisation B)	*...there needs to be formal acknowledgement of people wearing both hats. . . . It has to come from the top down. And there's got to be a clear signal that it's appreciated and not. . . to manage the risk. (Kevin, MHPIe, Organisation A)*
Perceived supervisor support	*I think [my supervisor] checked in with me a little bit more, gave me a bit more support around [taking on a senior role]. . . . [my supervisor] supported me to learn the skills to do that, instead of saying, "Well, you're not capable of doing that because of all of those things that you've disclosed."* (Amanda, MHPIe, Organisation A)	*I still often go through periods where I think, "Is [my supervisor] wondering about whether I'm valuable?" Because I know [my supervisor]'s not the type of person to see some of the other things that I do. . .. And [my supervisor], sometimes, doesn't explain [them]self very well. . .. So, I often feel like I'm in trouble. . .. but I don't exactly know what it's for.* (Anastasia, MHPIe, Organisation B)
Individual differences	*By being myself fully, I felt it might allow space for other people to feel they can be themselves fully, […] feeling permission to be themselves and to be their authentic selves…. can create… contribute to the change that is maybe needed.* (Tanveer, MHPIe, Organisation B)	*The older you get, and the more senior you get in your position, the more people value what you say. . .. When you. . . do disclose something, that it carries a lot of weight. And so, it's important to be very careful about how you do that and judicious.* (Quinn, MHPLE, Organisation A).
Team culture	*We are a multi-disciplinary team but there's no hierarchy at all. It's a very flat structure. . .. there's no person or professional on the team is more or less than anyone else. . .. and I've only received encouragement to. . . discuss issues, and consumers, and struggles with the team.* (Halcyon, Peer worker, Organisation B).	*I'm there to say stuff like that but then what happens with what I say? It just gets tossed aside.* (Abby, Peer worker, Organization A).

Private versus open sharing

All staff with lived experience (i.e., MHPIe and peer workers) interviewed reported sharing privately in the workplace with trusted confidantes. However, of the twenty-one MHPIe interviewed, only five shared their experiences openly in the workplace (e.g., team meetings, group supervision). Of the seven peer workers interviewed, only three reported sharing openly in the workplace.

The greater the number of supportive factors (see above) reported by a participant, the more likely they had shared openly in the workplace. To share openly in the workplace, all but one participant, needed two or more factors supporting sharing. For example, a personal preference for "being open" alone did not support staff to share openly, without a supportive work environment. Similarly, psychological safety alone did not support sharing, without explicit support for sharing from supervisors and/or a personal preference for being "open." However, …

All those who shared openly in the workplace reported having been supported to share openly by their team leader, either through opportunities to reflect on how they might share or invitations to share in team meetings.

A more detailed description of the factors supporting and not supporting sharing and their impact on the ways in which staff shared (i.e., privately or openly) and what they shared (i.e., lived or living experience) is provided in **Appendix 1.**

Impacts of sharing for staff with lived experience

The individual impacts of sharing reported by staff with lived experience can be broadly grouped into the following five themes.

"Lifting the burden"

A common impact of sharing reported by staff with lived experience was improved wellbeing. Participants described living experience as a "weight," "burden," or "load" that was "relieved" or "lifted" when shared. Being able to share with colleagues relieved staff of the burden of pretending everything was okay (when it wasn't) and helped them to get on with their day. As described by Pragun:

I, definitely, feel that talking about it is quite… healing and … it definitely, lightens the load. (Pragun, MHPIe, Organisation A)

"Sharing the load"

Sharing with colleagues created opportunities for mutual support in the workplace. Staff with lived experience received and provided emotional and practical support in the workplace. Melissa found the reciprocal support of colleagues helped her to cope with the demands of her work:

So, the ones that you care about, and they care about you, you actually would go out of your way to help them. . .. If you're closer to someone they naturally volunteer to help you more and you feel more supported. If you don't have that, it's just stressful. (Melissa, MHPIe, Organisation A)

"Bringing my whole self to work"

Those participants who felt supported by their team leader and colleagues to share openly in the workplace described a sense of authentic engagement in their work. As described by Yarden:

What's developed from that is a feeling of real satisfaction within my role because I feel like I can bring all of myself to this work. It's not like I have to put on a professional façade and feel like I have a whole lot of experience that might be informing the way I do my work but that I need to keep a secret. (Yarden, MHPIe, Organisation B)

The relationships between the factors that supported sharing, and the positive impacts of sharing *in supportive relationships and teams,* are shown in **Figure 2**.

Figure 2. Factors supporting sharing and the positive impacts of sharing in supportive relationships and teams

Given that most participants were selective in who they shared with and what they shared, fewer negative experiences were reported than positive. These are described below.

Fear

Staff with lived experience who shared privately in unsupportive team cultures, described worrying they had "overshared," shared unnecessarily, or that information shared might be "used against them." Kate observed:

> *I do know of a clinician who has had a long and very significant psychotic disorder. . .. They shared it with me. . . but just completely, really scared like, "Don't, don't let this out."*
> *(Kate, MHPle, Organisation A)*

"Once bitten, twice shy"

Experiences of prejudice and discrimination in other workplaces, or with previous managers, made staff with lived experience cautious about sharing again. As described by Ione:

> *I had one manager who, actually, used to use it against me. That manager isn't working anymore but… um… it did a lot of damage. (Ione, MHPle, Organisation B)*

The paper describing these findings (King, Fortune, Byrne, & Brophy, 2021) is available by scanning the QR code in Figure 2 or at this link: **IJERPH | Free Full-Text | Supporting the Sharing of Mental Health Challenges in the Workplace: Findings from Comparative Case Study Research at Two Mental Health Services (mdpi.com)** (https://www.mdpi.com/1660-4601/18/23/12831)

Beyond the personal impacts of sharing, interview participants also described impacts on individual colleagues, teams and service users.

Impacts of sharing on colleagues

Participants reported both positive and negative responses to sharing within teams.

Reflection

Sometimes sharing resulted in colleagues reflecting on their assumptions and perspectives, as Barbara described:

> *Perhaps [they] wanted to show me. . . this mindset of mental health diagnosis, schizophrenia, hopelessness. This is a stereotype. . . And that was a clear 'wow' moment for me because I saw a clear example in front of me. (Barbara, MHP, Organisation B)*

Defensiveness

In other circumstances, staff who shared described being "shut down," "ignored" or "brushed aside." This was a more common experience for peer workers, who felt an expectation to "speak up" for service users despite perceiving their team to be unsupportive. Like 'mansplaining' in gender relations, the term "clinsplaining" was used by Abby to describe clinicians' responses to sharing:

> *Clinsplaining… you, basically, get told why that won't work. . . and then they just take over the conversation. (Abby, Peer worker, Organisation A)*

The degree of defensiveness encountered was attributed by some to the way in which lived experience was shared. Wynn reflected upon their responses to sharing by different team members:

> *I think that the way that [the peer worker] shares [their] experience. . . is a game changer in wanting to engage with that and wanting to pursue it further.*
>
> *You just kind of secretly roll your eyes in the back of your head and go, "Here we go."*
>
> *(Wynn, MHP, Organisation B)*

Impacts of sharing on team culture

As well as supporting sharing (see above), team culture was influenced by sharing. Intentional efforts by team leaders to create a safe space for sharing enabled a more supportive the team culture. Blake and others described this as important to meet the demands of their work role.

Most people are okay with looking at… at naming their strengths and weaknesses and working together around that… which is quite challenging, really. . .. It's hard but we're getting really good at it. It's a great environment now, and necessary for the work. Like, we've got a great healthy team… really supportive team. (Blake, Peer worker, Organisation B)

Participant suggestions for supporting the sharing of lived experience

Participants were asked at the end of their interviews the one thing they would change to support the sharing of lived experience in the workplace. Their responses to this question are summarised in **Appendix 2**. Participant suggestions, analysis of interviews and documents, and the wider literature on the topic informed the recommendations found at the end of this report.

Summary of interview findings

Overall, interviews indicated that sharing of lived and living experience with colleagues and supervisors most often occurred 'behind closed doors' in the context of trusting relationships. Sharing more openly in the workplace for the purpose of sharing experiential knowledge and 'speaking up' for service users was less common. Sharing within supportive relationships and teams had benefits for staff wellbeing and engagement, mutual support, reflection, and growth. MHPIe tended to avoid negative responses to sharing by being selective with whom and what they shared, whereas peer workers who shared in unsupportive teams, experienced negative responses to sharing that affected their sense of value in the workplace.

DOCUMENT ANALYSIS FINDINGS

This section of the report provides an overview of 48 documents sourced from participant organisations describing policies and procedures as they relate to the cultural context of sharing lived experience in the workplace. Themes were found relating to layers of cultural influence outside and within organisations as shown in **Figure 3**.

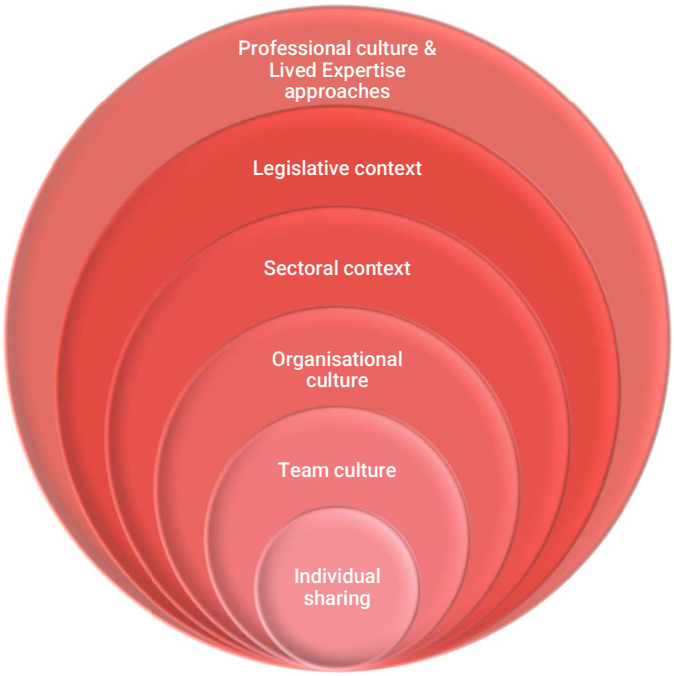

Figure 3. Levels of cultural influence on individual sharing

Major themes from each level of influence will be described in terms of its influence on sharing within the organisations participating in this research.

Professional culture

Professional culture was evident in the documents of both organisations with reference to **professional standards** and the structures and processes undertaken to ensure compliance with them. Of relevance to this research are professional standards relating to sharing of personal information with service users, referred to as **"self-disclosure."** Documents from both organisations referenced the maintenance of **"professional boundaries":**

> *[Organisation B] has in place robust professional practice development and supervision processes to ensure issues related to the maintenance of professional boundaries and appropriate self-disclosure can be identified, discussed and resolved. (Professional conduct guideline, Organisation B)*

At Organisation B, these standards were described as extending to sharing between peer workers and service users, and between colleagues, in ways that suggested sharing as risky and staff with lived experience as needing other staff members' help to share "safely":

> *It is the responsibility of all staff to limit curiosity when a colleague is sharing their experience of recovery and to ensure that the person is not encouraged to disclose beyond their comfort level. (Professional conduct guideline, Organisation B)*

Reflective practice and professional development were described in the documents of both organisations as important in maintaining professional standards of practice and conduct. At Organisation A, opportunities to reflect on professional practice (i.e., clinical supervision) was explicitly distinct from line management relationships:

> *The role of the clinical supervisor is separate and distinct from the roles of the clinical team leader and manager. In practice, this means that managers and clinical team leaders will not routinely provide professional supervision to staff who they directly manage. (Supervision procedure, Organisation A)*

In contrast, at Organisation B, line managers also provided reflective opportunities to most staff alongside their managerial functions. The exception to this were registered health professionals who were provided clinical supervision in addition to supervision by their managers.

Lived Expertise approaches

Another influence beyond the workplace, reflected in organisational documents, was Lived Expertise approaches. The most cited in the documents of both organisations were **recovery** and **"recovery-oriented"** approaches:

> *Our multi-disciplinary workforce of skilled and dynamic clinicians, consumers and carers, provide a recovery-oriented approach to care. (Clinician position description, Organisation A)*

However, descriptions of "recovery-oriented" approaches include clinical interventions:

> *Demonstrate behaviours that support a Recovery approach to care. This includes: . . . A knowledge of treatments, therapies and targeted interventions and their contributions to innovative recovery-oriented service delivery approaches; Undertake alcohol and other drug screening, assessment, treatment planning, brief interventions. . .. Participate in the review of therapeutic goals, treatment and care within the clinical review setting. (Clinician position description, Organisation A)*

Similarly, despite reference to the tasks of **Intentional Peer Support** (e.g., mutuality, worldview) in documents, descriptions of peer support relationships reflected more closely the roles of mental health professionals:

> *Provide direct practical support to consumers so that they gain/maintain independent living skills. . .. Assist consumers to participate in recreation activities and the cultural life of the community by supporting them to develop interpersonal skills. . .. Provide support to consumers wanting to apply or reapply for NDIS. . .. Provide opportunities to discuss problem solving strategies, reflecting on helpful and unhelpful behaviours. . .. Provide social validation support by giving consumers feedback about their social interaction. (Peer Support Worker Position Description, Organisation B)*

Legislative context

Documents from both organisations referenced legislation influencing internal policies and procedures.

The **Health Practitioner Regulation National Law 2009** was cited in the documents of both organisations. It's relevance to the sharing of lived experience is that it mandates the reporting of "notifiable conduct" by employers or supervisors without the consent of professional involved:

> *…confidentiality refers to a situation in which the discussions that take place between a supervisor and staff will not be disclosed to anyone else. Exceptions to this include when: . . . Mandatory reporting requirements require an issue to be disclosed. (Supervision procedure, Organisation A)*

Whilst mandatory reporting guidelines in Australia create an ostensibly high threshold for reporting, a conflict of interest may exist for supervisors between upholding the self-determination of supervisees and meeting their obligations to their employer. The supervision policy at Organisation B particularly emphasised the role of supervision as a site of surveillance of professionals' behaviour:

> *[Organisation B] accepts its responsibility as an employer to monitor the standards of professional practice of its allied health and clinical staff and its legal obligation to report notifiable conduct. As such, [Organisation B] will ensure allied health and clinical staff have access to appropriate professional development and supervision. (Supervision policy, Organisation B)*

The **Fair Work Act 2009** and **Equal Opportunity Act 2010** provide for protection of the working conditions of employees. Of relevance to this topic is employees' access to flexible working arrangements and reasonable adjustments that support their inclusion and wellbeing. Access to these provisions is described in both organisations' documents as subject to a number of conditions favouring organisational needs over those of workers:

> *[Organisation B] is committed to reasonably accommodating any staff member's need for flexibility, subject to reasonable business needs including operational context, impact on service delivery, funding agreement and local team environment. (Staff diversity and inclusion policy, Organisation B)*

Descriptions of the **Occupational Health and Safety Act 2004** in documents highlights organisations' responsibility as employers to address risks to staff health, safety and wellbeing, again with the condition of "practicality":

> *The [occupational health and safety] Risk Management Procedure assists [Parent health service of Organisation A] to meet its obligations under the Victorian OHS Act (2004) whereby [Parent health service of Organisation A] must ensure the health and safety of persons by eliminating health and safety risks so far as reasonably practicable.*
> *(Occupational Health and Safety Procedure, Organisation A).*

The **Mental Health Act 2014,** which permits the compulsory detention and treatment of service users at Organisation A, was notable in its absence from most of the documents reviewed, except as legislation staff should be familiar with.

Sectoral context

Descriptions of the sectoral context in organisational documents were noteworthy in terms of their reference to **external regulation and standards intended** to regulate the quality and safety of organisations:

- National Safety and Quality Health Service (NSQHS) Standards (ACSQHC, 2021)
- National Practice Standards for the MH Workforce (Department of Health, 2013)
- National Standards for Disability Services (Department of Social Services, 2013) (Organisation B only)
- QIC Health & Community Service Standards (Quality Improvement Council, 2017) (Organisation B only)
- Human Service Standards (State of Victoria, 2021b) (Organisation B only)

Ensuring staff members' compliance with these standards was a central focus of policies and procedures relating to the supervision, performance review and training provided to staff at both organisations:

> *[Organisation B] will ensure there are mechanisms and robust systems in place to support the effective and efficient operation of the organisation and ensure compliance with quality standards and all legislative, regulatory, and funding requirements. (Mission statement, Organisation B)*

The different funding models of participant organisations were reflected in references to the sectoral context at each. However, both suggested impacts on staff related to inadequate or precarious funding. Whilst funding was not explicitly addressed in documents from Organisation A, reference to high demand for crisis-focused services implied the impact of long-term **underinvestment** in state funded mental health services:

> *Reduce the risk of consumers presenting to emergency department in crisis; Reduce the pressure off emergency departments and acute inpatient units.*
> *(Peer Support Worker Position Description, Organisation A)*

The transition to a "market-driven" NDIS funding model at Organisation B was reflected in the language of business within organisational documents, suggesting the influence of **funding precarity** and externally driven **organisational change**:

> *We will become a provider of choice by taking practical and systematic steps to improve our public profile so that potential consumers and carers understand who we are, what we do and how we can contribute to their lives. (Strategic Plan, Organisation B)*

The implications for staff within this environment were also evident in staff position descriptions:

> *Demonstrated ability to effectively perform in an environment of change.*
> *(Manager position description, Organisation B).*

In contrast, organisational documents at Organisation A were silent on the topic of **sectoral reform**, despite the research being conducted during the Royal Commission into Victoria's Mental Health System.

Organisational culture

Organisational culture, as described in the documents supplied by both organisations, was influenced by the external factors described above.

Organisational values

Descriptions of organisational values in documents from both organisations particularly emphasized: **quality and performance**; **safety and risk management**; and **outcomes**:

> *Clinical supervision for nurses will contribute to maintaining and developing a competent and skilled mental health nursing workforce and will contribute to maintaining and promoting standards of practice, professional ethics and support safe quality outcomes for consumers. (Supervision procedure, Organisation A).*

References to **diversity and inclusion,** though less frequent, acknowledged the subjective nature of terms such as quality and safety for service users. Organisation B particularly highlighted the value of lived experience to the mental health workforce, beyond designated Lived Experience roles.

> *Further depth is brought by those from diverse cultural backgrounds, Aboriginal staff, and those with lived experiences of mental illness and recovery, all of whom are strongly encouraged to apply for any roles that match their skills and interest. (Clinician position description, Organisation B)*

Similarly, references to "**consumer experience**" and service users defining their own outcomes featured in some documents.

> *…to deliver safe & quality services that produce recovery-oriented outcomes and a great consumer experience. (Manager Position Description, Organisation B)*

Accountability

Within the context of ensuring standards and legislation governing services and professionals (see above), a major theme within both organisations' documents was upward accountability. This was reflected in, sometimes multiple, **hierarchies of reporting and responsibility**:

> *This position is operationally responsible to the . . . Program Manager, clinically to the consultant psychiatrist, and professionally accountable to senior of discipline for all matters relating to professional practice. (Clinician position description, Organisation A, p. 3)*

Individual staff were described as responsible for not only being aware of the standards and legislation guiding their work but also **monitoring** their own compliance with them and reporting their deficits to supervisors.

> *Allied health and clinical staff have a further responsibility to focus their practice supervision sessions around evaluating their practice against the relevant competency or professional practice standards and identifying and prioritizing learning needs. (Supervision policy, Organisation B)*

Processes of downward **accountability to staff and service users** were present but less strongly worded in the documents of both organisations. Accountability of supervisors to their staff reflected the influence of the psychological safety paradigm within the human resource departments of both organisations:

> *Particularly for leaders, their role to model our values and create a culture where people feel safe to speak up is critical. (Performance development and review guideline, Organisation A)*

References to reporting of breaches of sectoral standards outside the organisation varied between organisations. Staff raising concerns within or outside of the organisation at Organisation A were described as protected from victimisation:

> *Where a person makes a disclosure or reports a serious wrongdoing, they are protected without fear of reprisal. (Disciplinary procedure, Organisation A)*

Whereas preserving the **organisation's reputation** seemed more of a priority at Organisation B.

> *Staff and associate staff must not publicly engage in any activity/affiliation that reflects negatively upon [Organisation B]'s reputation. (Code of Ethics, Organisation B)*

Involvement of service users in service improvement activities was most commonly in reference to **consultation & feedback** and "partnering with consumers."

> *…partnering with consumers is critical to the design, delivery, implementation and evaluation of person-centred services. Consumer feedback and complaints management are critical to this process. . .. Co-design and improvement through partnerships are enabled when organisations listen to feedback and stories from consumers, carers and families and provide opportunities to be heard. (Service user participation policy, Organisation A)*

In contrast, **Lived Experience leadership** was a minor but emergent theme.

Learning and Growth

As previously mentioned in relation to the sectoral context, references to organisational change and sectoral reform were not featured in documents from Organisation A. In contrast, the organisational culture at Organisation B was explicitly described as being influenced by funding changes affecting the sector:

> *We have grown and developed a lot in the last three years, with a doubling of the number of people we support and in the staff who support them. . .. This growth and development can be directly attributed*

> *to the quality of our services and the culture of learning and innovation that drives us as an organisation. We believe in learning new things, considering new perspectives and testing out new ideas as we find better ways to do things. We are always looking ahead to ensure we can take advantage of new opportunities and respond to any risks or issues that are facing us and our sector. (Clinician position description, Organisation B)*

Staff wellbeing and engagement

Attention to staff wellbeing and engagement was present at both organisations. This was mostly evident in reference to supervisors' responsibility to monitor and support the wellbeing of staff, referring on to the organisation's Employee Assistance Program where needed.

> *Service and Program Managers are responsible for promoting the EAP program and supporting staff to identify when this program may be of value or needed. (Employee assistance program policy, Organisation B)*

Organisation B grants staff an additional two days of "wellness leave" each year:

> *Examples of when an employee may choose to or need to use wellness leave include. . . to proactively deal with fatigue or stress, . . . or attending a counselling session. (Enterprise bargaining agreement, Organisation B)*

The responsibility of organisations to address working conditions that might cause emotional distress in staff (e.g., high workload, stigma, occupational violence) was couched with similar references to "reasonable practicality" as provisions granting flexible work arrangements and reasonable adjustments:

> *The Chief Executive and senior management are committed to and accept overall responsibility for the provision and maintenance of a safe and wellbeing supported working environment so far as is reasonably practicable. (Occupational health and safety policy, Organisation A)*

At Organisation B, documents did link workplace conditions to the inclusion of lived experience perspectives.

> *We will listen to what is important for staff about what best supports their capacity, resilience and good practice in the workplace. . .. We will ensure our workplaces honour the diversity of lived experience. (Mission statement, Organisation B)*

Two other themes relating to staff wellbeing were only evident in the documents supplied by Organisation B, namely job insecurity and flexibility. As previously highlighted in relation to funding precarity in the psychosocial disability support sector, job insecurity was identified as an issue for staff:

> *[Organisation B] operates in an environment where funding cycles are often for a fixed period and therefore providing long-term job security can be difficult.*
> *(Enterprise bargaining agreement, Organisation B)*

Within the sectoral environment of Organisation B, it also appeared that flexibility was conditional on the part of the organisation (see Legislative context) but an expectation of staff:

> *Adapts to changing circumstances quickly. . .. Adapts interpersonal style to suit different people or situations and shows confidence in managing change. . .. Deals with ambiguity, making positive use of the opportunities it presents. (Peer Support Worker position description, Organisation B)*

Team culture

Team culture has been found to vary considerably within organisations (Edmondson, 2018). However, team culture may be influenced by organisational policies and procedures supporting good practice by team leaders. Documents from both organisations included attempts to reduce hierarchies in the workplace, such as managers inviting staff to give them feedback:

> *Asking for feedback helps create a culture where it's safe to give and receive feedback.*
> *(Performance development and review guideline, Organisation A)*

Only documents from Organisation B, however, described formal structures supporting team culture, such as team reflective supervision. Feedback from teams at Organisation B using team reflective spaces indicated the benefits for staff wellbeing:

> *For teams using [group reflective supervision] effectively, staff noted that the most common and valued outcome of [group reflective supervision] is the normalisation of their experience and practice struggle points. (Performance development and review guideline, Organisation B)*

Use of opportunities to reflect as a team, were also noted to improve staff members' work with service users:

> *Many service delivery leaders noted that staff's confidence, willingness and skill in engagement with [group reflective supervision] reflects their capacity to apply the coaching stance and skills with consumers, hence note its great value to practice development.*
> *(Performance development and review guideline, Organisation B)*

Summary of document analysis findings

Overall, documents reflect the influence of professional, legal and sectoral regulation in creating hierarchies of upward accountability, surveillance and reporting in the workplace. These structures, whilst intended to ensure high standards of support for service users, may serve to reinforce power differentials that stifle organisational learning, innovation and growth (Edmondson, 2018). More collaborative, inclusive, and reflective models of engagement with staff and service users were less prominent but present within the documents analysed, suggesting opportunities for progress towards improved staff engagement and service user experiences.

DIFFERENT WAYS OF THINKING ABOUT SHARING

Figure 4 shows ways of thinking about sharing and their consequences, which may be helpful for reflection and identifying areas for learning and growth. A paper reporting these findings (King et al., in press) is available at: https://www.researchgate.net/publication/365360642_Mental_health_service_staff_on_sharing_lived_experience_in_the_workplace

Figure 4. Ways of thinking about sharing and their consequences

How can we support the sharing of lived experience in our workplace?

This research set out to explore the sharing of lived experience in the workplace, as a means of reducing stigma in the mental health workforce and improving service user experiences of support. What it found, however, is that the sharing of lived experience is closely tied to the living experience of mental health service staff. In the context of under-resourcing and funding precarity, the expectation for staff to play the role of "invulnerable professional" has never been higher. Workplace conditions of organisational restructuring, unrelenting work demands, and occupational violence contribute to experiences of distress in mental health service staff, creating the conditions for burnout in staff and impacting the safety and inclusion of staff Lived Experience roles. Ironically, in attempting to meet the expectations of cultures that "rewards perfectionism and lauds heroism" (Sukhera, Poleksic, Zaheer, & Pack, 2022, p. 823), we undermine the core feature of effective mental health support: relationships with service users (Barzilay et al., 2020). As highlighted by the findings of the Royal Commission into Victoria's Mental Health System:

> *The workforce is under-resourced. The mental health workforce is diverse but there are serious shortages. . .. Despite the commitment and competence displayed by workers, many have struggled to perform their best in a crisis-driven system. (State of Victoria, 2021a, p. 18)*

Whilst lived experience in mental health professionals is not limited to experiences of burnout, factors that supported the inclusion of staff with lived experience show similarities with those that prevent burnout. Resources such as: job autonomy; social support; the quality of relationship with the supervisor; performance feedback; opportunities for growth; appreciation; innovativeness; and skill variety have been found to buffer the impact of high demand jobs (Bakker & Demerouti, 2017). Resources supporting the inclusion and wellbeing of staff were evident in the documents of both organisations. However, access to these resources was often limited by participants' concerns around stigma, prejudice and discrimination in the workplace, and team cultures that devalued lived experience perspectives.

The following recommendations may not apply to all organisations, supervisors, teams and professionals but serve as points of reflection for those wishing to create more inclusive workplaces and better experiences of support for service users. Focus group participants' quotes are included to illustrate recommendations.

AREAS OF REFLECTION FOR ORGANISATIONS

The following recommendations include service-wide initiatives that support the conditions in which staff perceive lived experience to be valued by their employing organisation.

Valuing lived experience across the workforce

> *I think there's been a tension in terms of non-designated and designated roles and, honouring the peer space, what the relationship should be between non-designated and designated roles. (Tanveer, MHPIe, Organisation B).*

This and similar research conducted in mental health services in the United States (Byrne et al., 2022), suggests that the open sharing of lived experience by mental health professionals in the workplace is not supported by the presence of staff in Lived Experience roles alone. Indeed, peer workers in this research described being discouraged from sharing in workplaces where professionals did not share. It is therefore recommended that organisations take action to address the misconception that staff outside of designated Lived Experience roles do not have lived experience. This may be achieved by:

- **Human resource policies and procedures that reflect the existence and value of lived experience across the workforce** in recruitment, induction, supervision, and appraisal procedures (Morgan & Lawson, 2015).
- **Invitations to share** for the purpose of projects and events being extended to all staff with lived experience. Sharing by staff in leadership roles within such forums may also demonstrate that lived experience need not limit your career progression or role within the organisation.
- **Review of guidelines around "self-disclosure"** with service users and in the workplace to incorporate current sharing guidelines and frameworks (Dunlop et al., 2022; Morgan & Lawson, 2015).

Understanding the value and purpose of sharing lived experience

> *Coming into [Organisation B] provided me an excellent framework or workplace to grow this [lived experience] identity. . .. Coming into a peer space. . . greater enhanced and supported it. And there was a lot more about how to do this with authenticity and mutuality. (Tanveer, MHPIe, Organisation B)*

Support to share must be accompanied by guidance on how to do it with purpose and skill. The following suggestions may support staff with lived experience, outside of designated Lived Experience roles, to honour their lived experience when sharing in the workplace:

- **Training in sharing lived experience** should be available to staff, with and without lived experience, to enable them to understand Lived Expertise perspectives and approaches to sharing (see below) that might inform their own sharing *and responses to* sharing. Ideally, this training would be co-facilitated by peer workers and professionals with lived experience, to challenge stigma beliefs and address differences in work roles. Priority groups would include team leaders, supervisors, professionals with lived experience and those working closely with peer workers.
- **Opportunities for professionals with lived experience to reflect with their Lived Expertise colleagues** (e.g., co-reflection) may further support professionals with lived experience to consider their explicit (i.e., sharing) and implicit (i.e., embodied) use of lived experience in their work. These could be available in individual or group formats, depending on staff preferences and local conditions.

Supporting the Lived Experience workforce

> *When the decisions and the policies and the direction of the organisation, they're being led by people who have that lived experience, then you build that faith and trust and that safety and that bleeds into everything lower. (Sasha, MHPIe, Organisation B)*

The recommendations of the Royal Commission into Victoria's Mental Health Service and *National Lived Experience (Peer) Workforce Development Guidelines* (Byrne et al., 2021) underscore the importance of embedding a sufficient number and diversity of designated Lived Experience roles at all levels of mental health services. Specifically, this research recommends:

- **Addressing disparities in remuneration for peer workers** conducting similar work duties as staff in non-designated roles.
- **Ensuring access to Lived Expertise co-reflection for peer workers** (i.e., supervision).
- **Supporting a greater number of designated Lived Experience roles** throughout the service delivery and operational functions of the organisation, including leadership roles.
- **Whole-of-workforce training in the unique role and expertise of the Lived Experience workforce.** This could be in integrated with training in sharing lived experience (see above).

AREAS OF REFLECTION FOR SUPERVISORS

The following recommendations are aimed at line managers and discipline supervisors wishing to support the sharing of lived experience by their staff and supervisees. These recommendations may also inform training, policies and procedures related to the management and supervision of staff.

Improving consistency in supervisor support

> *…training needs to be looked at, to make sure it's less generic supervision and . . . includes things about lived experience. (Sasha, MHPle, Organisation B)*

Participants in this research emphasised the variability of support they received from different line managers and supervisors within the same organisation. The *Dorset guidelines for staff sharing lived experience with managers and colleagues* (Morgan & Lawson, 2015) suggest staff are supported to share when supervisors:

- **Understand and value lived experience**
- **Provide opportunities to reflect upon sharing in supervision**, including the experience and impact of sharing
- **Support staff wellbeing**.

Research into burnout among Australian psychologists has suggested the need for clinical supervision to: "reorient from a focus on performance and technique to also include the recognition and support of the personhood of the therapist, their self-care and emotional needs, and the limitations of their capacities" (Turnbull & Rhodes, 2019, p. 1). Supervision activities supporting staff wellbeing include:

- Conflict resolution
- Interpersonal communication
- Strength-based supervision techniques
- Team-building (Welder & Salzer, 2016).

Supporting inclusion of staff with living experience

> *That actual quality relationship with the direct supervisor is so integral to whether or not we are able, and safe enough, to bring that whole self to the workplace. (Ione, MHPle, Organisation B)*

Participants in this study reported feeling valued and committed to workplaces where their managers navigated current mental health challenges collaboratively and supported them to put their wellbeing first. Welder and Salzer's (2016) *Creating Welcoming Work Environments* guidelines recommend specific training for supervisors, line managers and Human Resource staff and executives in supporting staff with current mental health challenges. The content of this training should emphasise the need for managers to:

- **Avoid responding to the sharing of living experience as a "therapist"** rather than a supervisor, by diagnosing a mental disorder; undertaking mental state or risk assessments; or providing professional advice or counselling.
- **Apply disability management principles consistently across psychosocial and physical disabilities** (e.g., reasonable adjustments, graded return to work)
- **Ensure access to counselling support** (e.g., employee assistance program), when needed. (Welder & Salzer, 2016)

As well as having an awareness of their responsibilities under equal opportunity, anti-discrimination and occupational health and safety legislation, managers should be provided with practical examples of their application in supporting the inclusion of staff with lived and living experience.

Transparency and choice in information sharing

> *It does feel, in a lot of situations, that confidentiality or privacy. . . can almost reinforce shame or stigma. . . When it came to having a conversation with our HR team, my manager was sort of like, "So, we don't have to say anything about what's going on" . . . but, in my mind, I was thinking. . . "Why would I need to hide that experience?" (Eden, MHPIe, Organisation B)*

The onward reporting of information shared within supervisory and collegial relationships needs to be particularly clear for staff with lived experience, who may fear discrimination or onward reporting. Managers are encouraged to:

- **Have open conversations with staff with lived experience about what information will be shared and with whom**. This includes managers' discussions with senior managers for advice and support.
- **Ask about staff members preferences for sharing** lived and living experience within the team. Staff may wish for privacy, but they may also wish to share. Making assumptions about this can contribute to internalised stigma and limit opportunities for collegial support.
- **Respect the expressed preferences of staff** or be transparent when this is not possible (see above).

AREAS OF REFLECTION FOR TEAMS

The following recommendations are aimed at team leaders and members wishing to cultivate spaces for sharing within the team. These extend to sharing of ideas, opinions and work-related challenges by all staff.

Understanding and supporting psychological safety

> *I know that, in general, [Organisation B] values lived experience and I'm confident in that, but I don't see it in my day-to-day work with the people I engage with and in the spaces, that I am working in. . . . How are you showing, in your individual interactions with people, that it's important. . .? In terms of "Hey, we want your perspective on this, because your perspective is important and it's unique. How can you bring that perspective to this piece of work?" (Eden, MHPIe, Organisation B)*

Team cultures described by participants as supportive of sharing resonated with descriptions of psychological safety, or "…a climate in which people are comfortable expressing and being themselves" (Edmondson, 2018, p. 16). Psychological safety has been linked to increased customer satisfaction, patient safety, and organisational innovation and growth (Edmondson, 2018). Whilst not limited to the sharing of lived experience, team members with lived experience may be motivated to 'speak up' within their teams to support better experiences of support for service users. To harness this resource, Edmondson (2018) recommends that team leaders and members:

- **Become comfortable with "not knowing."** Being curious and asking questions when someone shares is okay. People can be supported to set their own limits about how much they share through training and reflection (see above).
- **Invite participation.** This relates to both lived experience and work-related challenges staff might wish to bring to discussions. Staff should be invited to share within the limits of their comfort which will vary from person to person.
- **Listen humbly.** Learning from lived experience requires one to be aware of one's own worldview and open to new information or perspectives.
- **Respond productively.** Staff should be encouraged to reflect upon what has been shared and their own responses to it before responding. Consensus or agreement is not necessary to learn from sharing.

Team leaders and members may be more likely to demonstrate these behaviours when they understand the value and purpose of sharing. Integration of Lived Expertise (see *Understanding the value and purpose of sharing* above) and psychological safety approaches in training, policies and procedures may support this understanding.

Prioritising opportunities for team reflection & mutual support

> *I'm just reflecting on the time that I spend with my team and the conversations that we have. We do have spaces. . . to sort of connect . . . daily check ins and stuff, but they're very brief and they quite often do end up being very work focused. So, it just makes me think. . . are we actually creating a space where we can share and bring the extended whole parts of ourselves into our work? (Eden, MHPIe, Organisation B).*

Teams in which participants felt supported to share, prioritised opportunities for team reflection and mutual support. Participants spoke of the need for increased acceptance of looking after one's mental health, which was facilitated in workplaces where these discussions regularly took place. The *Dorset guidelines for staff sharing lived experience with*

managers and colleagues suggest managers support a "team culture of openness and talking about emotions" (Morgan & Lawson, 2015, p. 82). This culture may be supported by:

- **Regular opportunities to raise personal and work-related struggles impacting work**, such as morning 'check-ins' and group reflective supervision.
- **Team leaders modelling being 'vulnerable'** by talking about their own emotions (Morgan & Lawson, 2015).

As previously discussed, not all staff may feel comfortable sharing in a team situation but assuming a need for privacy relating to personal and work-related challenges may reduce opportunities for mutual emotional and practical support, increasing the burden on managers.

Addressing microaggressions in the workplace

> *If I'm somewhere that's not safe or if I have fear, then my lived experience is shameful, and it's something to be hidden, and something that I need to protect. And, if I'm somewhere where that is much more supported and open, and I don't have that fear and I have a sense of safety, then it's an asset and it's something that I'm proud of, and that I can bring forward and use.*
> *(Sasha, MHPIe, Organisation B).*

Participants in this research highlighted stigma beliefs expressed by colleagues and use of "black humour" as discouraging them from sharing their lived experience in the workplace. Of particular concern amongst many participants were attitudes expressed towards service users diagnosed with borderline personality disorder. These attitudes were often expressed when peer workers were not present but were also expressed in the presence of peer workers. As such, they could be defined as microaggressions: "…brief and commonplace daily verbal, behavioural or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative . . . slights and insults to the target person or group" (Sue, 2010, p. 5).

Team leaders and staff have a responsibility under the Occupational Health and Safety Act 2004 to support a safe work environment by:

- "Avoid[ing] usage of derogatory terms in reference to either the mental health status of consumers or staff, either advertently or inadvertently" (Welder & Salzer, 2016, p. 26).
- 'Calling out' negative attitudes expressed by colleagues towards service users in staff only spaces.

AREAS OF REFLECTION FOR INDIVIDUALS

The following recommendations are aimed at individual staff with and without lived experience recognising that is the responsibility of all staff to cultivate spaces for sharing. They are not intended to imply that staff with lived experience have an obligation to share their lived or living experience in the workplace.

Access to and use of reflective spaces

> *I think, it's about support to constantly navigate the intersection of self-growth and other support because. . . you're opening yourself up to constant growth, and constant renewal. So, support to manage that and manage all the feelings that are coming up in that space, creates safety. (Tanveer, MHPIe, Organisation B).*

Participants described the importance of spaces in which to reflect upon their lived experience, particularly its impact on their work and decisions to share with colleagues and service users. Reflection is a key feature of both professional (Dunlop et al., 2022; Morgan & Lawson, 2015) and peer support (Mead, Hilton, & Curtis, 2001) guidelines on sharing lived experience. It is recommended that staff with lived experience, including those in Lived Experience roles, seek out and make use of safe spaces available to them such as:

- **Individual supervision** with a trusted supervisor or manager
- **Group reflective supervision** with supportive colleagues
- **Lived Expertise co-reflection spaces** (that are open to professionals with lived experience)
- **Online peer mentoring spaces for mental health professionals with lived experience**
- **Online peer-to-peer support for health care professionals**

Organisations and their staff can support the safety of supervisory and team spaces through implementation of the above recommendations, or by releasing staff or providing time in lieu to access external spaces.

Negotiating one's own boundaries around sharing

> *As a [mental health professional], your drilled down to have boundaries, and it takes a long time to realise that these boundaries can't be prescribed. They are things that you develop your relationship with and your own practice competence and knowledge. (Tanveer, MHPIe, Organisation B)*

As well as support to reflect, participants in this research emphasised the need to negotiate one's own boundaries around sharing over time. Traditional notions of rigid professional boundaries may serve to restrict opportunities for reflection and support. Guidelines for professionals with lived experience suggest staff with lived experience should be supported to navigate these decisions for themselves: "For many, sharing is a personal decision with a set of options and choices to be made about to whom, where, when and at what level of detail to share" (Hogg & Kemp, 2020, p. 2).

Support for sharing lived experience in the workplace does not mean staff having no boundaries. Instead, it is about supporting staff, through training and reflective spaces, to critically reflect on their boundaries around sharing and how they serve (or don't serve) their engagement and wellbeing in the workplace.

‘Being a part of the culture you want’

> *I'm very good at being, well, [Organisation B]'s got to do this and then they've got to do this. . .. But. . . I can do some stuff, too. Like, I can talk to my team about what perceived support looks like. . . these little things that we can just start bringing day-to-day and have a little more ownership over rather than just pointing my finger at the structures and the systems. (Ione, MHPIe, Organisation B)*

The findings of this research highlight the role of not just employers and senior staff in supporting the sharing of lived experience. Enabling mental health services that are safe places to share lived and living experience demands that all staff take stock of their own contribution to cultures that silence sharing and consider the costs of these cultures to both staff and service users.

Conclusion

The sharing of lived experience by mental health professionals with colleagues and supervisors is complex and influenced by factors within and outside of the workplace. However, the findings of this research suggest practical ways in organisations, supervisors, teams, and individuals can support sharing. At the centre of these recommendations are shifts in longstanding beliefs about what it means to experience mental health challenges and what it means to be a professional. To harness the value staff with lived experience bring to the mental health workplace requires recognition of existing barriers to wellbeing and inclusion in the workplace. Addressing these barriers is within the power and interest of every staff member but will require the commitment of formal and informal leaders to achieve cultural change. If we succeed the benefits are wide ranging:

- Improved wellbeing and engagement of staff.
- Improved inclusion of staff with lived and living experience.
- Greater sharing of lived experience by staff in Lived Experience roles.
- Enhanced opportunities to share and learn from Lived Expertise.
- Increased opportunities for reflection, innovation and growth.

Ultimately, mental health services that value lived experience perspectives and support the wellbeing of staff are better equipped to respond to people seeking support.

Further reading and resources

Temple University Collaborative's guidelines for Creating welcoming mental health work environments:

CREATING WELCOMING MENTAL HEALTH WORK ENVIRONMENTS (tucollaborative.org)

http://tucollaborative.org/wp-content/uploads/2017/03/Creating-Welcoming-Mental-Health-Work-Environments.pdf

These guidelines were developed based research conducted with mental health professionals with lived experience by The Temple University Collaborative on Community Inclusion in the United States and include many practical recommendations for organisations.

Dorset guidelines for staff sharing lived experience with managers and colleagues:

Developing guidelines for sharing lived experience of staff in health and social care | Emerald Insight (https://www.emerald.com/insight/content/doi/10.1108/MHSI-01-2015-0001/full/html)

These guidelines were developed by staff involved in the *Hidden Talents* project, a project aimed at connecting and celebrating staff with lived experience within the Dorset NHS trust in the United Kingdom (UK).

Hand-n-Hand Peer Support

Home | Hand-n-Hand Peer Support (handnhand.org.au)

Hand-in-Hand (Helping Australian & New Zealand Nurses and Doctors) Peer Support were established during the COVID-19 pandemic to offer confidential online peer support to health care professionals. Whilst initially established to support doctors and nurses, they continue to grow and provide peer support to professionals of all disciplines working across the healthcare system through a collective of volunteer facilitators.

In2gr8mentalhealth CIC:

Valuing lived experience | Worldwide | in2gr8mentalhealth (https://www.in2gr8mentalhealth.com/)

In2gr8mentalhealth is a UK-based social enterprise operated by mental health professionals with lived experience. They offer training for mental health services, peer support and mentoring for mental health professionals with lived experience and are engaged in individual and systemic advocacy.

Sharing Lived Experiences Framework (NHS Leeds and York Partnership)

The Sharing Lived Experiences Framework (SLEF) was developed from research conducted in public mental health services in the UK and Australia and provides guidance on the sharing of lived experience with service users (Dunlop et al., 2022). The topic of sharing with service users is related to the sharing of lived experience with colleagues and supervisors but beyond the scope of this research. The framework is included in **Appendix 3**.

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Appendices

Appendix 1. Summary of factors supporting and not supporting sharing and their impact on sharing behaviour

Factors supporting revealing mental health challenges or identifying with lived experience								Factor influencing type of sharing		Outcome		
Organisational Support			Supervisor Support		Individual differences			Team culture		Type of sharing		
Supportive of…	…MHPIe	Acknowledgement of le[1] as an asset across the workforce, including opportunities to share and modelling of sharing by senior leadership	Encouraging of open sharing	Direct support and advocacy to explore and navigate lived and living experience individually and as a team.	" Being open"	Seeing sharing le in the workplace as fundamental to providing support to service users and supportive of personal and professional growth.		Psychological safety	Small and "close" teams in which explicit and ongoing efforts to cultivate sharing, include minimising hierarchies of power, having a higher proportion of designated LE roles, and positive responses to sharing.	Open sharing…	…of "living" experience	Sharing lived and living experience openly to support one's own wellbeing and to support others to share.
	…peer workers	Integration of a higher proportion of LE[2] roles with diverse functions across the organisation, including leadership roles.									…of "lived" experience	Sharing past experiences in response to invitations to share, to "speak up" for service users and to provide a le perspective.
Unsupportive of…	…MHPIe	Absence of acknowledgment of le across the workforce, except in relation to managing organisational risk, including lack of access to individual and group reflective spaces to navigate challenges.	Privately supportive	Supportive responses to sharing lived and living experience "behind closed doors."	" Being professional"	Seeing le as personal, shameful, irrelevant, inappropriate, or potentially discrediting information to share in the workplace, unless a risk to oneself or others, even in designated LE roles.			Teams in which formal and informal hierarchies of power and divisions between groups of staff are reinforced through "bullying" behaviour, defensive responses to sharing, and lack of individual responsibility.		Public identifying	Choosing not to share openly in the workplace, despite working (or having worked) in a designated LE role, due to past negative experiences with sharing openly or discrimination.
			Privately ambiguous	Lack of trust within supervisory relationship due to workplace instability, discomfort from supervisor or past experiences of discrimination.								
	…of peer workers	Poor understanding of LE expertise, as reflected in lack of leadership roles, discipline specific supervision/ co-reflection, fair remuneration and sole positions.	Privately unsupportive	Lack of accommodation or support offered for current mental health challenges, as providing support seen as "therapy."				Interpersonal fear		Private sharing	Public concealing	Being selective in what you share and with whom, for the purpose of seeking or providing support, whilst allowing one's le to be embodied rather than explicit in the wider workplace.

[1] personal lived experience of mental health challenges; [2] Lived Experience as a discipline of staff in designated roles

Appendix 2. Interview participant suggestions for cultivating the conditions and promoting the practice of sharing lived experience in the workplace

		Valuing lived experience across the workforce	*Valuing the Lived Experience workforce*	*Creating an inclusive workplace*	*Supporting staff wellbeing & living experience*	*Creating a psychologically safe workplace*	*Promoting the practice of sharing lived experience in the workplace*
Level of responsibility	Organisational	- Whole-of-workforce training on le & reflecting on our own "struggles" (incl. senior leadership)**** - Acknowledging le across the workforce* - Responding to feedback from staff*	- ↑ LE roles throughout the organization at all levels** - Equal pay & access to training for similar duties** - Whole-of-workforce training on LE & peer work* - Senior leadership support* - Responding to feedback from peer workers	- Improving consistency in supervisor communication & support* - Addressing "corporate" culture in head office - Supporting workers to be at work & stay in their role	- Providing increased job security - MHPle support person	N/A	- Whole-of-workforce training re: sharing******** - Training for MHPle re: sharing** - "Messaging" from senior leadership** - Supervisor training re: responding to sharing* - Advertising campaign - Providing opportunities to share - le register for opportunities to contribute - Reviewing policies and procedures re: sharing
	Team		- Equally valuing colleagues in LE roles	- Reflecting on how experiences as MHPs influence perspective - Being mindful of unknown le in conversations - Reflecting on language use	- Prioritising opportunities for team building & mutual support*** - Acceptance of looking after one's mental health** - Navigating challenges together**	- Listening to & hearing colleagues without judgement ***** - Being comfortable not knowing & asking questions* - Engaging with colleagues from other disciplines	- Understanding the purpose of sharing** - Respecting individuals' choice to share or not share** - Responding positively to colleagues' sharing - Negotiating boundaries of sharing
	Supervisor		- Acknowledging the living experience of peer workers - Acknowledging the emotional impact of peer work	- "Showing" & "speaking what your feeling"	- Prioritising staff wellbeing****** - Being available & checking-in with staff*** - Recognising effort* - "Gestures of support"	- Critical reflection supervision	- Supervisors sharing le - Supporting MHPle to access training opportunities re: sharing
	Individual	- Accessing reflective spaces for MHPle*		- "Showing" & "speaking what your feeling"**	- Reflecting on and taking responsibility for my own wellbeing	- Peer reflection & group supervision	- Leaders in non-designated roles modelling sharing**** - Negotiating my own boundaries around sharing** - Reflecting on professional norms and their impact

[1] personal lived experience of mental health challenges; [2] Lived Experience as a discipline of staff in designated roles.

Appendix 3. Sharing Lived Experiences Framework (included with the permission of the authors).