The contribution of the mental health support worker to the mental health services in New Zealand – An Appreciative Inquiry approach.

Julia Hennessy

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School of Healthcare Practice

Primary Supervisor: Professor Liz Smythe

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Juliette Allport provided a professional proof reading service.

Signed:

Dated: 6th November 2015

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ABSTRACT

The discipline of mental health support work in New Zealand now comprises a sizeable and significant part of the total mental health workforce. This study explores the contribution of mental health support workers taking an Appreciative Inquiry approach. It examines how mental health support workers add value to the quality of mental health services by asking "what is working well?" It examines possibilities for the role of a mental health support worker and discusses what it is that they do that is different from other health professionals in the mental health sector.

The use of an Appreciative Inquiry framework throughout this study resonates with the underpinning philosophy for mental health services in New Zealand. This study acknowledges the Shadow within Appreciative Inquiry and uses this as a positive transformational force.

The study of mental health support work remains relatively undeveloped. The findings from this study recognise the contribution being made by this group of health workers, highlighting what is working well and what could be different while examining the nature of relationships between mental health support workers, mental health consumers and other key stakeholders. This study also informs discussion around the regulation/professionalism of the support worker's role and future workforce development. Mental health support workers, in this study, sought to be part of aspirational service developments.

Mental health support workers desired to be regarded as health professionals and to have their input into consumer care sought by other members of the treating team. They saw the need to develop a self-regulating framework that would see them being viewed as health professionals. Through this recognition and valuing of the mental health support worker role they believe they have an important part to play in enhancing the consumer experience.

The role of the mental health support worker is different and complementary to the roles of other professionals working in mental health services. Mental health support workers

facilitate the consumer's journey of recovery. They are able to spend time with mental health consumers and not have those interactions restricted through legislation. Mental health support workers provide the human contact sought by mental health consumers because their role is seen as non-clinical and non-judgemental. They create space in the life of the consumer that enables hope for recovery to be the consumer's aspirational future. Managers, educators and other health professionals require an understanding about what it is that mental health support workers bring to the relationship that they have with consumers and how that knowledge can assist other health professionals.

CHAPTER ONE: INTRODUCTION TO THE STUDY

I like the dreams of the future better than the history of the past. Thomas Jefferson

INTRODUCTION

This study examines the contribution of mental health support workers to the New Zealand mental health services using an Appreciative Inquiry (AI) approach. The research question asks "What is working well with mental health support work in New Zealand?" This chapter provides the context for the study and explores the historical background of mental health services in New Zealand. Specific focus is given to how the mental health support worker emerged and evolved within the history of mental health services; the mental health policy development; and the subsequent development of the mental health workforce. The study aims to reveal the significance of the work that mental health support workers undertake and recommends the potential of this role to the future fabric of mental health services in New Zealand.

As this study evolved and the stories were told what became clear is that the information provided by the participants went beyond the initial research question. Tensions were identified that exist within mental health support work, including the perceived lack of recognition and understanding about the work they do, and their tensions with other health professionals. These tensions, along with the strategies towards change that arose from participants, are explored and discussed in Chapters Seven to Twelve.

Mental health support work has been defined "as a non-clinical role, the aim of which is to carry out supportive work with people who are or have been experiencing mental illness or disability" (Sutcliffe, 2006, p. 1). This study is not only important to me personally but also to the mental health consumers who have services provided by mental health support workers. The quote of Thomas Jefferson at the beginning of this chapter has a purpose; it reminds us that our history is important in enabling us to create a better future based on what we know of the past. It is within this historical backdrop of policy, service and workforce development that the contribution of mental health support workers voices will

be heard. My own involvement in some of these developments, which are now part of history, will also be told.

THE PURPOSE OF THE STUDY

Mental health support workers had their role recognised in New Zealand in 1998 with the introduction of a national qualification. As stated by the Mental Health Commission, New Zealand "creating a new support-work occupational grouping has been a great workforce achievement of the decade, and a specific New Zealand innovation" (Mental Health Commission, 2007, p. 115). This innovation within the workforce and its contribution was extensively recognised in the report *Te Haereranga mo te Whakaōranga 1996-2006* (Mental Health Commission, 2007). This report recognises the newness of the mental health support worker and the need for this new occupational grouping to understand its importance for the future of mental health services. However, many of the future propositions for mental health support workers contained in the report remain just that – future focused.

My role in this study provided me with the opportunity and privilege of hearing stories relating to mental health support workers and provided a way in which those stories could be heard including from the perspectives of mental health consumers, those that work with mental health support workers and mental health support workers themselves. Listening to and contemplating the stories that were told to me provides a generativity that in AI terms is "an outcome of an effective AI process and the means to creating positive change" (Bushe, 2012b, p. 49).

An appreciative approach was chosen as it allowed a positive way to understand the world of the mental health support worker. Information was generously and willingly provided through a number of sources including mental health support workers, mental health peer support workers, educators, managers that employ mental health support workers and other health professionals who work with mental health support workers. The methodology and method used for this study are more fully discussed in Chapters Five and Six.

The methodology for the study is significantly different from that which most people working in mental health services have generally experienced; indeed "mental health services have historically endured a culture of blame" (Hennessy & Hughes, 2014, p. 36). I sought to hear the stories and have participants celebrate what was working well and to describe how things could be even better. This provided a challenge for the participants, as this study required them to shift their thinking from the usual focus on problems to focus to on celebration and solutions. For this study, 34 people throughout New Zealand were interviewed. Participants were provided with options as to how they would prefer to be interviewed (that is in a group, one-to-one or as part of a paired interview). In total, there were four group interviews, 13 individual interviews and one paired interview. Of the 34 participants seven were from the Wellington region, 22 from Auckland and five from Invercargill in other words, spread throughout the county.

The application of AI provided an inclusive way of gathering the data through hearing and interpreting the stories of the participants. These data were then viewed through an appreciative lens (this being fundamental to the 4-D cycle) in order to illuminate and interpret the data. This adaptation of the AI cycle protected the integrity of the data while ensuring that the stories were heard.

THE APPRECIATIVE CYCLE

The 4 D stages of the appreciative cycle are described provide the framework for analysing the emerging ideas that are further discussed in Chapters Seven to Eleven. The model in Figure 1 is the traditional four phases of the AI cycle.

This study is important as it provides an agenda for change; it recognises what it is that mental health support workers do within their scope of practice, the vulnerable populations they work with, their interactions with other mental health services and their place within the tapestry of mental health services throughout New Zealand. From these insights it presents a design that articulates how the dreams voiced in the study could be translated to reality.

Figure 1: The 4-D cycle
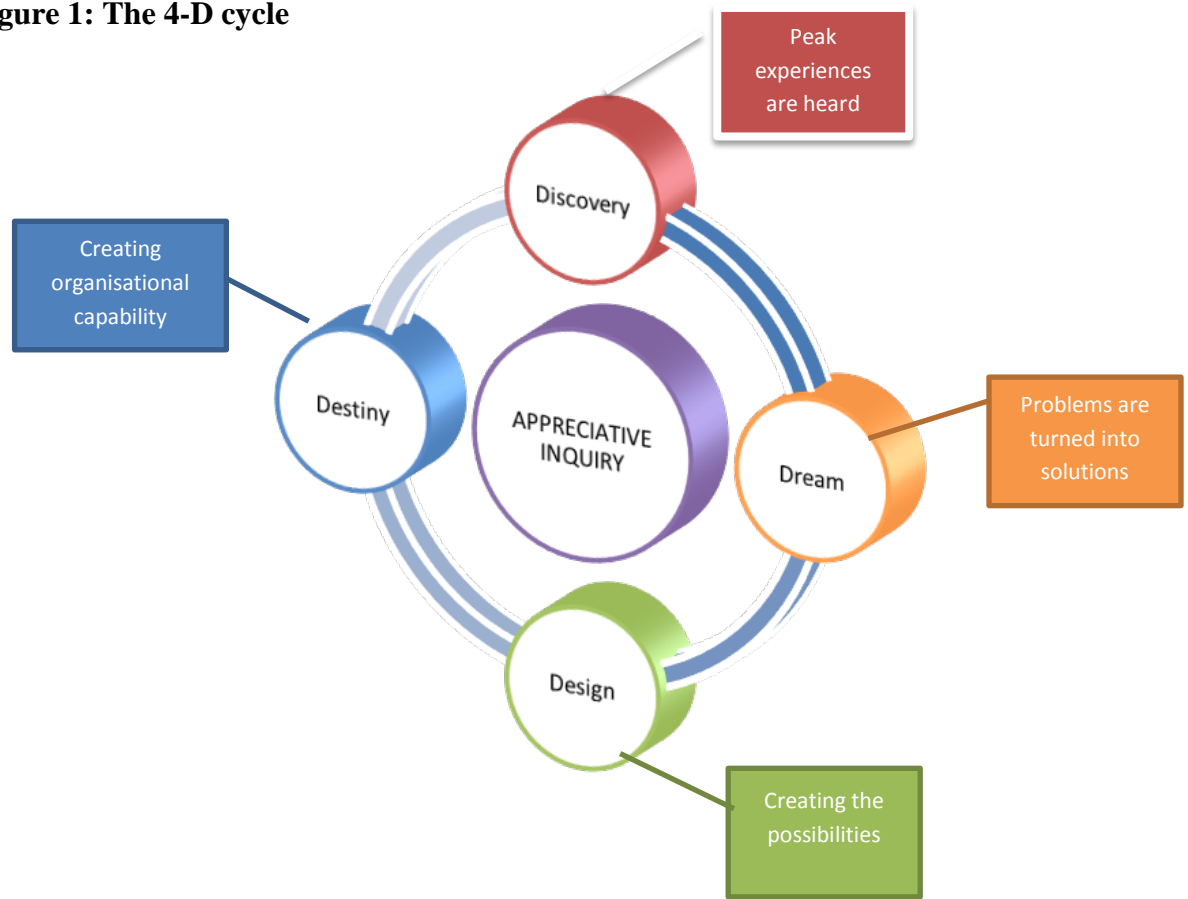
When translating research methodology into AI terminology, Cram (2010) and Whitney and Trosten-Bloom (2010) suggest that the first stage is the Discovery stage (usually referred to as the stage of initial inquiry). The next stage is the part of the research that provides the opportunity for participants to dream about what could be (Dream phase), the third stage is the Design phase, which enables participants to visualise or articulate the future and the action for what will change. The Destiny phase completes the cycle.

DISCOVERY PHASE

The Discovery phase of AI assumes that:

- All people have unique gifts – AI interviews are structured so that they can tell interviewers about those gifts.

- Organisations are human social systems – AI uses language and interviews to explore the human aspect rather than using observations. Participants have an environment created that encourages them to tell the "best of stories as this can

change the behaviour of others" (Bushe, 2001, p. 93). "Words create worlds" (Cooperrider, Barrett, & Srivastva, 1995, p. 163).

- The future is a result of our social relationships – AI interviews explore social relationships and focus on the generative aspects of these.

- Communication in interviews is used to shift attention away from problems and to focus on ideals and possibilities.

- Questioning should be positive and assume that people already have the answers.

The Discovery phase operates from a positive model, giving participants permission to reflect and receive acknowledgement for the best of what is already happening, together with providing the opportunity to create their own realities and future. As Bushe (2011) argues, the post-modern social constructionism of AI questions is intended to 'create' what is there, in contrast to traditional research methods, which are intended to uncover what is there.

A basic constructionist assumption of AI is that organisations are made and imagined and can therefore, can be remade and re-imagined (Cooperrider et al., 1995). The construction of the questions that guide the process of re-imagining is crucial (Bushe, 2011) as the language used shapes the whole process (Barrett & Fry, 2005). As the constructionist view of changes claims that all questions lead to change, the inquirer (interviewer) must make sure that the changes that the questions generate lead to conversations about positive future relationships and do not simply reinforce existing unhealthy relationships and hierarchies (Cooperrider & Whitney, 2005). Cooperrider and Whitney (2005) argue that not only are positive questions essential, but the more positive the question the greater and longer-lasting the change.

DREAM PHASE

The Dream phase is about creating a clear results-oriented vision in relation to discovered potential and to questions of higher purpose, such as 'What is the world calling us to become?' The dream aspect of analysis is the positive spin for turning issues and problems into innovative solutions. This is the aspirational phase or "preferred future" (Cockell & McArthur-Blair, 2012, p. 22). This phase of the 4-D cycle is intended to push the

boundaries to provide the fertile imagery for the next two phases. Sandu (2011) suggests that this phase is about creating a vision of the future based on experiences. These experiences are informed by historical and new understandings. This phase affords the opportunities discussed in the Discovery phase and allows the dreams, hopes and aspirations discovered within the stories to be articulated into the desired aspirational future.

The data were analysed to reveal the 'if only…..'. The dreams were of a personal nature rather than organisational; with many of the participants centring on personal rather than organisation-focused dreams.

DESIGN PHASE

The Design phase takes stories of the dreamt future and constructs these by utilising "provocative propositions" (Reed, 2007, p. 33). This phase presents "a clear compelling picture of how things will be when the positive core is fully effective" (Van-Vuuren & Crous, 2005, p. 405) and takes a more organisational view.

DESTINY PHASE

The Destiny phase is about strengthening the affirmative capability of the whole system, enabling it to build hope and sustain momentum for on-going positive change and high performance. The end goal of this study is to inform policy, education and service providers as to the strengths afforded by mental health support workers, and the innovative possibilities of the future.

Cooperrider (1986) initially identified five principles in his original work. He and others have further developed and expanded the original principles from five to eight.

THE INITIAL FIVE PRINCIPLES

Cooperrider (1986) initially identified five principles in his original work. He and others have further developed this and expanded the original principles from five to eight.

1. **The Constructive Principle**: the narrative or story of the participant is told and shaped by their experiences.
2. **The Principle of Simultaneity**: Inquiry and change are not separate moments.
3. **The Poetic Principle:** virtually any topic of human experience can be studied.
4. **The Anticipatory Principle**: relates to the ability to vision the future.
5. **The Positive Principle**: hope, excitement, inspiration, caring camaraderie, sense of urgent purpose and sheer joy of creating something meaningful (Cooperrider & Whitney, 2008).

The additional three principles are:

6. **The Wholeness Principle**: suggests that insight comes about when the total story(s) is told and heard and is not made up from one singular account.
7. **The Enactment Principle:** futures are visioned by the transformation of the current.
8. **The Free-Choice Principle:** people choose to contribute based on their urge for fulfilment (Whitney & Trosten-Bloom, 2010).

These eight principles are derived from "three generalized streams of thought – social constructionism, image theory, and grounded theory" (Whitney & Trosten-Bloom, 2010, p. 49). These principles are woven throughout this research.

WHAT STATISTICS TELL US ABOUT THE PREVALENCE OF MENTAL HEALTH ISSUES IN NEW ZEALAND

The World Health Organisation suggests that

> The worldwide, community-based epidemiological studies have estimated that lifetime prevalence rates of mental disorders in adults are 12.2–48.6%, and 12-month prevalence rates are 8.4–29.1%. 14% of the global burden of disease, measured in disability-adjusted life years (DALYs), can be attributed to MNS[1] disorders. About 30% of the total burden of non-communicable diseases is due to these disorders (World Health Organisation, 2008, p. 6)

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[1] mental health, neurological, and substance use

While it is estimated that 3% of the population experiences severe mental illness, it is also estimated that a further 17% have a mild-to-moderate mental disorder. A study undertaken by Oakley-Browne, Wells, and Scott (2006) estimated the 6 month, 12 month and lifetime prevalence of mental illness in the New Zealand population. This study showed "how common it is for New Zealanders to experience mental disorder: 39.5% reported sufficient symptoms to meet criteria for at least one disorder at some time in their lives. The 12-month prevalence of any disorder was 20.7%" (Oakley-Browne et al., 2006, p. 26). Their study showed that the prevalence of mental disorders amongst Māori was double that of non-Māori, only eclipsed by Pasifika people whose prevalence of mental disorders were quadruple that for the whole of population sample. When the data were adjusted for age and socioeconomic status, the researchers found that "much of this burden appears to be because of the youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage" (Oakley-Browne et al., 2006, p. 5). This validates an earlier Christchurch study by Oakley-Browne, Joyce, Wells, Bushnell, and Hornblow (1989) that found that 20% of the population have a diagnosable mental illness with 3% having a serious on-going and disabling mental illness requiring treatment from a specialist service. The Ministry of Health (1999) estimated the prevalence of mental health problems in the New Zealand population.

Figure 2: Estimated prevalence of mental health problems amongst New Zealanders

Figure 1: Estimated prevalence of mental health problems amongst adult New Zealanders

Percentage of New Zealanders............ As a percentage of the adult population

.06% of adult New Zealanders have high support needs — .06%

about 3% of adult New Zealanders have severe mental health disorders — 3%

another 5% of adult New Zealanders have moderate/severe mental health disorders — 8%

another 12% of adult New Zealanders have mild/moderate mental health problems or disorders — 20%

General adult population — 100%

Figure 2 provides that estimation suggesting that while 3% of the population are considered to have a severe mental illness, another 17% are considered to have moderate to mild mental health problems.

DEFINING A MENTAL HEALTH SUPPORT WORKER

In defining a mental health support worker and taking into consideration the expansiveness of their role it is evident that there is no one accepted definition of the role and no shared understanding of the work they undertake. Annadale and Instone (2004) described mental health support workers as being "developed to support consumers in the community, identify their support needs, co-ordinate consumers' care and assist clinicians with treating and assessing consumers" (p. 16). This definition is supported by Lui (2000). DeSouza (2003) suggests that mental health support workers have filled a gap in the provision of care in the community. Case Consulting (2003) defined mental health support workers as being "most commonly employed by non-governmental organisations (NGOs) who deliver services such as residential accommodation based support, home-based and mobile community support, respite and education, recreational, and employment support services/programmes" (p. 1). Clearly there is no universally agreed and accepted definition of a mental health support worker.

The first national qualification for mental health support workers was developed in 1998. This provided mental health support workers with the means for educational preparation for employment into community mental health services, i.e. residential or home-based services. Those employment patterns have changed over time with more mental health support workers now employed in 'clinical' inpatient services, both acute and long term. The Health and Disability Commissioner's website defines a mental health support worker's role as being there to "support people to take an active role in their recovery and offer a listening ear, advice and practical assistance. They are usually based in community services" (Health and Disability Commissioner, 2014).

EARLY EXPOSURE

My early exposure to mental health services was when I lived in Titahi Bay, Wellington for nine months. At that time the nearest town was Porirua. This suburb of Wellington was built around one of the largest psychiatric hospitals in New Zealand. As a child I would travel on the train into Wellington and see a tall formidable building perched on the hill. My childlike imagination ran wild I had images of people chained to walls of this building. I was later to become familiar with this building as it was in fact the female nurses home. I returned to Wellington many years later as part of the first cohort of nurses to be educated in the tertiary education system and was known as a 'polytechnic-educated nurse', whereas my hospital trained nurses counterparts were known as 'hospital-based trained nurses'.

As a very young 18 year old I was allocated a clinical placement in one of the male acute psychiatric admitting wards the only female student nurse on the ward. It was within this environment that I met my husband a newly graduated psychiatric nurse. When I graduated I decided to apply for a staff nurse position at Porirua Hospital. I had two reasons for this: the first was that I found my student placements there to be stimulating, in that no one day was the same and the second reason was that my husband continued to be employed at Porirua Hospital. My goal was to stay for one year and then apply to work in the surgical wards at Keneperu Hospital, also located in the city of Porirua. I was provided with the tools of the trade my uniform and keys then sent to work in the female secure ward, which I suspect was punishment for being one of those polytechnic trained nurses. I worked at Porirua Hospital for 11 years both in the inpatient setting and the community. It was hard work very rewarding at times. Despite negative views of the care provided, in the psychogeriatric wards I never saw a decubitus ulcer (pressure area). Young men with serious head injuries were sent to Porirua Hospital and expected to languish in wards with elderly demented men. Instead we were able to rehabilitate these men and most of them returned to the community to live independently; they just needed time, patience and support. The clinical experience and exposure ranged from addictions, acute mental illness, rehabilitation, psychogeriatrics, intellectual disability, community and the area known today as forensics.

When Parumoana Community Polytechnic, now known as Whitireia Community Polytechnic, sought a nurse with mental health experience to develop and deliver their mental health part of the nursing programme, I applied and was appointed. This was the mid-1980s and mental health was still predominately an inpatient service. I stayed in the education environment from 1984 until 1995 when I moved to the Central Regional Health Funding Authority (CRHA).

My role with the CRHA was to manage relationships with secondary mental health services in the central region, manage the deinstitutionalisation of Porirua Hospital and Ngawhetu Hospital in Nelson and decommission the national secure unit in Marton, as well as contract for new services that were being developed as a result of targeted funding from a number of Inquiries in the 1980s and 1990s. It was during my tenure with the CRHA that the development of mental health support workers became a dominant feature of the new model of mental health service delivery.

When I commenced employment at the CRHA, in 1995, it was evident to me and others that the delivery model for services was changing but that workforce development had not kept pace with the changes. The focus remained on the traditional health professionals, doctors, nurses, social workers and occupational therapists; however the model of care had changed from inpatient care to residential care, day care and home-based support.

I am proud to be part of the history. I recall being asked to attend a meeting being held between the four Regional Health Authorities, the Ministry of Health and the Mental Health Commission to put forward my thoughts on what was required by way of a workforce to meet the new model of delivery. My main focus was on the need to have a trained workforce that was not a replication of the existing workforce but would rather meet the needs of the changing environment. It was agreed that a project with an accompanying budget would be made available and I would represent the four Regional Health Authorities on a working group that would include the Mental Health Commission and the Ministry of Health to develop a training programme for the new group of health workers working in the community as part of the mental health service development.

In just one year, the group had consulted with the community, gathered information on the skill set required, and developed the first national qualification for community mental health support workers. The curriculum was consulted on, written and placed on the New Zealand Qualifications Framework. This brings me to the reason I undertook this study. The development of the first national qualification for mental health support workers was required to be undertaken within a very tight timeframe. The reason for this speed was that there were now large numbers of mental health consumers throughout New Zealand who were having their care provided by people who had no formal qualifications in this field. Furthermore the government of the day had invested substantial funding into the development of community mental health services and wanted to see a return on that investment.

The contribution to mental health services by support workers is therefore an interest I have had for a number of years. Undertaking this research has enabled me to focus on what that contribution has been, how this group of health workers has improved services for mental health consumers and how this workforce has evolved over the years. My interest in the area of the mental health support work also relates to my own work within the mental health field. My clinical practice and education background has influenced the roles I have played in the development of the National Certificate in Mental Health (Mental Health Support Work). In my view, the role of the support worker was designed and developed to fill an identified gap when the model for mental health service significantly changed. The intention for the development of a national certificate for support work was to ensure that there were workers in mental health who had skills that complemented and enhanced the skills of the existing health professionals there was never the intention that one group of workers would replace the other. I am fortunate that two of my supervisors are also active in the evolution of the mental health support workers and I have been privileged to have worked alongside people that have shared a vision to ensure better mental health services.

OVERVIEW OF THIS THESIS

This study examines the world of mental health support work through an appreciative prism and uses the AI framework.

Chapter One: provides the background and the context for this study. It looks at the purpose, examines some of the statistics and provides the documented definition of a mental health support worker.

Chapter Two: offers the historical and policy environment leading to deinstitutionalisation of mental health service in New Zealand. The consequences of these policy changes are also discussed.

Chapter Three: provides the context for the educational preparation and employment of mental health support workers as well as discussing the framework for the development of the qualification framework in New Zealand.

Chapter Four: a literature review examines the relevant literature related to mental health support work alongside other similar roles in the health and social service sector.

Chapter Five: introduces the methodology used for this study and how this aligns with the philosophies that define the developments of mental health services at the time this study was undertaken. This chapter links AI with the related philosophies that underpin AI.

Chapter Six: sets out the plan of inquiry and includes ethical responsibilities, recruitment and selection of participants, collection and management of data and interpretation of the data.

Chapter Seven: describes the Discovery phase of the 4-D cycle where the best of what is and has been is heard. The stories by and about mental health support workers are heard through an appreciative prism.

Chapter Eight: introduces the concept of the Shadow which exists within AI. The Shadow is examined as transformational and renamed a Dissonance within the Discovery phase.

Chapter Nine: takes the stories heard in the Discovery phase and transforms them into the Dream. The Dream phase is described as the phase where the discovered potentials are heard.

Chapter Ten: applies the Design phase in which the Dream for the future is constructed. The areas under examination are an educational pathway, professionalism, role clarity, remuneration and being part of the health team.

Chapter Eleven: gathers together the findings from the other three phases and puts in place a framework to build the sustainable future for mental health support work in New Zealand. In keeping with the 4-D cycle this chapter provides what is traditionally referred to as the recommendations of this study. The Destiny phase is used to build the sustainable future for mental health support work and the workers within this discipline.

Chapter Twelve: provides the discussion, areas for further inquiry and the limitation of this study.

SUMMARY

In undertaking this study, I have been able to hear stories told of the contributions of the mental health support worker. I have then taken those stories, which have previously remained silent, and lifted them up to view through an appreciative prism.

The importance of this study is not to be underestimated. Support workers are now providing autonomous services in the community as well as more directed care in hospital settings. The growth of this healthcare group is significant as a result of the move from predominately hospital treatment and care to community based services. The literature relating to this healthcare group is limited however, this study will provide the opportunity for a greater understanding of the mental health support worker role and how it has evolved over the years. Further, it will bring the insights from participants to point the way to the future.

CHAPTER TWO: HISTORY AND CONSEQUENCE OF DEINSTITUTIONALISATION OF MENTAL HEALTH SERVICES IN NEW ZEALAND

Nobody asked what came after hospital for one simple reason – almost nobody left the hospital (Fuller-Torrey, 1983, p. 132)

INTRODUCTION

Chapter One provided the context for this study; this chapter offers the historical and policy environment leading to deinstitutionalisation of mental health services in New Zealand. Within the historical, policy and legislative environment is the emergence of the non-government organisations (NGO) sector resulting from policy changes that saw increased activity within the deinstitutionalisation policy.

This chapter:

- Defines a mental health support worker

- Provides an historical overview of mental health services prior to the 1950s

- Outlines the influencing health policies from the 1970s together with the evolving health environment, and the influence that these had on the mental health sector

- Provides a context and influences on mental health services post 1950s

- Explores the workforce developments that were influential in the emerging role of and qualification for mental health support workers.

MENTAL HEALTH SUPPORT WORKER

The term mental health support worker is a relatively recent introduction into the health workforce.

The Mental Health Foundation described the mental health support workers as:

> …non-clinicians who work with people with mental illness. The mental health support workforce is mainly employed in the non-government community support services sector. They provide support and practical assistance and deliver rehabilitation services or programmes that facilitate the recovery process for people

experiencing serious mental illness or emotional distress (Mental Health Foundation, n.d)

Mental health community support workers are also considered part of the workforce that assists mental health consumers with the transition from residential or hospital services to independent community living settings. Mental health support workers are usually based within NGOs, but they are also employed in acute or rehabilitation settings within district health boards. When first developed the purpose of the national qualification for mental health support workers was to educationally prepare mental health support workers for employment into community mental health services, i.e. residential or home-based services. However the trend of employing mental health support workers into other areas such as acute and rehabilitation services has continued.

DeSouza (1997) suggests that the role of the mental health support worker had evolved "in recognition of the gaps in community care provision" (p. 3). The Mental Health Commission funded The Report on the Labour Market Constraints Affecting the Mental Health Sector (2004). Although this report focused mainly on the clinical workforce it did acknowledge that "there is a dearth of data about the non-professional workers in the mental health workforce" (Mental Health Commission, 2004a, p. 43). The Ministry of Health (1997) identified the need to have a workforce that was educated in a nationally consistent way with transferrable qualifications in its policy document *Moving Forward*. The Mental Health Commission (1998) recognised the need to invest in training for support workers, as they saw many organisations resorting to using untrained staff to deliver the increased volume of services being funded. The Mental Health Commission also identified that there were insufficient qualified support workers to deliver the increased services.

It had been estimated by the Mental Health Commission that 5,000 mental health support workers would be required to deliver services under the new service reconfiguration. This information was based on the ratios set out in the Mental Health Commission's Blueprint 1998 (Mental Health Commission, 1998). The Commission set a ratio of 30.5 full-time equivalent positions per 100,000 head of population (Mental Health Commission, 1998, p. 41). During a consultation meeting for the development of the mental health support worker

qualification, the Consumer Advisor for Wairarapa District Heath Board, in 1997, voiced her concern that the introduction of a national qualification would make the role unobtainable for many people as they would not be able to meet the educational requirements. She referred to the people undertaking mental health support worker roles as 'salt of the earth' and feared they would be lost to services if a formal qualification were to be introduced. The dialogue for these consultations has been lost as a result of the continued evolution of health and education services. This discussion relating to entry into the profession will be examined in more detail in Chapter Nine.

MENTAL HEALTH ENVIRONMENT PRIOR TO THE 1950S

The delivery of mental health services in New Zealand came with colonisation and reflected the practices of the 'home' countries. Pre-formal diagnosis and treatments for the mentally ill would have, through necessity, been provided by family and other untrained helpers from within the community. In New Zealand in the 1840s, undesirables were sent to 'goal'[2], with mental illness being seen as a law and order problem rather than a health issue (Williams, 1987). This thinking changed over time and the concept of the asylums evolved (Smith, 1991). Legislation in the form of the Lunatics Ordinance Act 1846 was introduced in order to provide a legislative framework for the establishment of such asylums.

Branton (1985) described five characteristics of these asylums:
- They were located on the outskirts of towns
- They were spacious to avoid the appearance of restraint and were therefore self-sufficient as a result of the establishment of a farm on the property
- Treatment was described as orderly and the staff provided a model of moral behaviour; mechanical restraints were replaced with padded cells
- Under the Lunatics Act (1846), any person certified could be admitted to goal, a house of correction, a public hospital or a public colonial asylum
- The average size of the asylum ranged from 47 to 238 'patients'.

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[2] Prison/jail

By 1876, the Lunacy Department had been formed. By-laws allowed local hospitals and charitable services to 'offload' their high-risk liabilities that had presented as medical problems, e.g. psychogeriatric individuals, intellectually disabled individuals, those with 'general paralysis of the insane', epileptics and alcoholics. Economic pressure also saw the committal of poor relatives, especially those who had no one to care for them (e.g. aging bachelors). The presenting profile for admissions, which up to this time had been acute, was changing; chronically mentally ill people with long-term problems were now being admitted to psychiatric hospitals. Williams (1987) implies that the historical evolutionary developments of mental health services has been driven by economic ideology rather than being treatment-based descisions; and suggests that the mood of the public, by the 1900s, was changing from sympathy to suspicion in the way that people with mental illness were viewed. As numbers of admissions into asylums increased, conditions became overcrowded. The hospitals grew in size and were frequently located in more rural areas. The idea of de-institutionalisation was unheard of prior to the mid-1950s.

HEALTH ENVIRONMENT FROM THE 1970S

Ashton (2001) suggests the health sector overall experienced relative stability for the 50 years leading up to the health reforms of the 1990s. Up until the 1990s New Zealand was considered relatively prosperous, with farming exports providing the main wealth for the country. The period 1975-1984, under the newly-elected National government, saw the establishment of Area Health Boards, under the Area Health Board Act (1984). This Act provided the legislation that replaced the existing hospital boards. An anomaly within the legislation did not make it mandatory for any region to adopt the Area Health Board model. Instead, the National government took the approach of seeking to pilot this new model prior to its implementation across the country. The pilot areas chosen were the Northland and Wellington regions. One of the aims for the new structure was to amalgamate existing hospital boards and to integrate their functions with some of the functions of the Department of Health (Gauld, 2001).

With these legislative changes came policy changes and reforms, including those that influenced the philosophical underpinning of the model of care for people accessing mental health services. Ashton (2001) suggests that these health reforms were driven by a desire to

improve public access to health services and improve efficiencies. Morgan and Simmons (2009) suggest that there was a third agenda, that of privatisation of the health system. While market reforms are generally associated with a National government, it was a Labour government that delivered some of the most sweeping reforms to the New Zealand health system. "Labour's machinery of government changes was the separation of the provision of policy advice from the provision of services" (Boston, 1991, p. 258).

A taskforce was convened in 1988 and chaired by businessman Alan Gibbs. This taskforce produced a report, *Unshackling the Hospitals: Report of the Hospitals and Related Services Taskforce* (Gibbs, Fraser, & Scott, 1988*).* This report was not widely available as discussed by Gauld (2001), due to the content being considered "politically untenable" (p. 60). However, the underpinning message in this report and in the subsequent and influential Arthur Anderson Report (commissioned by the taskforce) focused on the fiscal issues of health spending and suggested that there were "huge gains in terms of resources available for re-allocation or for other services in the hospital sector" (Gibbs et al., 1988, p. 13). The report suggested that the savings to be made in health could be equal to the expenditure of the police or tertiary education sector and that the savings could even be "more than the value of our greasy wool exports" (Gibbs et al., 1988, p. 13). The report also stated that "since 1977 hospital boards have been encouraged to develop good community and day care facilities in order to replace their heavy reliance on in-patient care" (Gibbs et al., 1988, p. 15). This document provided focused criticism of the public health service and in particular on lack of productivity, lack of fiscal controls and lack of quality and monitoring. These criticisms were then used to provide a contrast between the private and public health sectors, suggesting that the private sector was able to meet the requirements that were lacking in the public sector. The architects of the report failed to have a full comprehension of the complexities and public good responsibilities inherent within the public health system. One of the significant differences between the public and private health services is that there is a substantial cost for providing education, training and emergency treatment and care, which are only found within the public health system. Many of the medical, nursing and allied health staff employed in the private health system, have trained within the public health system.

By 1990, a National government had returned to power and health policies continued to be a major focus, with Treasury raising concerns about the structures within health. In particular, Treasury viewed the Area Health Board model as fraught primarily because the boards were both funder and provider, making gains and competition difficult to achieve. A Ministerial Taskforce on Funding and Provision of Health Services was set up under the chairmanship of Rodrick Carr, a banker. The recommendations from the taskforce were launched on budget night July 1991 in the form of a green and white paper *Your Health & the Public Health* (Upton, 1991). The aims for health reforms set out in the paper, were to increase efficiency of health provision through the strengthening of competitive internal markets and to apply commercial incentives to strengthen management in the public health sector (Ashton, Beasley, Alley, & Taylor, 1991; Borren & Maynard, 1994; Boston, 1991). Another aim was to "widen the choice of hospital and health services for 'consumers'" (Gauld, 2001, p. 82).

In 1993, four Regional Health Authorities were established under the Health and Disability Services Act (1993). This Act saw the introduction of a provider/funder split in the health environment and introduced competitive contracting. Section 10 of the Act set out the responsibilities of the Regional Health Authorities and required a funding agreement to be established between the Minister of Health and the Regional Health Authorities. Up until this time, funding had been the exclusive domain of the Ministry of Health. This funding agreement also gave the Regional Health Authorities direct access to the Minister of Health and the role of the Ministry of Health changed to primarily providing health policy advice to the Minister of Health.

The Regional Health Authorities were given the task to "achieve the best health gain for their region within resources available" (Minister of Health, 1996, p. 11). The consequences of the funder/provider split on mental health services are acknowledged as being the catalysts for creating positive change within the mental health and disability sectors. This was in part due to the competitive funding model but also as a result of the inquiries into mental health services which uncovered inadequacies including the lack of funding. The policy and service changes resulting from the inquiries are discussed in the

section, 'A critical lens is applied to mental health services'. Another advantage was that mental health services were split from other health services and gained directed 'ring-fenced' funding and reporting.

MENTAL HEALTH POLICY AND ENVIRONMENT POST 1950S

Mental health policy and service developments need to be considered within the wider health environment, as it is these broader health policies that prompted significant changes in how mental health services would be delivered.

Up until 1962 mental hospitals were managed by the Department of Health; this responsibility was then transferred to Area Health Boards. The third term Labour government (1972-1975) undertook a comprehensive review of the health sector. On "1 April 1972, the transfer of New Zealand psychiatric hospitals to regional hospital board control took place. In Wellington this was the beginning of the development of more new psychiatric services through the region" (Williams, 1987, p. 279).

A CRITICAL LENS IS APPLIED TO MENTAL HEALTH SERVICES

In 1987, a committee chaired by Ruth Manchester undertook a review of psychiatric services for the Wellington region. The resulting report, *Barriers to (Mental) Health Care: A Call For Reform* (New Zealand Board of Health, 1987) (referred to as the 'Manchester Report') made recommendations about services. The most significant recommendation was the need to reduce the numbers of inpatient 'beds'. This report was very much in line with developing government policy, i.e. replacing of inpatient services, with more community-focused care.

The Manchester Report, which focused on the Wellington region, was followed by a national inquiry. In 1988, Judge Ken Mason headed up an inquiry into mental health services throughout New Zealand. This resulted in *A Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (Mason, 1988) (commonly referred to as the 'Mason Report'). The report found fragmented and inadequate mental health services and noted that "the health services in New Zealand are at the crossroads of change"

(Mason, 1988, p. 231). It recommended that the way services were to be delivered be changed. A subsequent inquiry and report *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services (1994),* was also chaired by Judge Ken Mason. In this report, Mason, Johnstone, and Crowe (1996) were particularly scathing of the lack of traction within workforce development related to de-institutionalisation:

> [W]e acknowledge the considerable work and expertise which has gone into the Work Force Development report. Some managers have suggested to us that critical shortages have arisen because of the change from care in the hospital to care in the community. We reject that notion. It can hardly be said that de-institutionalisation crept up on the sector overnight - it has been an on-going phenomena for many years (Mason et al., 1996, p. 130)

The two inquiries chaired by Judge Mason (1988 and 1996), the Manchester Report (1987) and the looming changes in the wider health environment were to be the catalysts for major changes in the mental health sector.

A FORWARD VIEW

The four Regional Health Authorities were well established by 1993 with an expectation that they would develop plans for mental health services for their region and put in place a purchasing framework for the identified services. In order to inform the mental health plans for the four regions, the Ministry of Health developed *Looking Forward* (Ministry of Health, 1994). This provided the strategic framework for mental health services in New Zealand. "The major shift in direction is away from services dominated by psychiatric hospitals and towards community mental health teams" (Ministry of Health, 1994, p. 10). *A Better Life* (Central Regional Health Authority, 1994) was a document that set out the future of mental health services for the central region (Hawkes Bay to Nelson/Marlborough). There are descriptions throughout this document of what the services would look like, principally based on downsizing the large psychiatric hospitals and dispersing a range of services into the community. The plan was for more community-focused care supplemented by day-care services, supported residential housing and carer support. There were also indicators that the service provision would be vastly different

from that provided at the time. The aspect of community living was to be accommodated by "intensively staffed supported housing facilities" (Central Regional Health Authority, 1994, p. 45).

A study by Fairley, Siegert, Simpson, Wilson, and Roach (1993) examined the prevalence of physical disease, psychiatric disorder and deviant behaviour of a sample of 137 long term[3] psychiatric patients from Porirua Hospital near Wellington, New Zealand. This study also helped to inform the Wellington Area Health Board's planning for mental health services that resulted in a target to reduce inpatient beds from 720 in 1990 to 300 by 1994. Research undertaken by Clifford, Chapman, Webb, and Best (1991) identified that 20% of the patients in long-stay psychiatric inpatient services could manage in the community. This study further supported the view that a new way for delivering services, one that was not hospital based was needed.

By 1994, the wheels were set in motion to radically change the model for mental health services; however, the plans and policies were light on detail as to the type of workforce that would be required to implement this new service configuration. Throughout *A Better Life* (1994), it was identified that there was a "lack of community support in terms of suitable supported housing and clinical backup" (Central Regional Health Authority, 1994, p. 4). The document then went on to say that "what is required is a redevelopment of the whole range of mental health services in the area in order that they much more effectively meet the needs of present and future populations" (Central Regional Health Authority, 1994, p. 4). The second development was the emergence of the mental health support worker: "creating a new occupation in the non-clinical sector, with a tertiary certificate-level qualification" (Mental Health Commission, 2007, p. 112). This period also saw a shift of services to the NGO sector with a commensurate increase in the numbers of mental health support workers.

LOOKING FORWARD: STRATEGIC DIRECTION FOR MENTAL HEALTH SERVICES

Looking Forward: Strategic Directions for the Mental Health Services (Ministry of Health, 1994) was one of a number of plans by the Ministry of Health. This was followed by the

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[3] Long term was used to define a stay of more than 12 months for a primarily psychiatric condition.

National Mental Health Plan, Moving Forward: The National Mental Health Plan for More and Better Services (Ministry of Health, 1997). *Looking Forward* (1994) saw the beginning of an approach that set benchmarks and targets for mental health service delivery to the population.

> In New Zealand, benchmarks of 3 per cent have been established for the general adult population (and their families) and for youth (and their families). Benchmarks have yet to be set for other groups within the general population – the most important of which are children (and their families) older people, and those who require alcohol and drug treatment. (Ministry of Health, 1994, p. 7)

MODEL FOR CHANGE

The policy changes and the move to community-based care required Regional Health Authorities to close the large psychiatric hospitals and to have mental health consumers/service users[4] placed in either supported accommodation or in their own 'homes' with home-based support provided. This policy direction was generally accepted by most people within the mental health sector including mental health consumers. What was absent from the policy direction was a requirement for training and education of the workforce required to deliver the services. Knapp et al. (1990) suggested that closure or downsizing of psychiatric hospitals provided a means to generate large savings in health care. Armitage (1994) provided a cautionary perspective by suggesting that moving psychiatric patients into the community was not a cheap alternative to inpatient care and should not be undertaken on fiscal grounds alone.

Given the haste for the downsizing of hospitals in the 1990s; and the lack of attention to the workforce much of the new service delivery was being undertaken by staff with little or no qualifications. For example the Central Region's implementation document *A Better Life* (Central Regional Health Authority, 1994) set out the process for de-institutionalisation but failed to mention the need to have an appropriate workforce to

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[4] 'Consumer' and 'service users' are interchangeable terms and refers to a person accessing mental health services

implement this policy. It was not until after the introduction of the National Certificate in Mental Health (Mental Health Support Work) in 1998 that services were required to employ mental health support workers with any qualification.

The Ministry of Health's policy document *Looking Forward – strategic direction for mental health service* (Ministry of Health, 1994) it was acknowledged that the process of community care had been *ad hoc* and that the "mental health institutions were not well funded in the first place. As well, not enough funds were redirected to community services to deal with the increasing numbers of patients who were being transferred to community care" (Ministry of Health, 1994, p. 1). *Looking Forward* (Ministry of Health, 1994) identified a number of requirements to ensure the success of community care. However, it did not identify the need to develop another type of care provider, although it did suggest that specialist mental health services for people in the community, in their homes or in hospital ought to be increased (Ministry of Health, 1994, p. 14).

The non-regulated mental health workforce gained significant traction and visibility through *Rising to the Challenge: the Mental Health and Addiction Service Development Plan* (Ministry of Health, 2012) when the importance of the mental health support workers was recognised through the need for the "strengthening use of the non-regulated workforce" (Ministry of Health, 2012, p. 61).

COMPETITION IN MENTAL HEALTH SERVICES

In the early 1990s competition within the contracting environment was the prevailing model. Clinical and non-clinical services were competing for funding to deliver existing and emerging mental health services. McClelland and Warren (1996) support the notion that while the health reforms shifted health services from domination by large providers, one of the unintended consequences of these policies was that there was little opportunity or appetite for "health providers to work together" (McClelland & Warren, 1996, p. 14), as this was contrary to the competitive model. This was in part driven by economic imperatives that required health services to become more business-like with a drive towards greater efficiencies.

This separation of clinical from non-clinical services was a deliberate policy direction across many of the health sectors; however, the change was more noticeable within mental health than other areas of health as resulting from these changes was significant growth of the NGO sector. Prior to this NGOs had generally been contracted to deliver residential and support services, with Crown Health Enterprises delivering clinical services. This arbitrary split was in keeping with the prevailing competitive model, and supported the attempt to contain health spending, while simultaneously improving quality of services. Jones (1996) cautioned on the risks of transferring services from the hospital to community without establishing the required services and infrastructure in the community.

CREATING A BETTER WORLD

As discussed in the section, *A CRITICAL LENS IS APPLIED TO MENTAL HEALTH SERVICES*, the late 1980s and early 1990s witnessed a number of high-profile public incidents that were either directly or indirectly related to mental health services. The state of mental health services in New Zealand was considered to be in such a state of crisis that the Minister of Health (the Honourable Jenny Shipley) ordered a Commission of Inquiry, chaired by Judge Ken Mason. The resulting report was the *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* (1994). Amongst the many recommendations in the report was the establishment of the Mental Health Commission as a crown entity under its own Act, the Mental Health Commission Act (1998). The wide ranging functions of the Mental Health Commission were set out in Section 6 of the Act and included:

- Advocate for people with mental illness and their families
- Promote and facilitate collaboration and communication about mental health issues
- Promote better understanding of mental illness and reduce stigma and eliminate discrimination
- Monitor and report to and advise the Minister on, any matter relating to the implementation of the national mental health strategy
- Stimulate and support policymakers and the funders and providers of mental health services in developing services that meet the needs of their communities

- Stimulate and undertake research into any matter relevant to mental illness.

The Mental Health Commission provided a way by which mental health services could be monitored and reviewed. Their mandate also included taking a lead in the sector on matters relating to workforce development. A major piece of work undertaken by the Mental Health Commission was the report *Blueprint for Mental Health Services in New Zealand: How Things Need To Be* (Mental Health Commission, 1998). This was followed up by *Progress 1998-2000: Towards Implementing the Blueprint for Mental Health Services in New Zealand* (2001) (Mental Health Commission, 2001b). These reports laid out the requirements for mental health services in terms of staffing ratios based on the prevalence of mental illness and the development of specialist services. Additionally, but as important, the Mental Health Commission set about costing mental health services. The additional funding that they were able to have appropriated was to be 'ring-fenced' for mental health services with no cross subsidisation across other health providers.

WORKFORCE DEVELOPMENT

The difficulties related to the health workforce are not new. Even in early psychiatric services the lack of records and regulation was difficult. The labels used to identify staff were not clear, for example the terms 'nurse' and 'attendant' in early literature appear to have been interchangeable and did not denote the qualifications these people may have held rather it was a title for a position. Williams (1987) did note that many of the nurses or attendants employed at Porirua Hospital in the early 1900s were "from a wide range of trades, from labourers and domestics to cooks, plumbers, waitresses, horse-drivers and coffin makers... most of them had no experience in either nursing or with the mentally ill" (Williams, 1987, p. 73). It is therefore possible that this period may have been the beginnings of what we know today as the mental health support worker; people from many walks of life being attracted to work with people with mental illness. Training programmes for nurses and attendants working in psychiatric hospitals commenced in 1905, however, the majority of staff working in those areas remained unqualified (Williams, 1987).

A literature review regarding de-institutionalisation was undertaken by the Central Regional Health Authority (Bennie, 1993) in order to inform their processes. While 31

critical factors for successful transition into community care were identified in the report, only three of them touched on the need for education or training, with no mention made of the need for a formalised education programme for staff managing mental health consumers in community or residential settings. The report presupposes that "existing staff will be up-skilled and re-trained" (Bennie, 1993, p. 23).

Part of the health reforms of the 1990s saw the introduction of the Clinical Training Agency (CTA). This agency was a direct result of funding from Vote: Education transferring to Vote: Health. This saw the funding and accountability shifted from one Ministry and therefore one Minister of the Crown to another. The CTA had the responsibility for health education and training at a post-graduate level only and had no responsibility for the unregulated undergraduate workforce. This responsibility sat with employers, educational institutes and the industry training organisations (ITOs). The Community Support Services ITO (later rebranded as Careerforce), established under the Industry Training Act (1992), was given responsibility for the development of training for mental health support workers. However this ITO was not widely recognised by the mental health sector, including mental health support workers themselves. So the work they were tasked to undertake did not receive the support that the New Zealand Qualifications Authority (NZQA) expected. NZQA subsequently contracted a consultant to engage with the mental health sector to have unit standards and national qualifications written. This brought to the surface tensions within the education and health interface. The Ministry of Health identified that "the standards endorsed by NZQA in May 1995 have certainly not been accepted by the sector and are still being worked through" (Ministry of Health, 1996, p. 40). Within the complexities of the health environment described in this chapter and Chapter One, the four Regional Health Authorities, the Ministry of Health and the Mental Health Commission used their influence to put in place a project to develop a national qualification at certificate level for mental health support workers that would have the confidence of the sector.

Andrews and Titov (2007) identified and recognised the cost of health services including the prevalence of mental illness in the population. They also continued with the identification of solutions, one of these being the need for education of the regulated health workforce. Focus continued to be on developing services within the traditional model. "A

workforce consists of general practitioners (GPs) and their practice nurses, community mental health staff (mainly nurses), clinical psychologist and psychiatrist" (Andrews & Titov, 2007, p. 124). They did however see a place for the use of "web based education" (Andrews & Titov, 2007, p. 127) to enable people with mental illness and their families to gain access to information. The suggestion that mental health services were required to change could have provided the opportunity to revisit the composition of the workforce and introduce mental health support workers. The only potential reference that was made to the notion of introducing another discipline was through a broad interpretation of the word 'mainly'. An interpretation of Andrews and Titov's (2007) study suggests that there is the opportunity for non-nurses which might in turn mean mental health support workers.

Mental health services in New Zealand continued to evolve as have roles and expectations. Other countries including Canada undertook reviews of their unregulated health workforce through the Pan-Canadian Planning Committee (2008). The resulting report suggested that the development of the unregulated health worker is based on economic imperatives as well as the changing landscape of healthcare delivery. This view is supported by an earlier study by Caird (2001) who suggested that while there are economic imperatives, the main driver that challenged the dominant medical model of service delivery was a rethink about how to treat and respond to people with mental illness.

The complexity for developing education and training in the health environment are set out in diagrammatic form by Figure 3. In order to traverse these complexities an intersectorial approach is required. The complexities of such an approach cannot be underestimated in terms of securing funding and qualification development.

Figure 3: Regulation of education and training of mental health workers

Funding and contracting relationships
Accreditation relationships
Other relationships
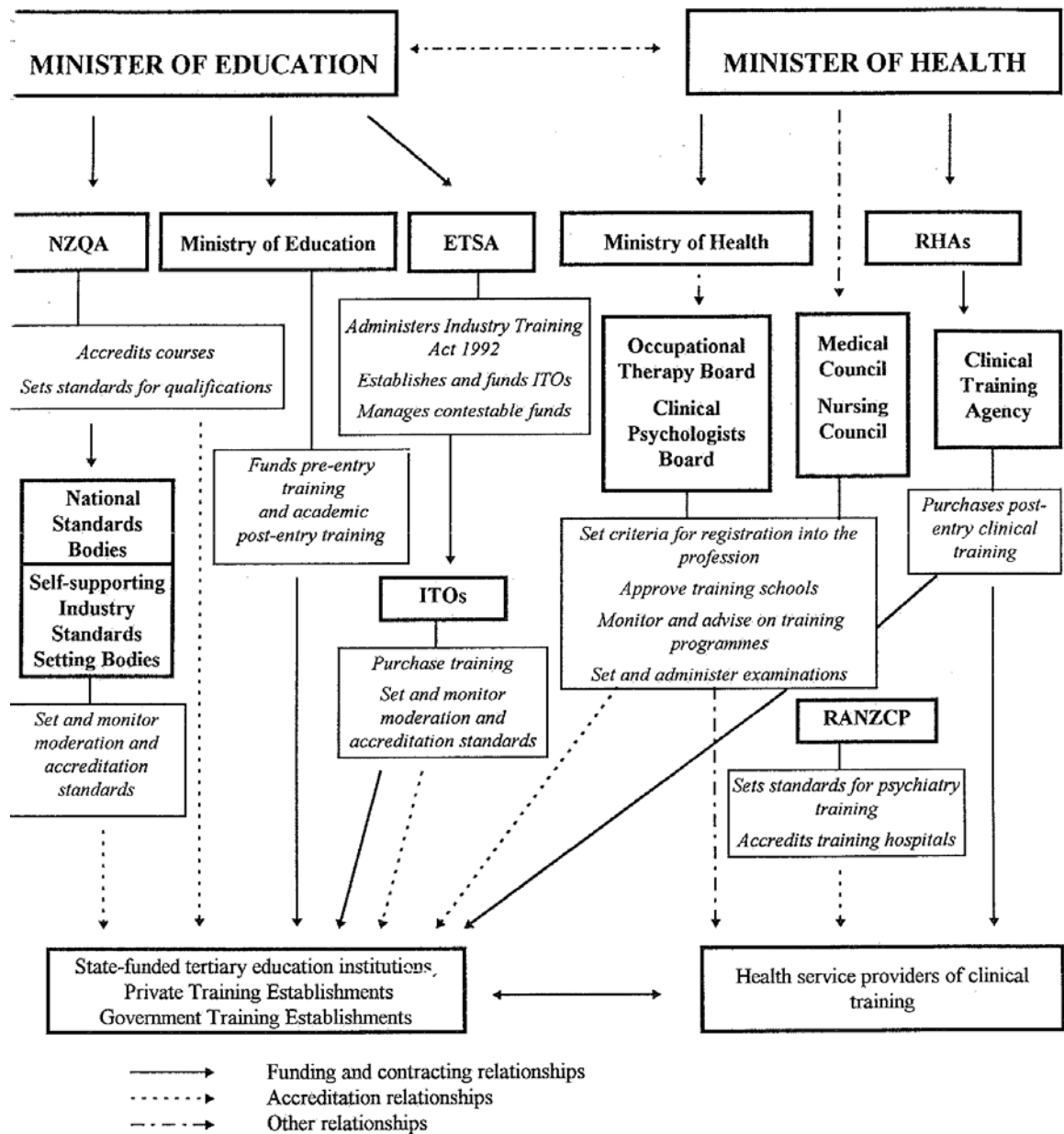
A DIFFERENT WAY TO DELIVER SERVICES

The dominant model within mental health services is that of the multi-disciplinary team. The team is generally comprised of medical practitioners, social workers, nurses, occupational therapists, psychologists, family advisors, consumer advisors and mental health support workers. This team operates in both inpatient and community settings with support workers being utilised in a variety of ways. Platform (2008) stated that the

introduction and development of mental health support workers has been innovative and ground breaking and improved the quality of mental health service delivery in New Zealand. This view is also supported by the Mental Health Commission (2007) which suggested that the creation of the support worker has been the "achievement of the decade" (p. 112). Stories by and about mental health support workers and their relationship with the multi-disciplinary team are told in Chapters Seven to Eleven.

A DIFFERENT WORKFORCE IS REQUIRED

The Ministry of Health (1996) took a lead role in examining the mental health workforce and identified through its report *Towards Better Mental Health Services* (Ministry of Health, 1996) that capability and capacity to deliver new service requirements were lacking. This report was acknowledged by Mason et al. (1996) for providing some leadership in the area of workforce development for the mental health sector.

The Ministry of Health formed a working party, the National Workforce Development Working Group, to examine the needs of the mental health workforce. The strategies adopted by this group recognised a need for workers in the community to provide support for mental health consumers. It suggested that this workforce might replace the traditional health professionals in the long term. The stylised flower developed by the Working Group (Figure 4) suggested that there could be overlapping skill acquisition as well as specialist knowledge with the core or stem representing the generic knowledge which should be known by all health and support staff in mental health services (Ministry of Health, 1996).

Figure 4: Model for development of a future mental health workforce
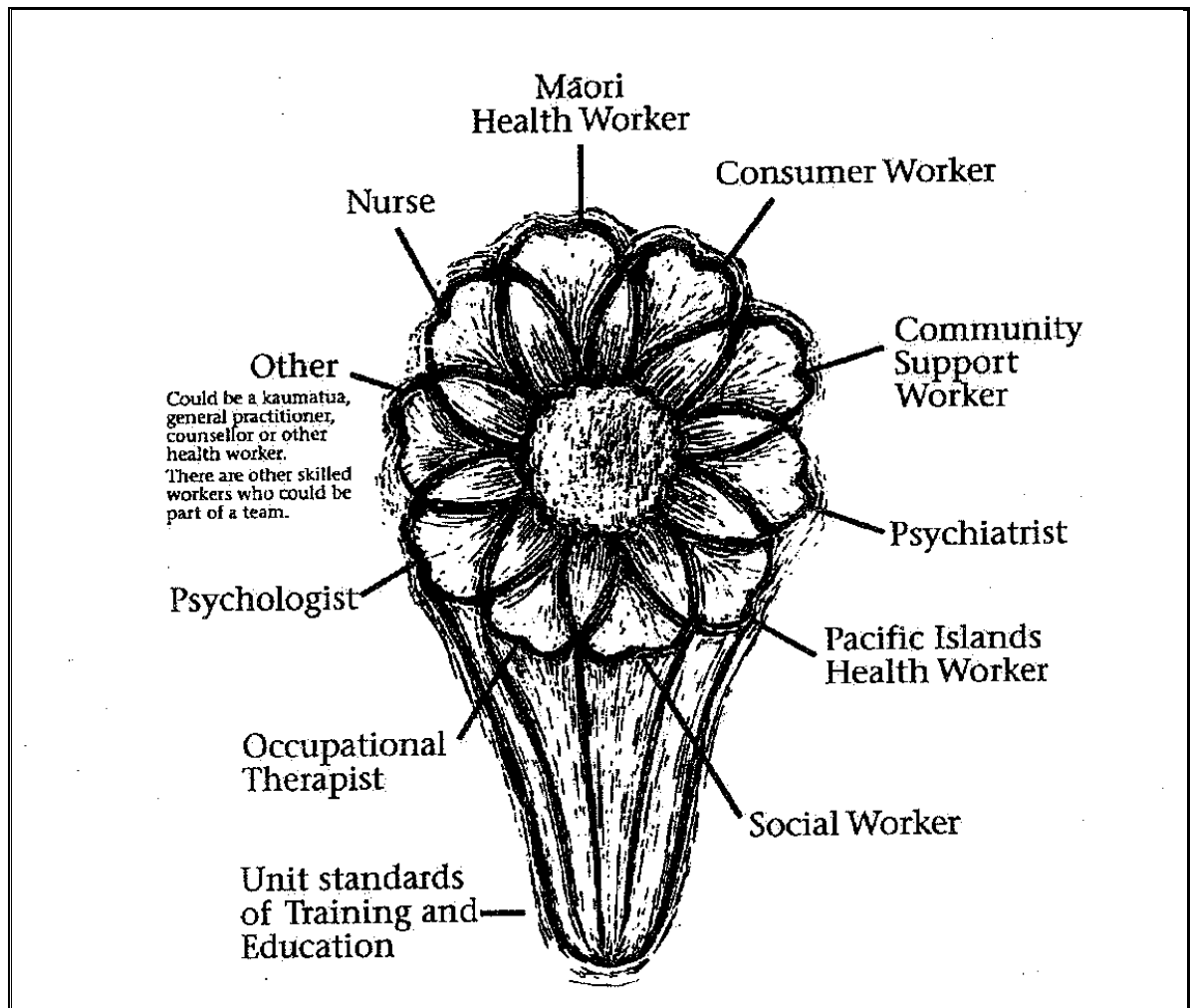
The interleaved model included two key areas for mental health support workers. The first aspect was that support workers were recognised as a distinct part of the mental health work force. The second aspect was that unit standards were recognised as a way of training and educating the workforce. The Working Party also noted that the responsibility for developing this workforce required a multi-agency approach. The section on mental health support work in the document described mental health support workers as "caregivers or support people working alongside people with mental illness or disabilities living in the community, Māori health worker, and consumers" (Ministry of Health, 1996, p. 26). It then went on to say that "a proportion of community support workers have health professional qualifications" but that "there is very little information available about these workers" (p. 26). When trying to comprehend what it is that mental health support workers do and what

education or training preparation they need to undertake this role the Working Party identified that "much of the workforce (for example, some community support worker and consumers) is prepared by life experiences" (Ministry of Health, 1996, p. 14).

SUMMARY

This chapter has provided the context of a change agenda within mental health services in New Zealand, catalysed by the closure of large psychiatric hospitals in the 1970's. This process was escalated and gained traction in the 1990s through policy changes and identification of significant system failures with the dominant institutional model.

This retrospective view of this environment clearly shows that while the policy relating to a greater emphasis on community based support was visionary the workforce required to realise these changes was either underdeveloped or not evident.

Chapter Three provides a view on the development of parts of the workforce in the early 1990s, a time which saw the emergence of the mental health support worker role and educational preparation.

CHAPTER THREE: EDUCATIONAL PREPARATION AND EMPLOYMENT OF MENTAL HEALTH SUPPORT WORKERS

*There is no such condition as schizophrenia, but the label is a social fact
and the social fact a political event (Laing, 1967, p. 100).*

INTRODUCTION

This chapter builds from Chapter Two by placing the development of the mental health support worker's role within the context of historical and policy settings. This chapter's focus is on the educational preparation and employment of mental health workers.

DEVELOPMENT OF A NATIONAL QUALIFICATION FOR MENTAL HEALTH SUPPORT WORKERS

Prior to 1998, differing models of mental health support work had already commenced. The majority of mental health support workers did not have any qualifications that were well understood by the mental health sector or specific to this role nor was there a shared understanding of the roles and functions of a mental health support worker. When a gap is created, there are ways for it to be filled; many educational providers worked with their local mental health services to develop local qualifications.

As described in Chapter One, I was privileged to have been given the mental health workforce portfolio while working for the Central Regional Health Authority. This portfolio required that focus was given to the on-going development of the regulated workforce; however, my attention was also directed towards the unregulated workforce. The upsurge in the development, by the non-government organisation (NGO)-driven sector of community based services (including the development of residential services), was being primarily delivered through an unregulated workforce in many parts of New Zealand.

The bringing together of the four Regional Health Authorities, the Ministry of Health and the Mental Health Commission for the sole purpose of developing a national qualification for mental health support workers was a significant milestone for me. A number of people at the forefront of this development included Fuimaono Karl Pulotu-Endemann (Pasifika

mental health consultant), Dr Frances Hughes (mental health clinician and educator), Mike Sukolski (mental health consumer advisor), the late Bob Henare (Mental Health Commissioner), Dr Janice Wilson (Director of Mental Health, Ministry of Health), John Hopkins (educational consultant), representatives from Te Puni Kokiri and Marion Clark (consultant). These people formed the initial steering group that developed the national qualification. At a time of increasing competitive behaviour, this was truly a co-operative multi-sector approach, with a shared goal of developing a new class of worker for the mental health sector.

By 1998, the National Certificate in Community Support Work (Mental Health) had been developed by a standards setting body accountable to the New Zealand Qualifications Authority (NZQA), with funding for the development coming from the four Regional Health Authorities. Once the qualification was developed, it was placed on the New Zealand Qualification Framework (NZQF) for educators to deliver. This was the first time in the history of mental health services in New Zealand that a national qualification was available to support the education of the unregulated mental health workforce. The Mental Health Commission (1998) and the Health Funding Authority (2000) prioritised the need for education and training of the mental health workforce including mental health support workers. This was achievable at last.

Platform (2007b), an umbrella service supporting mental health NGOs, described the National Certificate in Mental Health (Mental Health Support Work) as an entry-level qualification for staff working in the newly developing NGO sector. With approximately one-third of mental health expenditure going into this sector, it was becoming one of the largest NGO mental health sectors in the developed world (Ministry of Health, 2004). Platform also stated that "creating a new support work occupational grouping has been a great workforce achievement and has been specific to New Zealand innovation" (Platform, 2008, p. 2).

The Health Workforce Advisory Committee (2002a) undertook a stocktake of the issues and capacity of the health workforce and recognised the strategic shift from institutional care for mental health services to more community-based services. Data used by the Health Workforce Advisory Committee saw mental health support workers placed in the

unregulated health workforce category and described as the part of the "workforce which provides support with 'everyday things'" (Health Workforce Advisory Committee, 2002a, p. 88). The stocktake identified that the mental health support worker provides "support and delivers rehabilitation services or programmes that facilitate the recovery process for people experiencing serious mental or emotional distress" (Health Workforce Advisory Committee, 2002a, p. 124). Based on 2001 figures, the report identified 875 mental health support workers, the third highest grouping within the mental health workforce. Twelve percent of the mental health support workers identified as Māori and 3.2% as Pasifika. This meant this workforce had the second highest proportion of Māori staff, eclipsed only by alcohol and drug workers (23%) (Health Workforce Advisory Committee, 2002a).

The report *National Mental Health Workforce Development Co-ordinating Committee* (1999) identified six key problems relating to the mental health workforce including a number of significant workforce gaps in key clinical areas. The report went on to say that "overall there are low numbers of Māori and Pacific Islands people in all occupational groups" (National Mental Health Workforce Development Co-ordinating Committee, 1999, p. 23) as well as insufficient staff with certain skills and appropriate training to deal with a changed delivery environment. The report suggested that there was a requirement for "core competencies and specialist skills based on current and future roles for people working in the mental health service" (National Mental Health Workforce Development Co-ordinating Committee, 1999, p. 5).

A NATIONAL QUALIFICATION IS LAUNCHED

In February 1998, the then Minister of Health, the Honourable Bill English, launched the first national certificate, based on unit standards, for mental health support workers. One of the key strengths of the development of the national certificate was that "it provided a strategy to increase the number of Māori and Pacific Islanders trained to work in the mental health sector" (Hennessy & Ellis, 1999, p. 5). "There are few Māori mental health workers. Training programmes are needed in all areas of mental health – in particular, to increase the number of Māori who can provide community mental health services" (Ministry of Health, 1994, p. 9).

The Mental Health Commission (1998) and the Health Funding Authority (2000) identified as a priority the need for education and training of the mental health workforce including mental health support workers.

The Mental Health Workforce Development Framework (Ministry of Health, 2002) saw the need to ensure access to the National Certificate in Community Support Work (Mental Health) and to expand the range of training for support workers. In 2001, the then Minister of Heath, the Right Honourable Annette King, addressed a mental health support workers forum. She stated that "the National Certificate in Mental Health Support Work was one of the most significant achievements in the last few years" (King, 2001, p. 1). She went on to suggest that the national certificate was a vehicle by which the Māori workforce was being up-skilled and that Government commitment to the ongoing development of the qualification was evident by the continued funding of the standards setting body and the goals set out in *Tauawhitia te Wero – Meeting the Challenges: National Mental Health and Addiction Workforce Development Plan 2000-2005* (Ministry of Health, 2005).

GROWING THE WORKFORCE

The Health Workforce Advisory Committee (2002b) recognised mental health support workers as a separate occupational group and indicated that "there is a need for an increase of over 600 support workers to meet the increased service needs outlined in the Blueprint" (p. 125). One of the mechanisms to stimulate the market and ensure the required growth of mental health support workers, was the establishment of training grants to assist with the education fees. The majority of the funding for the educational delivery came through funding from the Ministry of Education; however, 25% of the total costs came from the individual student. The training grants were managed by the New Zealand Education and Tourism Corporation (NETCOR), who were themselves a provider of the National Certificate for Mental Health (Mental Health Support Work).

The National Mental Health Workforce Development Co-ordinating Committee (1999) identified that the 'Mason' money, allocated by Government for mental health services and workforce development, had enabled the Health Funding Authority and the Clinical

Training Agency to increase spending on the training of mental health workers, including support workers.

A mental health and addictions stocktake undertaken by Te Pou (December 2014) indicated that there are 10,845 full-time equivalents (FTE) positions employed in the mental health and addictions workforce in New Zealand. Of those employed, 7,097 FTEs are in mental health teams, 1,317 FTEs, in addiction teams and 515 FTEs in mental health and addiction teams; with a total of 429 FTE positions vacant. Of the reported positions, 8,929 were funded through Vote Health; funding allocated by government for the delivery of health services.

In district health board (DHB) mental health services, 74% of the workforce was clinical and 13% were non-clinical, whereas 73% of the mental health workforce in NGOs were categorised as non-clinical and 12% clinical (Figure 5). There were 2,631 FTE positons designated as support workers with 2,677 FTE designated as mental health nurses. Therefore mental health support workers, in 2014, make up a total workforce that is nearly the equivalent in FTEs to the largest group: registered nurses working in mental health services (Te Pou, 2014b).

Once the national qualification was introduced statistics on students enrolled in the programme were available through the New Zealand Qualifications Authority. However there is still limited research about the difference the educational preparation has made in preparing mental health support workers to provide services for mental health consumers.

Figure 5: Workforce data by regions 2014 (Te Pou, 2014)
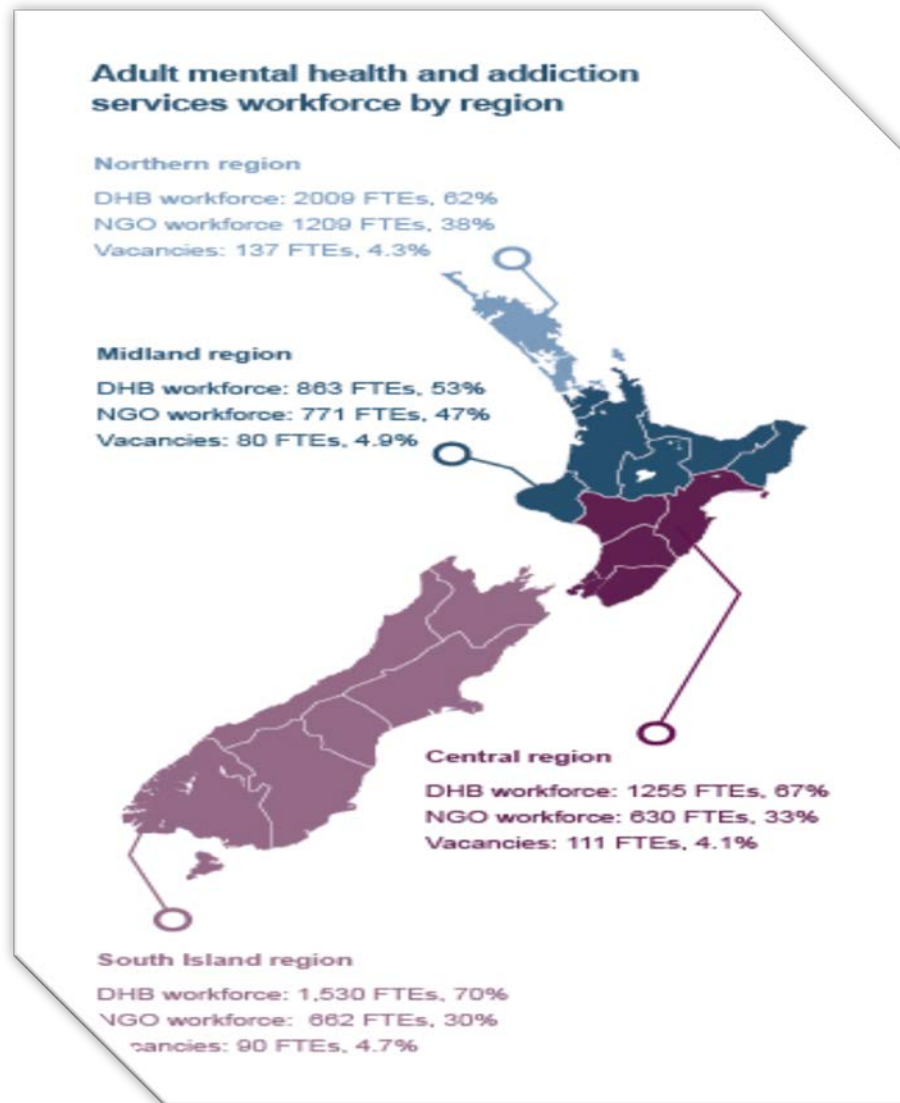
GAINING A RECOGNISED QUALIFICATION

New Zealand established a qualification framework – the National Qualifications Framework (NQF) in 1992 as a result of changes to the Education Amendment Act 1990. It was this Act that enabled establishment of the New Zealand Qualifications Authority (NZQA). Phillips (2003) suggests that the drive to develop a single framework was a result of the academic inconsistencies and the number of bodies involved with educational compliance. The aim of these changes was to develop "a coherent, integrated qualifications framework with all qualifications constructed of similar building blocks, the 'unit standard'" (Phillips, 2003, p. 291). Unit standards were one of the key requirements for

national qualifications that were developed at sub-degree level. Within this policy framework educational providers were still able to develop and deliver local qualifications, providing these were built on the qualification type and levels as set out in Table 1.

The NQF was subsequently replaced by the (NZQF) in 2010. The difference in the two frameworks was that the NZQF included the national framework as well as the quality assurance functions that had previously been delegated to other agencies. Under the NQF, education providers had slightly more autonomy and could be quality assured to deliver national or local qualifications. The quality assurance functions for the university sector remain unchanged.

Table 1: Qualification types and levels 5

LEVEL	QUALIFICATION TYPES
10	Doctoral Degree
9	Master's Degree
8	Postgraduate Diplomas and Certificates, Bachelor Honours Degree
7	Bachelor's Degree, Graduate Diplomas and Certificates
6 5	Diplomas
4 3 2 1	Certificates

The working party that established the National Certificate in Mental Health (Mental Health Support Work) was required to have this qualification based on unit standards in order for it to be considered a national qualification. After extensive consultation with the mental health and related education sectors, it was agreed that the entry level for mental health support work would be set at level 4, i.e. sub-degree. The level at that the qualification is awarded is determined by the 'graduate profile'. This then determines the level of skill and knowledge which is expected of any graduate holding this qualification.

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5 http://www.nzqa.govt.nz/studying-in-new-zealand/understand-nz-quals/

The uptake of the national certificate and diploma since 1998, provided by the New Zealand Qualifications Authority, is detailed in Figure 6. In 1998, 99 students were enrolled into the Level 4 National Certificate in Mental Health (Mental Health Support Work) with three accredited training providers. Four years later, 984 students were enrolled in the National Certificate programme, which was being delivered by 20 education providers. By 2005, the NZQA reported that 1,807 individuals had undertaken and gained the National Certificate. The portability of the national certificate meant that support workers were now able to move across geographical regions and have a qualification that would be recognised.

Figure 6: Number of people awarded the National Certificate or Diploma in Mental Health (Mental Health Support Work) (source NZQA)
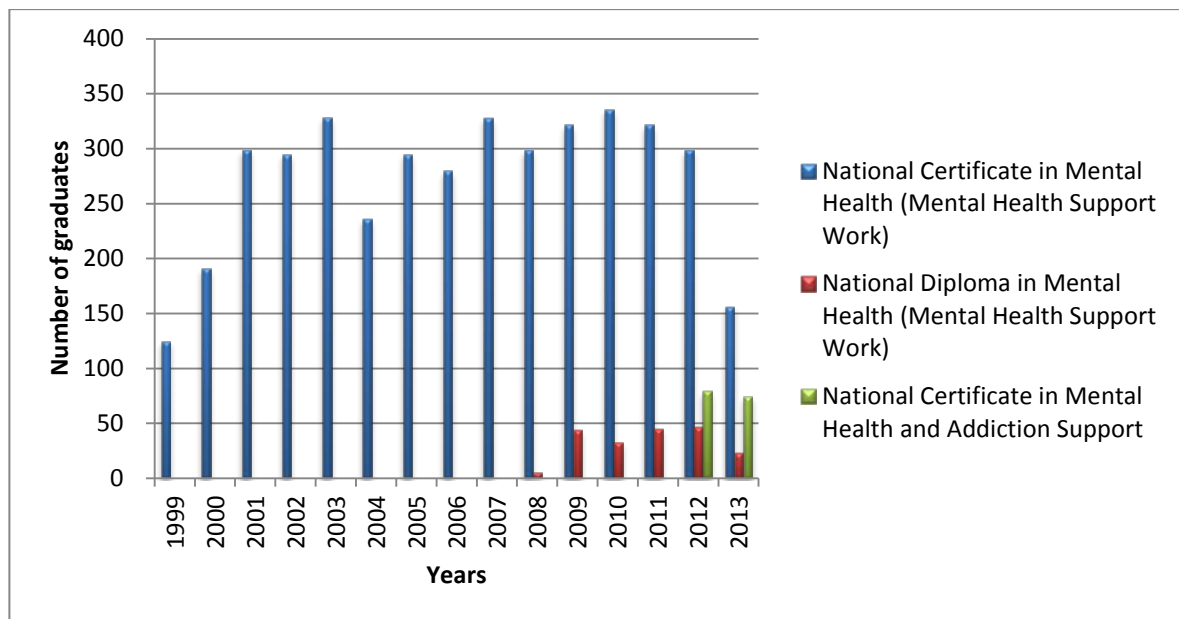
By the end of 2013 4,459 people had gained either the National Certificate or Diploma in Mental Health (Mental Health Support Work) or the National Certificate in Mental Health and Addictions. This shows significant growth from the inception of these qualifications in 1999.

In the first year of delivery of the National Certificate in Mental Health (Mental Health Support Work), 125 people had successfully completed the qualification. A national diploma was not introduced until 2008; since its introduction, there has been a slow but

steady uptake in this qualification. The National Certificate in Mental Health and Addiction Support was introduced in 2012. In the same year NZQA was tasked with reviewing the number of qualifications being delivered throughout New Zealand. This included local and national qualifications under Level 6 on the qualifications framework. This project is referred to as the Targeted Review of Qualifications (TRoQ) and is the second major review which has been undertaken for this qualification since it was introduced in 1998. The outcome of this review will be the introduction of the New Zealand Certificate in Wellbeing/Oranga (Level 4) with strands in Abuse, Neglect and/or Violence, Disability Support (with endorsements), Diversional Therapy, Mental Health and Addiction Support, Social Services and Tamariki Ora. These developments have expanded on the original national certificate to include other relevant areas such as additions and young people.

"The development of the national certificate for mental health support workers was one of the best things that has happened in this area for Pacific people," stated Fuimaono Karl Pulotu-Endemann, a leading Pasifika consultant and educator (August 2013). This suggests that the strategy to educate more Pacific people for employment into the mental health sector has been achieved.

SUPPORTING SERVICES AS THEY EVOLVE

It is important that workforce development is not undertaken in isolation from service delivery, especially when there is a need to up-skill an existing workforce. This complexity was recognised by the group that was tasked with developing the national certificate for mental health support workers. Prior to 1998, few of those employed as mental health support workers held any sort of qualification. In order to up-skill this group, services that released staff to attend the national certificate programmes needed to be provided with funding to backfill their staffing requirements and to assist with the tuition fees. This was in the form of training grants that were administered by NETCOR, a private training establishment on behalf of the four Regional Health Authorities. The administration of the grants was later transferred to the Community Support Services Industry Training Organisation (Careerforce). These grants were available only to the NGO sector; it was expected that DHBs employing mental health support workers would cover these expenses.

In 2003, a study of the New Zealand health workforce identified the need for the continued support and development of the 'support worker' and referred to its function as "providing support or assistance to remove barriers to participation and enabling people to live as independently as possible" (Health Workforce Advisory Committee, 2003, p. 89).

A review by Curtis (2004) identified that the grants were important in assisting both mental health support workers and employers with the costs of the training; however, it was also noted that the processes for accessing the grants was confusing and therefore potentially limited the access to the education programmes.

As mental health services have evolved, new categories of mental health workers in the form of peer support workers have been introduced. The introduction of roles such as peer support workers is discussed in Chapter Four: Literature Review. Many education providers, as was done initially for mental health support work, have introduced a local qualification for peer support work. The evolving landscape within mental health services also saw the introduction of a national qualification for mental health support work at diploma level.

THE MENTAL HEALTH SUPPORT WORK ADVISORY GROUP

The Mental Health Support Work Advisory Group (MHSWAG) was established in 1997 as a standard setting body under the quality management systems of the NZQA. Unfortunately, much of the documentation of this group and their subsequent iterations has been lost as a result of structural changes outside of NZQA as there was no 'owner' of the mental health support worker qualification. Platform provided administration support for MHSWAG and unearthed a quantity of documentation about the MHSWAG from their archives which was made available to assist with background information for this study. Platform was contracted to MHSWAG for administrative support prior to Careerforce taking on ownership of the mental health support worker qualifications.

The MHSWAG was subsumed into Careerforce when NZQA made policy adjustments and considered the MHSWAG too small to continue as a stand-alone entity. However the 2001 Health Workforce Stocktake (Health Workforce Advisory Committee, 2002b)

continued to recognise the MHSWAG as representing "the mental health support work sector during the accreditation process for education providers" (Health Workforce Advisory Committee, 2002b, p. 125).

The work of the MHSWAG extented beyond that of a standard setting body in that it undertook research in the field of mental health support work from a number of angles. In 2003, it commissioned Case Consulting to undertake an analysis of the unit standards within the National Certificate in Mental Health (Mental Health Support Work) against the Mental Health Commission's *Recovery Competencies for New Zealand Mental Health Workers* (2001) (Mental Health Commission, 2001a). This study identified that there was lack of uniformity of the delivery of the teaching, the need for the development of specialist areas for education and difficulties associated with assessment against unit standards. Two additional studies were undertaken by the MHSWAG; *Te Puawaitanga o Te Oranga Hinengaro* (2003) and *Sei Tapu* (2004). The main themes that emerged from *Te Puawaitanga o Te Oranga Hinengaro* (2003) was that the national certificate for support workers needed to be contextualised within Māori philosophy and practice for it to be appropriate for support workers and tangata whaiora[6]. *Sei Tapu* (2004) focused on the Pacific Island mental health support worker and identified the need to contextualise the delivery of support work for Pacific people, the need for some areas of specialisation and the need to develop a national qualification at diploma level.

Mulvale (2004) identified the vulnerability of local qualifications that are suggested to be associated with local factors. This view strengthens the requirement for a national solution to national workforce issues. It has been 15 years since the National Certificate in Mental Health (Mental Health Support Work) was developed and placed on the NZQF. One of the underpinning rationales for having a national qualification was to enable a portable workforce i.e. mental health support workers moving throughout New Zealand would be able to take their nationally-recognised qualification with them. Additionally, the skill level of a mental health support worker would be consistent as the qualification was a national qualification based on unit standards. This presupposed that the level and type of care provided to mental health consumers throughout New Zealand would be consistent.

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[6] Māori term person that has experienced mental illness

DeSouza (1997) suggested that the development of the mental health support worker role was intended to fill an identified gap in service delivery. The introduction of the mental health support role would provide a different model of service delivery and free up other health professionals within the service continuum. This would enable those health professionals prepared at degree level to divest themselves of tasks that were more in keeping with the educational preparation of the support worker and provide health care that was commensurate with their higher level of educational preparation.

Abbott (1988), MacDonald (1995) and Burrage and Torstendahl (1990) identified that occupational conflict could occur in the workplace as a result of these emerging health professionals, particularly for aspirational health professionals who were seeking to legitimise their roles. Nancarrow and Borthwick (2005) suggest that "disciplinary boundaries have come under pressure as a result of staffing shortages" (p. 898). The area of boundary stretch could also have been a result of economic expediency, as it is usually cheaper to employ a health worker with no or minimal educational preparation than to employ a degree prepared or registered health professional.

PATHWAY TO PROFESSIONALISM

Support workers employed in the alcohol and drug field, who have undertaken an identified education programme, are eligible to apply for membership to the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (Dapaanz), which is the recognised professional body for the drug and alcohol sector. While the membership is not compulsory, the practitioners within the drug and alcohol field are in a similar position to the mental health support workers, i.e. they are not a regulated workforce. However, the drug and alcohol field has established their own mechanisms for self-regulation through the Dapaanz. This body has developed a code of ethics and established competencies that practitioners are required to meet in order to gain 'registration'. Mental health support workers also attempted to establish a body representing their sector. In 2004 the Support Workers Association New Zealand (SWANZ) was established; however, this representative group was predominately subscribed by the Northern region but not widely accepted by the

entire sector. In 2015 there is no representative body that covers the 'professional' requirements of a mental health support worker.

When the role of support worker was established many mental health support workers viewed themselves as 'professional'. However, Chambers (2006) suggests that this was not a universally held view and that mental health support workers were more likely to have a similar status to health care assistants, another unregulated health worker, by virtue that their educational preparation was not at degree level. This finding, which relates status and professionalism only with degree-prepared health workers, is supported by Sutcliffe (2006) and the Health Workforce Advisory Committee (2003), who found that mental health support workers feel as disempowered as the consumers they provide support too and are viewed by other health professionals as having a low status.

LEGISLATIVE FRAMEWORK

Another facet related to this study is the introduction of the Health Practitioners Competence Assurance (HPCA) Act (2003) . This Act provides a framework for regulation of some health professionals, where it is considered that there may be public safety issues. By the time the Act was passed, there were 15 groups of health professionals operating under this Act. One of the overarching principles of the legislation is the protection of the public receiving health care from health professionals; mental health support workers are not a designated group under this Act. This does raise some important questions as to how the public is protected when care is delivered by an unregulated health care worker. Holloway, Baker, and Lumby (2009) reported that there is an expectation by health consumers that care providers are knowledgeable in assisting with their health care needs. While it is accepted that this principle was being applied to the profession of nursing, this could also be an expectation of mental health support workers. The Health and Disability Commissioner Act (1994) provides some protection for those health practitioners who are not regulated under the HPCA Act (2003) . Gilmore (2005) argues that workers who provide aspects of what is seen as nursing care and work closely with nurses should be regulated and suggests that competency standards are required to ensure practice boundaries are identified. While the National Certificate in Mental Health (Mental Health Support Work) is a competency-based programme, the

mechanism in place to ensure on-going competencies is generally through the contractual process of employment agreements. Mental health support workers provide support to some of the most vulnerable sections of our community, yet they are not regulated – this raises the question should they be?

REGULATION OF HEALTH SECTOR

The regulation of some other health professionals through registering bodies predates nursing, although it is of note that the regulation of social workers is a recent event and registration has only just become mandatory. It was not until 1901 that nurses in New Zealand were registered under the Nurses Registration Act (1901). There were two main purposes of the Act; to ensure that the women completing the programme were 'fit and proper' to practice and the title 'nurse' was protected so that the public were afforded some protection and safety as a result of a training programme with resulting registration. The area of regulations is further discussed in Chapters Six to Eleven, with more in-depth discussion in Chapter Nine.

In a study of the healthcare support workforce Griffiths and Robinson (2010) postulate that the establishment of a professional body for otherwise unregulated healthcare workers facilitates guidance and support as well as contributing to the area of workforce planning.

RESPONSIBILITY AND LIABILITY

As discussed in the section under health policy, there has been a clear direction for mental health services shifting from institutional inpatient services to a community focus, with a greater involvement with the onus on primary health care sector "to take on greater responsibility for managing mental illness" (MaGPIe Research Group, 2001, p. 13).

This move towards a more community-based approach has seen services being provided by NGOs with a significant proportion of services being delivered by unregulated mental health workers. These changes continue to pose a challenge for employers. Generally unregulated health workers are a less expensive workforce than many regulated health workers; however, there is lack of clarity around the issues of accountability for them and the services they deliver. This lack of clarity and "the accountability and liability of regulated health-care providers working in collaboration poses challenges and requires

careful consideration" (Pan-Canadian Planning Committee, 2008, p. 8). Traditional boundaries within healthcare delivery are often blurred (Department of Health, 2009) with the question around regulation of all health workforce remaining unanswered. In 2009, the Minister of Health established a taskforce chaired by Professor Des Gorman (Gorman, Horsburgh, & Abbott, 2009) to review health education in New Zealand. While the terms of reference for this review were broad, the report itself primarily focused on post-entry education and the need to establish a single health and disability workforce agency. Very little attention was paid to the unregulated health worker, although this group now makes up one of the largest workforces in the mental health and disabilities areas.

The New Zealand Nurses Organisation (NZNO), the largest nurses' union in New Zealand, has urged the Nursing Council of New Zealand to challenge the training and qualifications of unregulated health workers, notably in mental health, in its submission on the scope of practice and education of enrolled nurses. The concerns of NZNO relate to the number of unregulated health workers gaining qualifications up to Level 6 on the NZQF. The NZNO suggested this needed to be challenged as it was contrary to the principles and intent of the HPCA Act (2003) (New Zealand Nurses Organisation, 2010, p. 6).

SUMMARY

The first national certificate for mental health support workers was introduced in 1998. By 2004, "1,176 people had graduated with the National Certificate in Mental Health (Support Work)" (Mental Health Commission, 2007, p. 113). The introduction of the national certificate was a landmark occasion for the sector; however, it also posed some questions about career progression, regulation and on-going changes within education and the policy environment. Chapters Seven to Eleven of this thesis explore and provide insight into the contribution of the work undertaken by mental health support workers. The lack of clarity over role definition creates an environment of confusion and this has contributed to mental health support workers' sense of disempowerment and invisibility within the health sector.

CHAPTER FOUR: LITERATURE REVIEW

INTRODUCTION

This chapter examines the literature and its relevance to mental health support work. Key words used in the search were; **mental health support work**, **unregulated health care worker, peer support worker, health regulation** and **mental health workforce**. Electronic database searches were under taken using Medline, CINAHL, EBSCO and ProQuest. As well as this, the search engines Google and Yahoo were also utilised. Within the values of appreciative inquiry the approach to literature is to examine the positives, to find the connections, while at the same time to acknowledge the shadow.

An initial search of the literature specifically related to mental health support workers revealed a dearth of information, i.e. ProQuest had 38 related articles hits, with EBSCO (Health) yielding 50 articles for New Zealand and another eight related international articles. Some literature explored specific aspects such as supervision for mental health support workers or the development of the support worker role. Other literature focused on reviews of the National Certificate in Mental Health (Mental Health Support Work) from a recovery competency perspective and considered them as to their relevance for Māori and Pasifika mental health service delivery. The lack of literature resulted in the search being widened and a more generic search was undertaken to include other unregulated workers within health and areas that may have a relationship with the health workforce. The literature was sourced from national and international studies and revealed the skills, attitudes and attributes that mental health consumers considered were required to work in mental health services.

The literature review examined both national and international concepts, their relevance to recovery and their relationship with the mental health workforce, including how these concepts relate to the mental health support worker.

"New Zealand has one of the largest mental health and addiction NGO sectors in the world, delivering a wide range of community based support services that account for one third of the total national mental health expenditure" (Te Pou, 2014a). Rapp and

Chamberlain (1985) believe that the lack of community based services and appropriately trained personnel have provided significant obstacles in the delivery of these types of services. Coop (2006) describes mental health services as an area of health that is poorly understood by the public at large and that this may also provide another area of exploration in relation to the role of mental health support workers.

MENTAL HEALTH SUPPORT WORKERS

Studies undertaken in New Zealand with a focus specifically on mental health support workers are limited. The Mental Health Support Work Advisory Group commissioned three evaluative pieces of research: *Evaluation of the National Certificate in Mental Health* (Case Consulting, 2003), *Sei Tapu- O le Ala o le Ola An Evaluation of the National Certificate in Mental Health* (Annadale & Instone, 2004), and *Te Puawaitanga O Te Oranga Hinengaro* (Rangiaho, 2003). The focus of this research was to evaluate the effectiveness of the National Certificate in Mental Health (Mental Health Support Work) (Level 4) rather than evaluating the nature of the support work of the mental health support worker. The findings from the report *Evaluation of the National Certificate in Mental Health* (Case Consulting (2003) were generally positive about mental health support work; however, the report identified that even though mental health support workers were working towards a national qualification, there were significant regional variations in what was being taught. They found that the diversity of the work and the breadth of the roles meant that the qualification was designed in such a way that the learning outcomes and graduate profile was narrower than the service reality. Māori reported that the qualification was so broad that its applicability to Kaupapa Māori services was restrictive. It is of note that Māori-specific services were not part of the service configuration when the national certificate was first developed in 1998. Furthermore, other health professionals interacting with mental health support workers did not understand their role. Concerns were raised by some respondents in regards to qualification 'creep', whereas others saw the need for a diploma level qualification. Mental health support workers were positive about an 'earn and learn' structure so that they could maintain their income. Some respondents did not see the need for a qualification and felt that mental health support workers only needed life skills and experience. In the evaluation report undertaken by Annadale and Instone (2004), key findings were that education provided a pathway for Pasifika health workers and went as

far to suggest that "the health sector looks to mental health as a leader in workforce development" (Annadale & Instone, 2004, p. 1). The report suggests that language competency is as valuable as other required competencies when working with Pacific consumers. The report also identified attributes such as passion for the work, caring about consumers, listening and involving the family in the consumer's recovery. Another important finding was that "there has been limited study done on the impact that community support workers have had on the mental health sector" (Annadale & Instone, 2004, p. 5) and that "anecdotal evidence suggests that their contribution has been significant" (p. 5). The report also recommended that there needed to be a qualification at a higher level. *Te Puawaitanga o Te Oranga Hinengaro* (Rangiaho, 2003) found that Māori were generally positive about the national certificate as a qualification, but saw areas for improvement and suggested that this could happen at the time that the qualification was reviewed. One important point that was identified was the 'streaming' of the qualification into separate Māori standards. The report also suggested that additional qualifications be developed to meet the needs of Māori diploma to degree. A number of recommendations were made in regard to what needs to change with the national certificate when it next underwent a review.

When investigating competencies for the New Zealand mental health workforce Prebble (2002) also suggested that there needed to be a focus on competencies for the Pacific and Māori mental health workforce. Like others, this report identified qualification 'creep' from certificate to degree level. Prebble (2002) also noted that some regions were delivering the national qualification while others were delivering a local qualification. Comments were raised about what could be lost or gained if mental health support workers were to become 'professionalised'.

Sutcliffe (2006) undertook a study that examined the meaning of supervision for mental health support workers. This study found that as mental health support work "is a developing profession" (Sutcliffe, 2006, p. 2) supervision was provided by disciplines other than mental health support workers. The form of supervision described by Sutcliffe (2006), was about role development rather than line management supervision. Role development supervision is considered by many in mental health services to be the norm however, as described by Sutcliffe (2006), financial constraints either mean that this is not available for

mental health support workers or that it is usually undertaken within a group rather than in an individual setting.

A New Zealand study by Bisogno (2009, p. 50) investigated recovery and mental illness from the perspective of mental health support workers. Three value propositions were posed: the mental health support worker's understanding of recovery; the role of mental health support workers in facilitating recovery; and autonomy in relation to recovery. This study identified that mental health support workers have a role in facilitating consumers to "regain lost roles" (Bisogno, 2009, p. 48). In order to equip mental health support workers to facilitate this process, they noted "recovery requires multi-skilled, well-resourced MHSWs (mental health support workers); and MHSWs are more able to advance service users recovery when MHSWs values correspond with the recovery philosophy" (p. 50). This study also found that autonomy while being an enabler could also be a barrier to the service user's recovery if it was introduced too suddenly in the journey towards recovery.

The literature that describes the New Zealand context firstly suggests that within the policy environment there is a place for mental health support workers to make a significant difference to the services being provided for mental health consumers. Secondly, it shows that there has been very little research undertaken about this group of health workers. The two main studies by Sutcliffe (2006) and Bisogno (2009) examined aspects of the mental health support worker's role i.e. recovery and supervision but did not discuss their contribution to mental health services. What is evident from the literature in the New Zealand context is that mental health support workers are a valuable but not well understood resource that is much needed in a resource-constrained health system. The challenge of understanding their role and how their full scope of practice can be realised will be explored through this study.

SUPPORT WORK IN OLDER PERSON MENTAL HEALTH SERVICES

A study undertaken by McCrae, Banerjee, Murray, Prior, and Silverman (2008) examined the area of older person mental health services and its relationship with support workers. This study found that the lack of role clarity caused confusion with other members of the health team with support workers reporting "their input was heavily influenced by

professional practitioners' understanding of the role" (McCrae et al., 2008, p. 738) and that this lack of understanding then influenced the responsibilities they were given. The support workers reported that they were "confident that they were making a valuable contribution to the services" (McCrae et al., 2008, p. 739) however there was a mixed view of this from other members of the professional team. The other findings were that the ambiguity of the role had led to confusion with other health professionals and "new roles cannot be presumed to mean the same thing to all staff" (McCrae et al., 2008, p. 741). These findings are consistent with the findings of other writers when examining the role of support workers and the interface with other health professional.

GLOBAL VIEWS OF RECOVERY

The Mental Health Commission of New Zealand's report *Our Lives in 2014* (Mental Health Commission, 2004b) described a whole of system approach to enable recovery rather than defining what recovery is. The aspirations described in the report were consumer lead, inclusive and sought equal access to services that would meet the needs of the consumer.

The Mental Health Commission of Ireland cites New Zealand as one of the countries that has developed recovery-orientated services through the *Blueprint for Mental Health Services in New Zealand* (1998). *A Recovery Model* (Mental Health Commission Ireland, 2005) acknowledges that "since the experience of recovery from mental illness is necessarily individually defined and is much wider than the remission of clinical signs and symptoms there is an increasing need for researchers to develop more outcome measures which reflect this broader definition of recovery" (Mental Health Commission Ireland, 2005, p. 10). However this report does take a whole of systems approach, suggesting that recovery is about self-management.

The desire to develop outcome measurements for recovery is at odds with the study of Borg and Kristiansen (2004) who identify that it is aspects of the relationship that are important for recovery from the consumer perspective. Borg and Kristiansen's (2004) study viewed recovery from the perception of mental health consumers. The aim of their study was to "deepen our understanding of personal experiences in recovering from severe mental illness" (p. 494) and "to understand the characteristics of helping relationships in mental

health services" (p. 494). Their findings were that mental health consumers found "empathy, respect, and a general person-to-person investment" (Borg & Kristiansen, 2004, p. 495) as being the "most helpful" (p. 495). Participants also identified 'being seen' as important; this interpretation of *being seen* relates to health professionals sharing the ordinariness of their own lives with mental health consumers. Participants also valued the health professional that "allowed them *ill and well* at the same time" (Borg & Kristiansen, 2004, p. 497). Furthermore, this study also showed that the mental health consumers valued the health professional that was available when required and would assist with whatever was required. Participants spoke of the health professionals who broke the rules and did simple things such as accepting gifts from consumers. The breaking of the rules not only demonstrated to the consumer the humanness side of the health professional but it also gave power to the consumer as they were in control of the process. It was the ordinariness and the 'human side' within the relationship between the health professional and the mental health consumer that provided the therapeutic climate in which the consumer could aspire to recovery.

Liberman and Kopelowicz (2005) suggest that "many consumers and professionals have confounded recovering with recovery by failing to grasp this distinction" (p. 735). Their study primarily focused on recovery from schizophrenia and suggested that "symptom remission alone is inadequate to define recovery" (Liberman & Kopelowicz, 2005, p. 738). Liberman and Kopelowicz (2005) plea for the "acceptance of operational modes of defining recovery" so that "criterion-referenced definitions will help move the important goal of recovery into the mainstream of psychiatric research" (Liberman & Kopelowicz, 2005, p. 740).

Onken, Craig, Ridgway, Ralph, and Cook (2007) undertook a review of the literature related to recovery. They considered that recovery is more than a whole of systems approach and describe it as involving "the constant interweaving of the elements of one's life context (such as psychosocial, cultural, spiritual and economic experiences)" (Onken et al., 2007, p. 9). Their study suggests that recovery is about change, i.e. both first-and second-order change. They define first-order change as being that which is recognised by the individual, whereas a second-order change is defined as a systems change. Onken et al. (2007) explored two forms of recovery, that which is "recovering from the illness itself or

overcoming of disabling symptoms" and suggest that others would view recovery as "overcoming the impact of and eliminating the deviant status imposed by society" (p. 10). They suggest that recovery from mental illness is defined as "a process of gaining mastery over the illness" (p. 10). They do sound a note of caution about the barriers for successful recovery from mental illness which includes poverty and stigma. In this respect they see recovery as being about societal inclusion. They identified several elements associated with successful recovery; these include "hope, self-determination, agency, meaning/purpose and awareness/potentiality" (Onken et al., 2007, p. 10). They present an argument that "re-authoring is a pivotal task in the recovery process" (p. 13). In order to re-author, consumers need to have opportunities created that provide a transformational discourse by reclaiming their lived experiences as challenges and not as disabilities. Onken et al. (2007) suggest that consumers must be able "to choose with whom they work with towards their goals" (p. 16). This study considers that recovery does not so much reside within the individual consumer rather it lies within our society and society's ability to remove social and economic barriers.

Adeponle, Whitley, and Kirmayer (2012) identified two concepts of recovery. This first is described as clinical recovery which is further defined as "remission of symptoms" (p. 109). In contrast mental health consumers suggest that the emphasis needs to be on personal recovery, as this has an emphasis on "hope, purpose, self-identity, connection, spirituality, empowerment and overcoming stigma, in addition to symptom management" (Adeponle et al., 2012, p. 109).

Seminal work by Deegan (1988, 1997, 2000) and Deegan and Drake (2006) focuses on the concept of recovery and suggests that there is a need for improved communication between the consumer and health professionals, as well as involving consumers in the decisions over their care and treatment. The earlier works of Deegan (1998, 1997) suggests that rehabilitation is "the *world pole* and that recovery refers to the *self-pole* of the same phenomenon" (Deegan, 1988, p. 11). Deegan (1997) also suggests that the labels used in defining mental illness and the labels used to define people who become mentally ill are pejorative and remind the world at large that that people with a mental illness are first and foremost a person. Deegan's (2002) contemporary work suggests that "recovery is not the privilege of a few exceptional clients". We can now tell people the good news that empirical data indicate most people do recover" (Deegan, 2002, p. 20).

A delphi study of recovery was undertaken by Lakeman (2010). This study suggests that there is still confusion as to the true meaning of recovery. In this study, Lakeman compares the use of the term 'recovery' in an alcohol and drug setting with its use in mental health services. The addictions sector uses recovery to convey abstinence whereas the mental health sector views recovery as more of an aspirational concept, where the affected individual may or may not be free of symptoms of their illness. Lakeman (2010) introduces the notion that many of the treatments within mental health services are "incompatible with ideas of mental health recovery" (Lakeman, 2010, p. 64). The study by Lakeman (2010) identified and recognised "promotion of an individual's capacities, strengths, resourcefulness, and autonomy" (Lakeman, 2010, p. 72) as being the top-ranked competency required for working in mental health services. However, Lakeman (2010) did caution on the limitations of the survey suggesting there may have had a cultural bias with respondents not fully aware of the New Zealand context as an example, the relevance of "whanau (family)" (Lakeman, 2010, p. 71).

The concept of recovery provides an international perspective for this study. There is an understanding that recovery is individually focused and that the aspects of incorporating whanau into recovery provides a uniquely New Zealand emphasis.

A PASIFIKA VIEW OF RECOVERY

Fotu and Tafa (2009) introduced a model of recovery known as the *Papao Model*. The use of the term 'popao' is based on the outrigger canoe as used by the people of the Pacific. This "metaphorical model" (Fotu & Tafa, 2009, p. 164) uses the canoe as a way of describing the journey of the mental health consumer through recovery and suggests that "each consumer paddles their own canoe towards their desired destination, mapping and personalising their journey and identifying any obstacles in the lagoon" (Fotu & Tafa, 2009, p. 164). As a way of individualising the consumer's journey, this model recognises that there are many different names for the canoe throughout the Pacific Islands; however "they all have similar structures" (Fotu & Tafa, 2009, p. 168). This analogy is also relevant to the concept of recovery, showing that while there may be some differences, the basic structures are similar. When consumers board the canoe, they should be given the position where they can both steer and row as "this symbolises their strength" (Fotu & Tafa, 2009,

p. 169). The model discussed in this study is a Tongan model however it is suggested that this model could be used across Pacific Island groups as a way for mental health consumers to understand recovery from the perspective of their own cultural background.

Globally culturally appropriate models have been evolved based on the principles of recovery. These models have taken the concepts from a western ideology and moulded these to suit the requirements of different cultural groups.

WORKING EFFECTIVELY: CHARACTERISTICS OF MENTAL HEALTH SUPPORT WORKERS

People who experience mental illness have a number of services provided for them by a range of health professionals. A feature of the mental health support worker's relationship with mental health consumers that is not shared by others in the mental health sector is the closeness of that relationship. This closeness is a result of the time that the mental health support worker spends with the mental health consumer and takes place in a number of settings including the consumer's 'home'. This makes the identification of desirable characteristics important when employing mental health support workers. These are positive characteristics that educators and trainers need to build on in order to get the best out of mental health support workers; as this will ensure that even better services are provided to mental health consumers. Mental health support workers bring to the relationship the characteristics associated with hope, trust, faith, happiness and fulfilment, they are able to create spaces for mental health consumers.

CHARACTERISTICS FOR POSITIVE SUPPORT

A study undertaken by Evans and Moltzen (2000) identified six characteristics for effective support for mental health consumers in the community. These are acceptance, positive atmosphere, expectation of change, incidental learning, responsiveness, normalisation and educative functions. These findings were based on empirical evidence provided within a broad range of literature. They researchers found that there was "a paucity of information on the support staff behaviours most habilitative for patients with PSMI (persistent and serious mental illness)" (Evans & Moltzen, 2000, p. 637). While this study posed the question "What would an ideal therapeutic environment look like?" (p. 642) and sought to

be future focused, the language used in this study (e.g. 'patient') is very traditional and has the unintended consequence of de-powering the therapeutic relationship. Within this study were some thought-provoking assumptions that would assist to provide an agenda for change and when reframed, strike a resonance with the language used by Aubry, Flynn, Gerber, and Dostaler (2005).

Aubry et al. (2005) undertook a study to identify the competencies that mental health consumers considered were required by mental health support workers. The study recruited 34 mental health consumers and 34 mental health support workers. It sought to differentiate the competencies required "prior to assuming the position versus those that could be learned on the job" (p. 352). Aubry et al. (2005) identified that the competencies required of a support worker before starting the job "involved mostly personal; attributes and that these reflected individual qualities that are consonant with a respectful, optimistic, accepting and sincere approach" (p. 352). They observed that the main requirements for mental health support workers once in employment were more skill based and that this was not limited to a particular discipline but rather drew from such disciplines as social work, psychology, sociology, nursing, and medicine. The eclectic nature of community support is consistent with the range of disciplines from which community support providers in community mental health programs across North America commonly originate (p. 352).

CARE IN THE RELATIONSHIP

Finfgeld-Connett (2007) undertook a study to explore the concept of comparing caring with social support. While they primarily took a nursing focus, they found that caring and social support are intrinsically linked concepts. They also suggested that the precursor to caring is 'professional maturity', which is defined as a protective mechanism that provides the nurse with the ability to "cope with the routine stresses of clinical practice" (p. 60). However Finfgeld-Connett (2007) suggests that there is no evidence supporting the notion that social support requires 'professional maturity'. It is for this reason that she defines social support as being provided by lay people and may including family members and suggests that social support is only provided by "healthcare professionals only when lay providers are unable" (p. 60). Finfgeld-Connett's (2007) study suggests that social support falls into two categories "emotional and instrumental" (p. 59) and that the situational context of the

relationship is more important than professional expertise. The other characteristics identified were that "unconditional positive regard is highly valued along with reliable availability, mutuality and reciprocity" (p. 62). Finfgeld-Connett (2007) also puts forward the view that "psychic growth is associated with caring, whereas feeling of normalcy and decreased isolation are more common to social support" and that nurses are "urged to remember that they are not the preferred providers of social support" (Finfgeld-Connett, 2007, p. 65).

Millet (2011) extends the concept of care that occurs within professional relationships and suggests that "a living thing ought to be looked after or cared for simply because it exists as a living thing" (p. 272). The relationship that mental health support workers have with mental health consumers transcends beyond that of a professional relationship in the purist sense of the word that is not to say that their relationship is not professional but rather that their relationship and the nature of that relationship is one of professional care.

GIVE HOPE

In an early exploration, Deegan (1988) argued that the concept of recovery is synonymous with the "concept of hope" (p. 11). More recently, Deegan's research was considered by Adeponle, Whitley and Kirmayer (2012), whose interpretation of the work suggests that recovery means "a way of life, an attitude, and a way of approaching the day's challenges, built on the cornerstones of hope, desire for a full life, and responsible action" (Adeponle, Whitley, & Kirmayer, 2012, p. 111). This adds the dimension of hope when considering the concept of recovery.

BUILDING TRUSTING RELATIONSHIPS

While numerous studies have been undertaken regarding the relationship between other health professionals and patients, the literature regarding the relationship between mental health support workers and mental health consumers is scarce.

A study undertaken by Verhaeghe and Bracke (2011) showed that mental health consumers have a distrust of mental health professionals that is "due to stigma expectations and self-stigma despite an absence of any concrete negative reaction from other people" (Verhaeghe

& Bracke, 2011, p. 300). The study then went on to suggest that this sense of distrust by mental health consumers of health professionals is one of the identified factors that "impedes the positive relationship between stigma expectations and satisfaction" (Verhaeghe & Bracke, 2011, p. 300), thus indicating that the stigma related to having a mental illness is a barrier for mental health professionals (including mental health support workers) even before they engage with a mental health consumer.

A study of relationships by Gilburt, Rose, and Slade (2008) within an acute mental health inpatient unit identified one of the main themes in attending to positive relationships was the concept of 'trust'. Mental health consumers "attribution of *trust* or *mistrust* was described only in relation to other staff" (p. 6). The attributes that mental health consumers described in this study and used for those staff that they saw as trustworthy were "described as being professional, able to manage situations in which the safety of patients was at risk, flexible, non-coercive, committed, and caring about patients" (p. 6). This study also identified a connection between trust and professionalism and that those staff who fell short of the consumer's expectation of professionalism were deemed to be untrustworthy (Gilburt et al., 2008).

McDonald, Cox, Paterson, and Lafrenière (2008) investigated the trust within the relationships of health workers. The study found that there was a strong, positive correlation between high levels of trust and the status of the health worker however, the participants conveyed that although they did have a high level of trust associated with certain health workers this was not "blind trust" (McDonald et al., 2008, p. 39), "Creation of trust is a reciprocal process" (McDonald et al., 2008, p. 40).

FAITH

Illingworth (2008) identifies that 'trust' and 'hope' have been extensively researched as key factors in developing "a therapeutic relationship" (Illingworth, 2008, p. 9). However this study focused on the concept of 'faith' in the therapeutic relationship. Illingworth (2008) suggests that "faith is not knowledge or a weak belief, but a conviction about that not yet proven. Faith is rational when based upon knowledge and comprehension of past experience. Faith, it could be suggested, is paradoxical as it is not certainty in the sense of

unquestionable predictability, but is the certainty of the unknown" (Illingworth, 2008, p. 10). When studying faith Illingworth (2008) suggests that it "is not bound by time and space and does not need to be based on past experiences" (Illingworth, 2008, p. 11). Further examination of the concept of faith reveals proximity to recovery; the aspirational and future focused aspects of faith can allow this concept to be embedded into the aspirational futures created through Appreciative Inquiry. Illingworth (2008) describes faith as something that sustains one's conviction that what we are doing is worth doing; faith that our actual existence has meaning; and faith that our concern for others reflects the concerns of others. Faith allows people to transport the future into the present (Illingworth, 2008, p. 11).

Within the context of mental health, the concept of faith should not be confused with religious beliefs related to faith. However if faith is applied in the broadest sense it provides a nexus between faith as a religious belief and faith as a concept interconnected with hope and trust. Illingworth's (2008) study focuses on mental health consumers having faith in others and only in part touched on faith within the context of religious beliefs.

HAPPINESS

A study by Haybron (2008) examines the concept of happiness from the point of how happiness matters. The approach taken by Haybron is to examine some of the earlier concepts related to happiness such as well-being, welfare, flourishing and eudaimonia. Haybron examined the eudaimonistic theories, interpreting them to mean that "we flourish by fulfilling our natures" (Haybron, 2008, p. 22). Hayborn (2008) suggests that living in conflict with who we are and what we want to be places people in this conflicted position and that these "values are misplaced" (Haybron, 2008, p. 26).

Haybron (2008) introduces the term 'mood propensity' and defines this as "when one is happy, bad moods can still occur in response to negative events. But they are less likely and will tend to yield quickly to positive ones. This sort of emotional resilience is one of the great benefits of being happy" (Haybron, 2008, p. 30). Here Haybron introduces the concept of resilience from an emotional perspective. Haybron then links the concepts of happiness to that of self-fulfilment so that "happiness has intrinsic prudential value as an

aspect of self-fulfilment"(Haybron, 2008, p. 47). The concept of self-fulfilment can be linked back to the discussion on recovery and what recovery means for individual mental health consumers.

Intrinsic Fulfilment

It is my view that a recovery and strength-based approach is found in the work of Aristotle. Boston's (2000) interpretation of Aristotle's work uses the word 'eudaimonia' to suggest that this has a similar connotation to the concept that I have called 'intrinsic fulfilment'. Eudaimonia, has been referred to as greater than an immediate state of happiness and "requires more than mere contentment and satisfaction" (Bostock, 2000, p. 7). Haybron (2008) suggests that "certain goals are explicit" (p. 22) and that the "eudaimonistic theories share a teleological structure, grounding well-being in ideals of nature-fulfilment: we flourish by fulfilling our natures" (Haybron, 2008, p. 22). Haybron (2008) then suggests that there is a significant level of agreement between self-fulfilment and happiness and that this is a reflection of an individual's temperament. The concept of existential fulfilment is described by Tomic and Tomic (2011) as "a way of life that is full of meaning and purpose" (p. 469). It is these characteristics that describe the mental health support worker in the Discovery phase. Diener and Lucas (2000) suggest that there is an implied need to 'test' whether 'needs' have a high correlation to resources and therefore the greater the resource the more likely the level of fulfilment however, they did not define what those resources were.

ROLES SIMILAR TO MENTAL HEALTH SUPPORT WORKERS

Roles similar to mental health support workers have emerged. While there are some differences with the roles such as peer support workers, many of the characteristic that consumers value in mental health support workers are also seen as valued in other types of support work.

Peer support workers

The peer support worker's role is based on the premise "that mental illness must be understood through the perspectives of those directly affected by them" (Tse, See, Wong, Kan, & Kwok, 2014, p. 211). The formal recognition of mental health consumers employed

into the role of peer support worker is a very recent development in mental health services in New Zealand. A study by Tse et al. (2014) looked at the emerging workforce of the peer support worker. The study found that there needed to be a relationship between "service providers and policy planner" (p. 217) and in order for peer support workers to be successful in their role they required training that was "*learn as you practice* versus a set curriculum" (Tse et al., 2014). The United States of America has recognised certified peer support workers through a training programme that has resulted in this group of health workers being able to seek reimbursement through Medicaid. The process of training has allowed certified peer support workers to work as "professional peer support workers" (Tse et al., 2014, p. 216). This suggests that one of the requirements for professionalisation is training. An Australian study by Nestor and Galletly (2008) described a peer support worker as someone who brings "their experiential knowledge and understanding of mental illness" (p. 344). The findings from their study were that "peer support workers can work in successful partnerships with other health professionals" (Nestor & Galletly, 2008, p. 347); however, the study identified "ongoing support and supervision for PSW (peer support work) is essential and training programmes are needed for those consumers who are interested in qualifying as PSWs" (Nestor & Galletly, 2008, p. 347).

A New Zealand study of peer support practice in New Zealand was undertaken by Scott, Doughty, and Kahi (2011). The findings from this study were that while peer support work in New Zealand is variable so too is the available training. The study did not support a compulsory national qualification for peer support workers but argued that adequate funding must be made available for supervision and training of peer support workers. The study also recommended that "specific training in peer support needs to be offered to clinicians" (p. 127).

PEER SUPPORT WORK IN THE AREA OF ADDICTIONS

A study by Norman et al. (2008) looking at the peer support worker role in treatment for injecting drug users was undertaken in Australia. The study identified the attributes that service users found most helpful were: the ability of the peer support worker to empathise, being non-judgemental be able to listen and be able to provide good advice. The concerns raised by the service users in respect to peer support workers were issues over

trustworthiness and "professional ramifications" (Norman et al., 2008, p. 5) for unprofessional behaviour. This study extends the boundary of peer support work into the realm of the area of addictions and suggests that this is an area that requires further consideration.

SUPPORT TIME AND RECOVERY WORKERS

The introduction of the Support, Time and Recovery (STR) worker for mental health services in Britain in the late 1990s was one of the "more radical ideas to ensure that the workforce can be secured and sustained to deliver a mental health service fit for the 21st century" (Allock & Hollingsworth, 2009, p. 12). The introduction of STR resulted from the National Service Framework which sought to introduce a new type of worker into mental health services (Allock & Hollingsworth, 2009). Allock and Hollingsworth (2009) suggest that the introduction of the STR worker has been "hugely rewarding" and "the difference it has made is significant" (Allock & Hollingsworth, 2009, p. 14). The evaluation of this new workforce identified a number of themes. These were the remuneration disparity of STR workers both within teams and across different services; the need for future career options; the need for a supportive infrastructure; the need for education and training; understanding job titles; and role clarity. This study also identified the importance of other staff within mental health services understanding the new and emerging roles so that existing staff do not have concerns of "their own roles being eroded"(Allock & Hollingsworth, 2009, p. 16).

Huxley, Evan, Beresford, Davidson, and King (2009) undertook a study that evaluated the relationship that STR Workers in mental health services in England have with mental health consumers. The role was defined as, spending negotiated time with service users, providing appropriate support, so aiding their recovery; having a specified education and training pathway (in practice this has taken a variety of forms); work in a variety of statutory or non-statutory service settings and across traditional service boundaries; supervised as part of a team; focused on practical help, promoting independence and integration into the community (Huxley et al., 2009, p. 100).

The findings from that study showed there were inconsistencies in the introduction of this new workforce, which was mainly composed of middle-aged people and included some

mental health consumers. The study findings were that the service mental health consumers received from the STR workers was of a "superior quality" (Huxley et al., 2009, p. 113) than the service they had previously received from other health professionals. Other health professionals interviewed expressed concern about STR workers "breaching the boundaries between professional help and personal friendship" (p. 113). This concern was not supported by the STR worker or the mental health consumer; rather they reported an awareness of the boundaries and made "conscious efforts to avoid them" (p. 113). Further questions raised in the study were around whether the positive attributes identified as positive by the mental health consumers can be taught or whether they are innate in workers who are drawn to this type of employment. This study and similar studies have shown that mental health consumers place a high value on "the nature and quality of the relationship with the worker in social care practice and the importance of positive human qualities in workers" (p.114).

An earlier study by James, Chadwick, and Rushforth (2006) provided the rationale for the development of a new category of worker in mental health as being not only to look at new models of delivery but also noting that "frontline professionally qualified staff were burdened by increasing workloads" (James et al., 2006, p. 31). The introduction of the STR worker would "promote recovery and social inclusion/community engagement as being implicit in the role of the STR worker (James et al., 2006, p. 31). The initial concerns associated with this new health worker related to terms and conditions within the employment contract, ensuring service users were involved in the "planning and delivery of services" (James et al., 2006, p. 34) as well as "target driven managers" (p. 31) and the need for education and training.

PRIMARY MENTAL HEALTH WORKER ROLE

A study by Hickey, Kramer, and Garralda (2010) investigated the role of primary mental health support workers and found that, despite the expansion of this workforce very little research had been undertaken to determine the effectiveness of this workforce. This study specifically focused on mental health support workers employed in child and adolescent mental health services. One of the key aims for the introduction of this role was to "broaden the range of children and adolescents accessing mental health services" (Hickey et al.,

2010, p. 26). The study reported that the numbers of primary mental health support workers (PMHSW) had rapidly expanded with the most likely referrers to be general practitioners (Hickey et al., 2010). The study also found that key to the role was flexibility and that where the support worker was employed by a clinical service, those relationships were strong within those services; this is similar to the findings for those employed, into a primary health service. Positive job satisfaction was linked to good working relationships. The study also found that no matter where the support worker was employed that there was a need for interagency understanding and that this "would benefit from training" (Hickey et al., 2010, p. 28). This need for continued training not only for the mental health support worker but for other health professionals to understand the role was considered essential for the role.

THE WORKING ENVIRONMENT

The regulated and non-regulated areas of health are complex. In New Zealand regulatory bodies are designated under the Health Practitioners Competence Assurance Act (HPCA) (2003), with the overarching requirement to ensure public protection. It is suggested but not required that areas of health practice not covered by the HPCA Act (2003) should meet the threshold of public protection through self-regulation and employer policies. The HPCA Act (2003) defines scopes of practice for certain health professional occupations however, mental health support work, does not sit under this act and therefore sits within the area of a non-regulation occupational group.

There are models within the health sector that have successfully developed their own form of 'registration', which sit outside of the HPCA Act (2003). This has provided requirements to maintain competency, which in turn generate public confidence in the discipline. While regulation of a particular sector of the health workforce can be a way where 'professionalism' can be potentially achieved, regulation can also set restrictive scopes of practice, narrowing the ability of the health worker to engage with the consumer in order to meet the variable needs of the individual consumer. The policy frameworks allow for and encourages self-regulation as a means demonstrating the level of 'professionalism' that many support workers aspire to.

Beddoe and Duke (2009) undertook a study that looked at the registration of social workers in New Zealand. This study identified that the educational preparation of social workers has been debated for a number of years with the "educational qualification being the major focus" (Beddoe & Duke, 2009, p. 791). Beddoe and Duke's (2009) study saw the pathway to registration for social workers as a way for the profession to be strengthened and to gain credibility. They suggested that New Zealand is still ambivalent "about professionalization through regulation" (Beddoe & Duke, 2009, p. 787). The argument mounted by Beddoe and Duke is that unregistered social workers would be considered by other health professionals as "second-tier" (p.789) and that through gaining registration they gain credibility and professionalism. This would be achieved through registration, a registration board and demonstration of ongoing competencies. Beddoe and Duke (2009) provide a salutary note that "Regulation is not a process that sits outside the profession: it is a professional issue and responsibility. Professional leaders and educators will need to caution against expectations that registration alone can improve practice" (Beddoe & Duke, 2009, p. 794).

WORKFORCE PLANNING FOR MENTAL HEALTH SERVICES

The Ministry of Health's (1996) report *Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development* was the most comprehensive report of its kind in New Zealand and focused specifically on the future direction of this workforce. While noting the complexities of the health reforms of the 1990s, this report also recognised the requirements to build a workforce that would meet the needs of Pasifika and Māori mental health consumers and the new environment. The report signalled that "a major workforce crisis is currently affecting all mental health services and required a major "rethink" as to how workforce development issues can be dealt with now and in the future" (Ministry of Health, 1996, p. 11). This report recognised that in order to gain traction in the health workforce an intersectorial approach was required with a workforce that was "multiskilled, flexible and adaptable to work with a range of consumers across a range of settings" (p. 23). The report identified that skilled consumers could be delivering services along with mental health support workers. The report also noted the difficultly of having robust information on the unregulated workforce when undertaking workforce planning. This report sought the opinion of mental health consumers

who highlighted the need for staff working in mental health services to have the 'right' attitude. They defined this as needing more emphasis on "the possession of key personal attributes in the recruitment and selection of mental health workers. They value mental health workers who are practical, respectful and optimistic and form good relationships with consumers based on understanding and empathy" (Ministry of Health, 1996, p. 52). When the report defined mental health workers, it took a liberal approach and this title was applied to all those employed in mental health services.

When considering the needs of mental health services, Mulvale (2004) examined planning that took place in New Zealand, Australia and the United Kingdom. The focus of the study was to review policy documents with a particular emphasis on workforce planning for community mental health services. This report identified that new categories of mental health workers were being introduced. These included: gateway workers, mental health graduates, STR workers and community development workers. The report raised a concern that workforce planning continued to take place in a vacuum without considering factors such as the regulatory and contractual environment. The report also found that "funds earmarked for mental health may be used for other purposes" (Mulvale, 2004, p. 4) and that there was lack of co-ordination for workforce development, limited expertise and lack of buy-in for providers. Like the experience of New Zealand, the report identified that the emphasis on mental health services and the workforce in Australia came about as a result of a number of national inquiries into mental health services. Mulvale (2004) recognised the complexities of workforce development for mental health services across the three countries. However, in doing so, recognition was given to the work undertaken in New Zealand through the leadership of the Ministry of Health and the Mental Health Commission including the recognition of the mental health support worker; "The certification of a community support worker is an opportunity to raise the competency of an unregulated workforce. If additional training is required, issues of coordination with educators and funding would need to be addressed" (Mulvale, 2004, p. 14).

Careful consideration of these issues and questions early on in the policy development process can help to ensure that the resulting human resources policy will be most effective for the Ontario context. Otherwise, considerable resources can be put into developing

strategies that may be overwhelming to local agencies and the development of workforce plans that cannot be attained (p. 17).

A CRITICAL CONSIDERATION

In considering mental health support work and the staff that undertake these role thought needs to be given to the shadow of neoliberalism which exists when examining mental health services. A humanistic public and social good approach is in tension with the neoliberalism philosophy. The tension plays out in the fundamental questioning of the rights and responsibilities of the state for people with mental illness versus the rights and responsibilities of the individual to provide for their own health and social service care. These tensions become magnified in the mental health sector due to the "clash of ideologies" (Carney, p. 105) between medicalisation and therapeutic interventions. Neoliberalism ideology has been discussed in Chapter Two through examining aspects of health policy and health reforms of early 1990s. It was this period of New Zealand's health reforms that witnessed the growth of the non-government organisations in providing services for mental health consumers, but also saw a move away from state control of services to private service providers. Esposito and Perez (2014) support the view that neo-liberalism reaches far beyond policies and regulations it is a" vision of the world in which all aspects of social, cultural, and economic life are shaped" (p. 416). Resulting from such views is the assumption is that there are inefficiencies in the state system which are not found in the private system and that "free functioning of the market forces leads to a better utilization and allocation of resources" (McGregor, 2001, p. 83). This approach suggests that "social equity, participative democracy, sustainability and economic growth" (p. 83) are not interconnected but that economic growth should be the overarching driver for policies. The conflict which then exists between the ideology of mental health services and mental health support work if taken from a neoliberalism view is the challenge to place a value on mental health support work. This challenge is highlighted by John in Chapter Seven when he suggests that there has to be a new way of accounting the value of mental health support work and that this needs to move from the current output approach to a more humanistic evaluative framework.

It could be viewed that if it were not the low wages of mental health support workers they would become an unaffordable commodity due to the amount of time that they spend with clients. Further there is the issue of what they do with mental health consumers. From a neoliberalism approach individuals are responsible in finding "their own solutions to their lack of health care" (McGregor, 2001, p. 84). From such a perspective it could be argued that clients need to find their own support people from within their own family and social circles. Ramon (2008) suggests that the neoliberalism movement takes away the collective responsibility towards the individual and has contributed "to the continuation of perceiving mental health service users as social and personal failures in the twenty-first century" (p. 121).

Generally governments in first world countries continue to maintain control of individuals through legislation while rationing resources thereby preventing "clinicians, consumers and carer interests to win the sufficient share of resources needed to realize the promise of dignified community based care of the mentally ill" (Carney, 2008, p. 111). This goes back to the heart of mental health consumers having the rights of citizenship. While research findings tend to address questions of role and function, it is important to remember that mental health support work is enabled or constrained by political ideology.

SUMMARY

The complexities of workforce planning require scrutinizing when undertaking mental health service reconfiguration. Some members of our most vulnerable population are placed at risk if this is not performed. New Zealand looked at de-institutionalisation and took future workforce requirements into consideration. Like many other Western countries, New Zealand has made a conscious attempt to adopt a recovery philosophy when developing policy for services. The concepts of recovery are possible for countries to use and develop into a model that suits their environment. It is evident that many of the earlier philosophies about what makes human beings feel valued such as hope, faith, care and trust, positive relationships, and happiness are aspirational concepts. When these are considered in the relationship between the mental health support worker and the mental health consumer, recovery becomes a reality.

Changes in the workforce have seen the introduction of mental health support workers as well as peer support workers. Many overseas countries (in particular England) have seen the introduction of the STR workers who undertake a role that is very similar to the mental health support worker in New Zealand.

The literature in relation to characteristics identified by mental health consumers as important in assisting with recovery are characteristics which have been identified as belonging to mental health support workers and the STR workers. While competencies for the mental health workforce have been identified, it is the nature of the relationship that mental health consumers value the most. It is the ordinariness, the non-judgement and the non-clinical and non-labelling approach that mental health consumers believe is the most helpful in their recovery. It is these characteristics that they see in the mental health support worker.

The literature revealed that there are limited studies about the role of mental health support workers within mental health services and about how that role is perceived and understood by others within mental health services. Since the formal introduction of the mental health support worker role in New Zealand in 1998, other countries such as Britain and Australia have introduced similar roles under different titles. Since the 1990s New Zealand has also seen the introduction of the peer support worker into mental health services. The available literature contained in policy documents suggest that the mental health support worker's role has not been fully realised within the New Zealand health context. This study illuminates the work being undertaken by the mental health support worker and describes an aspirational future for this workforce. The literature also highlighted the shadow of competing tension between opposing ideologies that of 'public good' versus individual responsibilities.

CHAPTER FIVE: METHODOLOGY

Appreciative Inquiry (AI) is not the latest feel-good fad; it's a proven methodology that draws upon the past to create a new positive organizational culture. Appreciative Inquiry is the antithesis of problem-solving, appreciating people and processes that have worked and revitalizing the organization by emphasizing its many successes. (Tom González, President of Front Range Community College in Colorado)

INTRODUCTION

This research aimed to identify what is working well with mental health support work in New Zealand and what could be done differently.

This chapter outlines the appreciative inquiry methodology for this study including theoretical influences, limitations, key characteristics of AI and recognition of the Shadow. The findings from this study will help to inform mental health services, those that use these services and those who work in those services. The use of an AI approach for this study is supported by recovery and strength based approaches that mental health services in New Zealand are based on.

The foundation on which AI is built provides the crafting of an environment for individual stories to be told and enables "a unique climate for collective dreaming where the forces of ridicule and repression are momentarily suspended" (Bushe, 1998, p. 2). Participants came to this study as 'storytellers'; Frank (1995) suggests that the point of storytelling "is not what is learned from their content" (p. 159) but "rather what a listener becomes in the course of the listening to the story" (p. 159). I had the privilege of being that listener; I heard the stories being told, and therefore having assumed the responsibility to ensure those stories were collected, voiced and interpreted through this study. White and Drew (2011) suggest that the traditional approaches to interviewing in research tend to rely on conceptions of neutrality, wherein the interviewer just has to ask the right questions in order to get to the heart or truth of the interviewee's experiences, perceptions and opinions their voice.

Throughout the study participants discussed their ideas for change. It is these ideas that were formulated into recommendations for change in Chapter Twelve. Traditionally research has applied a rear view mirror approach to look at what went wrong. An appreciative approach acknowledges and celebrates what is working well while providing the opportunity to create an aspirational future through seeking to identify what can be done better. AI is not interested in providing answers to problems; its approach is to envisage and to be aspirational, even if in the present this is unachievable. Research using an AI approach is not about "what is but in allowing a collective to uncover what could be" (Bushe, 2012a, p. 12).

Mental health support workers comprise a significant part of the mental health workforce in terms of numbers and the time they spend with mental health consumers. Research about mental health support work and the workers that undertake these roles has not been examined to the depth of this study, which has sought to reveal the work they do, the services they provide and the difference they make. Clossey, Melmert, and Silva (2011) agree that AI and the recovery model share a commonality in that they both seek to change the culture as they both build on strength, "all of which create hope" (p. 261).

THE APPLICABILITY OF APPRECIATIVE INQUIRY FOR RESEARCH

Bushe (1995) suggests that most researchers approach research in a linear fashion and that in doing so they "have a tendency to want to generate abstract lists and propositional statements out of the interviews" (p. 18). He argues that AI ensures "fresh images and insight come from exploring the real stories people have about themselves and others at their best" (p. 18). AI-framed questions are about the nature and worth of quality and significance of certain situations (Preskill & Catsambas, 2006) and that appreciative interviewing takes the participants through a self-reflection process and invites them to examine their successes and to identify ways of improvement (Preskill & Catsambas, 2006).

The use of an AI approach is said to be transformational and aims to seek improvement (Smythe & Payne, 2008). This approach was applied to this study as it supports growth and movement away from a more scientific perspective on research towards a humanistic

approach (Cooperrider & Srivastva, 1987). This is premised on the fact that human relationships are not static but are constantly evolving and subject to many of the influences that are part of what it means to be human. The use of AI as a research approach for mental health is in itself innovative and provides the opportunity to be transformational. "When we engage in appreciative inquiries, we focus on what makes us feel most alive, on our successes and their determinants and on the strengths" (Collopy, 2009, p. 1).

This study also uses an ontological and an epistemological approach in order to explore 'what is true' and a way to 'discover those truths'. Therefore, "issues of what or who is represented for the positivist researcher are silenced by virtue of the fact that the researcher is talking about their truth, their reality, and the laws of nature or society" (Mantzoukas, 2004, p. 997). The use of AI as the framework for this study "was chosen as a supportive methodology which would facilitate discussion. This was in contrast to using other methodologies which could seem hostile or punitive" (Reed & Verma, 2012, p. 55). Scott (2014) suggests that "AI seems more useful as a therapeutic and individual means of building self-esteem and morale" (p. 30), which makes it particularly powerful for groups that see themselves as having little or no power. Mental health support workers revealed in this study the lack of appreciation by other health professionals about the work they do.

LIMITATIONS OF APPRECIATIVE INQUIRY

Richer, Ritchie, and Marchionni (2010) suggest that the limitations of AI relate to the need to address the context of its application. They also suggest that there is a challenge "in keeping the discussions focused on the positive" (p. 169). Richer et al. (2010) cautions of the need for skilled facilitation when applying AI in the health sector due to "unexpressed resentments from healthcare workers, is unlikely to cultivate the desired results" (p. 170). Dematteo and Reeves (2011) provide a view that suggest that it is also agencies and structures that play a role in achieving positive change but cautioned about the lack of attention AI placed on "examining or accounting for existing problems and challenges" (p. 207) as this does not provide a critical analysis of the issues and therefore creates limitations. Grant and Humphries (2006) put forward the view that the "lack of methodological consistency and rigor may also be viewed as a limitation of AI" (p. 99). However, they also suggest there are merits of using AI methodology in "various healthcare

context" (p. 99) but in order to gain rigor more studies are required in these particular settings.

Grant and Humphries (2006) suggest that a critique of AI does not imply criticism. Alternatively they suggest the tension between critical theory and appreciative inquiry are a way in which contribution can be made towards "the development of new research and practitioner activities" (p. 414). Robinson, Priede, Farrall, and Shapland (2012) suggest that an AI approach challenges the interviewer as it "departs somewhat from 'regular' qualitative interviewing" (p. 16). Grant and Humphries (2006) suggest another lens in which to view AI is through that of a "Critical Appreciative Processes (CAP)" (p. 415) lens to providing a "fruitful contribution to action research process" (p. 415). Ridley-Duff and Graham (2015) suggest that there is a need to acknowledge and respond to the 'Shadow side' of AI. They acknowledge that "there is a dissonance created by unfulfilled expectations"(p. 1593). This study acknowledges the Shadow and that the tensions created by the Shadow needs to be acknowledged throughout the 4 D-cycle.

Richer et al. (2010) identified that the single main concern for using AI as a research methodology is the "lack of methodological consistency in application" (p. 170). Whereas in a critique of AI by Trajkovski, Schmied, Vickers, and Jackson (2013a) they identified that the limitations of AI were due in part to "the way in which the four phase were reported" (p. 1232). However they also suggested that the application of AI being through a "cyclical process" (p. 1232) brings with it a uniqueness to each study.

CRITICAL APPRECIATIVE INQUIRY

Critical Appreciative Inquiry (CAI) applies a social constructionism and critical theory lens to AI and, by doing so, provides an "understanding of how we construct our worlds and of how important social justice and emancipatory work is" (Cockell & McArthur-Blair, 2012, p. 52). I chose not to bring an explicit critical lens to the approach of this study in order to be open to the issues that arose from the participants themselves. I did not want to bring assumptions about who held power and how that was exercised, nor did I wish to make issues of power the key focus of the conversations. The application of critical AI is said to

be appropriate for use where "non-dominant cultures may not have been included in the dominant institutional conversations" (Cockell & McArthur-Blair, 2012, p. 53).

Detractors of AI suggest that if you go looking only for good that is what you will find. This critique could justifiably be applied to problem-based research which commences with a negative (problem) therefore suggesting problems will always be found. The AI approach does not mean that problems are silenced, instead they are reframed, future focused and aspirational. AI takes the approach that issues are presented in terms of 'how could things be better'.

RESEARCH DESIGN

Cooperrider and Whitney (2008) believe that the core or heart of the AI cycle "is the affirmative topic choice" (p. 174) and that "it is possible through our assumptions and choice of methods that we largely create the world that we later discover" (Cooperrider et al., 1995, p. 160). The AI approach provides a shift from the problem-solving approach that dominated action research in the 1980s. It has been argued by Cooperrider and colleagues that methodology based on positive assumptions could be expected to generate positive results and new ideas (Cooperrider & Srivastva, 1987). Reed (2007) suggests that there are two requirements in the gathering of information using an appreciative approach; these are inclusivity and positive focus. Inclusivity aims to ensure that as many people as possible are included in the research inquiry whereas the positivity is what focuses the entire process from framing the questions, 'taking care of the participants' and appreciation that is shown, including the sensitivity given to the writing up of the data.

The phases within the 4-D cycle can take place as "as a formal conversation with a friend or colleague, or as formal as an organizational-wide process" (Cooperrider & Whitney, 2005, p. 16). It is the topic selected that sets "the stage for the 4-D process" (p. 17).

Participants were encouraged to relate experiences that they described as being at their best; in AI terminology, is called 'peak experiences'. Chapman and Giles (2009) describe this as "an alternative process for personal development as well as for organisational and social change" (p. 298). The use of positive questions often reminds people of their accomplishments and experiences. This study embraces the positive, building on those

strengths. Kesselring, Chelsa, and Leonard (2010) support the notion that the use of qualitative methods in research will help to enable health "professionals and lay caring-practitioners gain an in-depth understanding of their situation and of self" (p. 14).

THEORETICAL BACKGROUND

Reed (2007) suggest there is a connection between "research approached and AI methodology" (p. 66). AI is no one of these approaches however it has been influenced by post-modernist European philosophy, so that the weaving together of these theoretical perspectives using an AI approach suggests:

- There is no fixed reality; everything is open to interpretation and in constant state of change
- Bringing together positive expectations to an inquiry influences the nature of the stories told
- There is value in nurturing what is best
- Working with participants can empower them
- Listening to stories of lived experience can draw the researcher and the reader into deeper thinking.

Post modernism: Post modernism constructs assume a preference for qualitative methods. It assumes that nothing is definitive and that there are no universal laws. The concept of objective, individualistic, historic knowledge is too limiting. The perspective in this study seeks to identify the value that mental health support workers add to the health system in a way that has not yet been analysed. "The postmodern voices suggest that Western conception of knowledge, including its romance with permanence, belief in progress, the search for reliable patterns beyond contingencies towards the service predicting and controlling future events, has not fulfilled its promise" (Cooperrider et al., 1995, p. 158). This suggests that nothing is permanent, with everything open to multiple interpretations – thereby requiring the researcher to capture all such interpretation within the interview process.

Social constructionism: Social constructionism stresses the importance of social interactions, narrative and discourse in producing phenomena such as organisations.

Relationships and interrelationship of groups provide the needed knowledge without requiring an 'organisational diagnosis' from the outside world. This allows the creation for our own futures with language and discourse creating our realities which are evolving, thus providing a way to look to the future rather than try to explain the past. Therefore the researcher must construct questions that generate future possibilities for mental health support workers. Gergen (2008) describes social constructionism as "the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live" (p. 15).

Expectation theory: This is also referred to as the placebo or the Pygmalion effect, premised on that belief that when attention is paid to an individual and that individual is seen as a success they will in fact then succeed. This phenomena was first described by Rosenthal and Jacobson (1992). While this can be suggested as the researcher influencing the participants, when applying an AI lens, this is about the creating an environment where mental health support workers are valued and respected for their contributions opening up their visionary possibilities. Muldoon's (2012) critique of Henry Landsberger's Hawthorne studies (1924-1932; undertaken at the Hawthorn Works, based outside of Chicago) considers that Landsberger made a significant contribution as they were "amongst the first studies to quantify a worker's frustration level" (Muldoon, 2012, p. 107). He also considered these studies focused on the interactions between workers and management. The outcome of the studies is referred to as the 'Hawthorne effect'.

Positive psychology: This approach is based on the work undertaken by Seligman in the 1990's. Much of the work that Seligman and Csikszentmihalyi examined were studies by "Abraham Maslow, Carl Rogers and other humanistic psychologists" (Seligman & Csikszentmihalyi, 2000, p. 7) putting forward the view that there is a difference between positive psychology and humanistic psychology. Seligman and Csikszentmihalyi (2000) suggest that "treatment is not just fixing what is broken; it is nurturing what is best" (p. 7). Waterman (2013) suggests that there is a greater alignment between positive psychology and humanistic psychology than what Seligman and Csiksentmihalyi chose to acknowledge. Waterman (2013) puts forward the view that positive psychology is related to "each person discovering their latent talents" (p. 127) and that the focus is on "developing the best within each person" (Waterman, 2013, p. 127).

Participatory inquiry: Thesen and Kuzel (1999) point to participatory inquiry as being "rooted in humanistic psychology (e.g., Maslow and Rogers, 1961)" (p. 269). While is it considered that participatory inquiry "has deep roots in education" (Thesen & Kuzel, 1999, p. 271) it has been seen by those in the health environment as a way to engage with and research the patient / health professional relationship. Caution for this type of research was expressed by Thesen and Kuzel (1999) as they viewed that health professionals frequently saw participatory inquired research as a way to empower patients. They argued that "the empowering process must come from within the disempowered group or individual" (Thesen & Kuzel, 1999, p. 275).

*Phenomenology***:** Morse (2012) defines phenomenology as "the goal is to zero in on the essence or the meaning of the phenomenon and to reflect on it interpretively, using phenomenological concepts" (p. 86). Chamberlain (2009) acknowledges that there are many forms of phenomenologists. The most recognised theorists in this field come from the works of "Merleau-Ponty, Spiegelberg, Heidegger and Husserl" (Chamberlain, 2009, p. 52). The borrowing from phenomenology for the AI approach is suggested by Miller and Crabtree (1999) as, like phenomenology, AI "seeks to understand the lived experience of individuals" (Miller & Crabtree, 1999, p. 29). When considering phenomenology Smythe , Ironside, Sims, Swenson, and Spence (2008) suggest that "the quest of Heideggerian phenomenology is not to provide answers, for that shuts down and closes thinking. It is rather to invite readers to make their own journey" (p. 1393).

Humanistic approach: Much of the humanistic approach is derived from two main theorists Abraham Maslow and Carl Rogers. Humanistic theory is described as striving for "maximising the human potential" (Crandell, Crandell, & Zanden, 2009, p. 46).

*Image theory***:** Beach (1998) suggests that image theory is about four dimensions of the decision maker: the self-image (guiding beliefs, values, ethics and morals); the trajectory image (the aspirational future); the action image (the set ways in which goals are achieved; and the projected image (anticipation of what will happen). This cyclical approach resonates with the 4-D cycle of AI with image theory being "proposed as a descriptive mode of decision making" (Beach, Smith, Lundell, & Mitchell, 1988, p. 27).

***Grounded theory*:** Grounded theory was first introduced by Glaser and Strauss. It has been described as "theory discovery methodology that allows the researcher to develop a theoretical account of the general feature of the topic" (Remenyi, 2013, p. 23) and "is sometimes described as requiring the application of the positivistic mind set" (p. 57).

ALIGNMENT OF PHILOSOPHIES

As well as being a rich amalgam of theoretical approaches, AI shares many of the characteristics of philosophies that underpin mental health services in New Zealand. The concepts of strength-based service delivery, tidal model and recovery "seeks to reveal the strengths, achievements, values, ethos and positive practices that those involved recount with excitement and pride to indicate how the service provided works effectively" (Smythe & Payne, 2008, p. 4). Cooperrider and Srivastva (1987) argue that organisations are living systems that connect to a "full and rich omnipresence of strengths" (p. 74). It is the uncovering of this richness that provides some of the fabric for this study.

Antonovsky (1979) introduced the term 'salutogenics' to try to define and develop a paradigm for looking at what makes up a healthy person, their coping abilities, strength and resilience. Stuhlmiller's (2010) interpretation of salutogenics is that it "is one of positive possibilities and acknowledges that people have achievements, capacity, and constructive potentials. Deficits are viewed as challenges and opportunities that can lead to growth and learning" (p. 78). This way of viewing our world is shared through the application of AI for this study.

STRENGTH BASED

A strength-based ideological approach supports the basis on which AI has been built. Similar to AI the strength-based approach seeks to deliver and discover from a model of empowerment. This gradual acceptance of a strength-based approach and recovery models within mental health services has shown these services to be more caring and benign entities. Rapp and Goscha (2012) contend that "the strength perspective is an alternative to a preoccupation to the negative aspect of people and society" (p. 4). They suggest that the historical focus on the 'problem' and the resolution of that problem in itself generates new problems which "exists in a new way" (Rapp & Goscha, 2012, p. 7). This self-generating

way of working with mental health consumers "provides the rational for the existence of professional helpers" (Rapp & Goscha, 2012, p. 7). While strength theory creates opportunities to do things differently it tends to be focused on the individual rather than seeking a whole of organisation approach. The strength-based approach does however share a commonality with AI in that it believes that "people have desires, goals, ambitions, hope and dreams" (Rapp & Goscha, 2012, p. 38). It has been suggested that the awakening of Appreciative Inquiry, positive psychology and strength-based management were fused together when these ways of approaching organisational change were presented at the Power of Positive Change Conference in 2007 (Stratton-Berkessel, 2010). They suggest that all three "are branches on the same trajectory, with their focus on positive institutions, elevating well-being, and human strengths" (Stratton-Berkessel, 2010, p. 23).

RECOVERY: PHILOSOPHY TO GUIDE SERVICE DELIVERY

Recovery, as defined by the Mental Health Commission's Blueprint (Mental Health Commission, 1998), suggests that recovery requires a whole of system approach in order to provide hope for mental health consumers as "it enables people to imagine a better life" (p. 15). However, recovery in mental health may be defined in terms of an outcome (Onken et al., 2007), such as the ability to lead a good and satisfying life despite illness or presence of symptoms (Deegan, 1997; Deegan & Drake, 2006). There is also a notion that recovery is a process that is described as being a non-linear lived experience involving both self-discovery and transformation, and culminating in an understanding that symptoms of the illness are not definitive in terms of one's self-identity (Cobigo & Stuart, 2010; Davidson, Sells, Sangster, & O'Connell, 2005). Cobigo and Stuart (2010) describe how the concept of recovery emphasises the development of new personal meanings that go beyond the illness experience, social empowerment, and participation. Deegan (2002) uses the term "transformative process" (p. 6) when describing her own journey of recovery.

Maslow, a humanistic psychologist theorised that the point of ultimate achievement for humans is what he named 'self-actualisation' (Newman & Newman, 2012). This is defined as having all basic needs met within a hierarchy of needs. A study undertaken by Spear (2006) found a strong correlation between self-actualisation and job satisfaction: "Mental health staff working to fulfil self-actualization needs had higher job satisfaction and well-

being" (Spear, 2006, p. 178). Recovery as a concept and philosophy has defined the way in which mental health services in New Zealand are developed, delivered and evaluated. The Mental Health Commission (2004) characterised the term recovery as being when services provide an environment that gives mental health consumers "hope and optimism" (p. 11). Tensions exist between recovery models and some 'evidence-based practice' models as was evident in *The President's New Freedom Commission on Mental Health: Transforming The Vision* (2003), where the emphasis on the recovery model had been interpreted by some critics as saying that everyone can fully recover through sheer will-power. It is said that giving false hope to those judged unable to recover implicitly blames those people for their lack of recovery. However, the critics have themselves have been accused of undermining consumer rights and failing to recognise that the model of recovery is intended to support a person in their personal journey rather than expecting a given outcome. There is another view that recovery, while focused on the individual, also relates to social and political support and empowerment with a whole of system approach. Fotu and Tafa (2009) suggest that recovery can be both a destination and a journey (p. 64).

An audit of mental health education in New Zealand undertaken by Prebble (2002) indicted a high level of congruency of the recovery competencies embedded within the National Certificate in Mental Health (Mental Health Support Work). This then presupposes that mental health support work has a strong alignment with both recovery competencies and strength-based models. Cooperrider and Srivastva (1987) argue that organisations are living systems that connect to a "full and rich omnipresence of strengths" (p. 74). It is the uncovering of this richness that provides much of the fabric for this study. Many of the therapies developed and used in mental health support an appreciative approach as they seek to re-programme negative thinking into positive ways of operating within society.

THE TIDAL MODEL: A WAY OF VIEWING MENTAL HEALTH SERVICES

Another way of viewing recovery has been developed by Barker (2003) by way of the Tidal Model. This model aims to protect the ever-evolving story, language, and understanding of each individual and has been used to study outcomes with some success in several countries (Barker & Buchanan-Barker, 2006). This was the first research-based model of mental

health recovery, developed originally by nurses, with the active support of people who were using, or had used, psychiatric services.

The Tidal Model is seen as an ebbing and flowing process where recovery commences at the person's lowest point. The development of the Tidal Model represented a unique collaboration between professionals involved in delivering mental health services and people who needed such support. From its earliest beginnings, the Tidal Model drew upon the support of 'user/consumer consultants', both within the UK and internationally. These consultants helped to field test the various individual and group processes of the Tidal Model, helping to shaping and refining them so that they became 'consumer-friendly'. This model of collaboration continues to the present day, as we make fine adjustments to some of the original processes, and additions to the menu of supporting activities.

The Tidal Model as described by Barker (2003) empowers people to *reclaim* their personal story by recovering their voice. The use of empowering language, metaphors and stories by people is used in a way that expresses meaning for the individual's life. This is the pathway towards recovery. AI uses these same principles for discovery and reclamation through giving voice, through the storytellers, furthering the move towards 'recovery'.

RESEARCHING USING APPRECIATIVE INQUIRY

AI is well understood as an approach to organisational change; however it "began as a research method for making grounded theory-building more generative" (Bushe, 2012a, p. 10). Bushe (1998) suggests that AI developed by way of action research as a means for creating social change. AI has been described as a collection of stories with people telling the stories which provides the mechanism for "new generative ideas or images" (Bushe, 1998, p. 1). When using AI, it is accepted that the research may not follow 'normal' constructs, as the basis of the approach is to see the world differently "AI practitioners create variations of the model to adapt them to particular context and the language of those contexts" (Cockell & McArthur-Blair, 2012; McArthur-Blair & Cockell, 2012). This approach enables the researcher to create and transform the knowledge gained during the telling of the stories and appreciative interpretation of the data. It gives permission for the usual rules of research and the boundaries these create to be pushed beyond what is

generally accepted. Whitney and Trosten-Bloom (2010) argue that AI is built on the premise of grounded research by "engaging members of an organization in their own research – inquiry into the most life-giving forces in their organization, the root causes of their success, and discovery of their positive core" (p. 52). Mace, Hocking, and Waring (2015) argue that AI is a "methodology that has a solid foundation in theory and rigor, and takes itself seriously" (p. 205).

FOUNDATION FOR AN APPRECIATIVE APPROACH

AI discovered its roots within participatory research (also known as Action Research) the divergence comes where participatory inquiry seeks "to insist on a sharp separation of theory and practice, and to underrate the role of theory in social construction" (Cooperrider & Srivastva, 1987). Thesen and Kuzel (1999) suggest that the question posed for participatory inquiry is, "How can life be better?" (p. 271). They also suggest that the challenge that this type of research brings is that it needs to "conform to acceptable structure" (p. 273) and "the investigator needs to have or acquire extensive knowledge, preferably insider knowledge, of the local culture" (p. 274).

Barrett and Fry (2005) emphasised that bold choices of topics need to be studied so that the inquiry can be generative, can challenge assumptions can open up new possibilities for action. More specifically, choosing a positive, hopeful topic for inquiry will dislodge old patterns, interrupt taken-for-granted assumptions, provoke wonderment and lead to capacity building. Whitney and Trosten-Bloom (2010) suggest that affirmative topics should focus on what people want to see grow and flourish and should evoke conversations of the desired future. They suggest that:

- Topics are positive. They are stated in the affirmative.
- Topics are desirable. The organization wants to grow, develop, and enhance them.
- Topics stimulate learning. The organization is genuinely curious about them, and wants to become more knowledgeable and proficient in them.
- Topics stimulate conversations about desired futures. They take the organisation where it wants to go. They link to the organization's change agenda. (Whitney & Trosten-Bloom, 2010, p. 133).

The art of what makes AI successful lies in the crafting of the questions, with the focus of the inquiry unlocking potential and possibilities. Cooperrider and Whitney (2003) found that the more positive the question asked, the more long lasting and successful the change effort. The purpose of this approach was to "accept that respondents' views were sequenced as one possible version of events and that each theme carried an inspirational title and is expressed in a positive, substantive future based goal" (Bowles & Jones, 2005, p. 285). The affirming of aspirations and goals sits comfortably within a strength-based recovery-focused approach of mental health services. Bushe (1995) contends that groups do not need to be fixed or have their problems solved, what they require is affirmation and an appreciation of the past and the history in order to affect change within the social system by "exploring their best of what is and has been" (Bushe, 1995, p. 16). While my research does not directly seek to initiate change, I am hopeful that participants will be encouraged to make their own changes, see the outcomes of this study as having positive change in the wider mental health context and consider that the possible futures identified. Further, I hope that the insights of the study will influence and prompt change.

Cowling (1999) suggests that "scholars of nursing science have been preoccupied with emphasis on distinction between paradigmatic perspectives, theoretical assumptions and methodological approaches" (p. 132) and therefore a disconnect has developed between the relationship of theory and action in practice. If such a disconnect has occurred between health professionals and mental health support workers, how have those relationships developed and matured in terms of role clarity and role distinction between the professional groups? This study seeks to maintain a strong focus on practice.

Friedlander and Brown (1974) identified the shortcomings of traditional research and sought emancipation from it through AI. According to Carter (2006), the use of an AI approach to research is more about "working and thinking with people rather than just about them" (p. 49). This is congruent with mental health services being about working with, rather than doing to, people. Watkins and Cooperrider (2000) describe AI as "a theory, a mind-set, and an approach that leads to organizational learning and creativity" (p. 6).

APPRECIATING THE SHADOW

This study has recognised the value of also exploring the Shadow - not as a polarising effect (i.e. good versus bad, positive versus negative), but rather as a Dissonance that in itself is transformational by the mere acknowledgment of its existences. Fitzgerald and Oliver (2012) have interpreted the Shadow to be those parts about one-self that are not disclosed. Fritzgerald, Oliver, and Hoxsey (2010) further suggest that "few pages are devoted to dealing with problems and "negatives," yet without guidance as to how to discern that which is positive from that which is negative" (p. 224). They suggest that this is not the fault of the AI process but rather the fault of the AI practitioners who have ignored the Shadow and that the fault is "not integrating the Shadow, rather than the Shadow itself" (p. 221). Fritzgerald et al. (2010) suggests that the Shadow, as identified by Jung, is that part of our personality that we chose to hide and it polarises parts of our personality that could be viewed as a juxtaposition of 'good versus bad, dark versus light'. This has also been referred to as "the denied aspects of the personality" (Fawkes, 2010, p. 215). Fitzgerald, Oliver, and Hoxsey (2010) suggest the Shadow is also a protective mechanism and that by acknowledging the positive this creates an important awareness "focusing on the strengths had, in fact, created an awareness of the Shadowed side" (Fitzgerald et al., 2010, p. 222). Ketola (2008) poses an alternative view and suggests that "the Shadow stays mostly hidden and comes out only on special occasions" (p. 201).

USE OF THE SHADOW

When embarking on any qualitative research using an appreciative approach, there is a natural tendency to move into the Shadow and state the problem. However, when the Shadow is used during the appreciative interview, Seel (2008) suggests that the technique to be adopted is to "suggest that all negative stories are the Shadow of something good" (p. 9). This adaptive mechanism acknowledges the participants' concerns and provides a "signpost" (p. 9) or Global Positioning Satellite (GPS) reference that allows the participant to get back into the flow of traffic. Bushe (2012b), Reed and Verma (2012) and Verma (2012) introduced the Shadow - seen and described it as a "benign force" (Bushe, 2012b, p. 51).

SUMMARY

The application of AI as the methodology and philosophical underpinning of this study was not by accident. For many years mental health services operated from a deficit model only moving to strength-based model in the middle of the 21st century. It is within this environment that AI provides an approach that is a "mutually participatory and transformative process" (Bonham, 2011) and has a connectedness with a strengths-based philosophy and approach (Preskill & Catsambas, 2006, p. 7), linking with the recovery concepts used throughout mental health services in New Zealand.

This study provides the foundations that enable mental health support workers and others to gain a better understanding and an appreciation of their work. However, given the paucity of knowledge about the work they do, more research will need to be undertaken to build on what was discovered through this study. The lack of research about mental health support workers has challenged their ability to articulate their role and to have its importance understood.

While the focus for this study is on (and provides acknowledgement about) what is working well with mental health support work, it also draws on the Shadow. As this study moves through the phases of the appreciative cycle it seeks to envisage a future in terms of what would make things even better in the work of mental health support work and what could be done differently. The application of AI into the mental health setting provides the opportunity to view these services differently and creates an opportunity "to develop a vision of the possible" (Rapp & Goscha, 2012, p. 179).

CHAPTER SIX: PLAN OF INQUIRY

INTRODUCTION

This chapter describes the plan of inquiry undertaken for this study. Included in this chapter are:

- Ethical responsibilities
- Recruitment and selection of participants
- Collection and management of data and
- Data interpretation

In remaining authentic to the appreciative approach, I use the term 'Plan of Inquiry' (Josselson & Lieblich, 2003) rather than the more traditional term 'Methods'. Rudestam and Newton (2007) suggest this approach focuses the researcher on the line of inquiry rather than on the mechanics of the procedure. Many researchers describe the way that they view information gathered for the purpose of research as 'viewing through a lens'. I suggest that Appreciative Inquiry (AI) provides the opportunity to go beyond a one-dimensional view and instead have the appreciative world viewed through a prism. This creates a kaleidoscope of coloured narrative through which to view the world of a mental health support worker.

This study has been undertaken as part of my academic studies, which places me in the domain of researcher. I prefer to refer to myself as a 'story gatherer' (Carter, 2006) with the participants defined as 'story tellers'. This terminology is used because it informs the reader that this study, while defined as research, does not follow many of the traditional orientations prescribed for research.

REMAINING AUTHENTIC

Participants for this study were interviewed using an AI approach. Cooperrider and Whitney (2003) suggest that there are three main components of the appreciative interview identification of the 'highpoints', 'valuing' and 'what gives life to an organisation'. While

the valuing of the topic is important, equally important is the way in which the participants are nurtured and respected throughout the interview process. Reed (2007) also validates the use of AI into research as a movement that takes the researcher away from the more traditional form of research. Research typically starts with identifying a problem, however, an AI approach starts from a positive position - to inquire about what is working well. Cooperrider, Whitney, and Stravos (2003) identified three stages for the interview: opening questions (peak experiences), questions centred on the topic (actualities) and concluding questions (what the future holds). The interview process is broken into two parts. In Part A the question must evoke a real personal experience and narrative story that helps participants see and draw on the best learnings from the past (and present). In Part B the participant is allowed to go beyond the past to envision the best possibility of the future.

Lahaye and Espe (2010) view the structure and content of appreciative interviews as being essential for the success of any AI process. The Discovery phase provides the opportunity for participants to tell their stories about positive moments related to the area being examined. What makes AI unique is that all questions are framed as positive. The use of positive questions reminds people of accomplishments and experiences and also builds on strengths and opportunities that are seen as heartening and inspiring. Smythe and Payne (2008) suggest an AI approach to research should reach out and widen the research question rather than narrowing it down to one particular aspect. This study embraces AI as its methodology encouraging the exploration of the issues through a transformative approach, by facilitating the participants to 'hear' their positive experiences while still seeking to find the answers to the research question. As the context for this study is mental health support work it was also appropriate to use a non-judgmental strengths-based approach that created an alignment to existing mental health policies in New Zealand. Kvale (2007) suggests that analysis of interviews begins with and occurs during the interview process. The researcher hears and then clarifies their understanding of the spoken word of the person being interviewed. This type of participative research emphasises the lived experience, so that the stories and voices can be effectively used with people who are perceived as disadvantaged or vulnerable. The influence of the researcher in qualitative research should not be underestimated. Mantzoukas (2004) suggests that the researcher is very much a central figure in the gathering and constructing of information and, as such, it is the researcher who ultimately decides "what to include in the analysis, and who or what

to include in the findings or discussion" (p. 1000). This study seeks to discover the contribution of the mental health support worker, through understanding the lived experiences of those who received services from, worked with or were mental health support workers. As a result of seeking to understand from the lived experience, this study borrows a lens from phenomenology. As such, my involvement in this study means that my own experiences within the mental health sector should not be discounted. Throughout the interviewing process I sought a degree of objectivity, although Benjamin and Miller (1999) acknowledge that the researcher's use of "self as an experiencing interpreter" (Benjamin & Miller, 1999, p. 28).

As suggested by Bushe (1995), rather than undertaking the traditional mode for 'data analysis' when unpacking and analysing data, an 'appreciative interpretation' has been applied. This term provides a more meaningful context and suggests that researchers who view and make sense of the data using an appreciative approach do so by viewing through an appreciative prism. This approach allows and validates the interpretation and creates an environment whereby the data can be influenced by the researcher's own world view and experiences. This interpretation brings with it important insights.

Kvale (2007) argues that a substantive part of the analysis of interviews in fact occurs during the interview process, where the researcher clarifies their own understanding of the meaning of the stories of the person being interviewed. In applying this approach, the method of analysis of the findings will vary from project to project.

This study used the 4-D cycle of AI to listen to the stories. Bushe (1995) supports the view that an appreciative approach moves the researcher to do things differently and states that,

…stage of action research needs to be done totally differently in an appreciative inquiry. I no longer call it 'analysis'. I haven't found a great term for it yet but I've used 'proalysis' and 'synergalysis'. We're trying to generate new theory that will have high face value (p. 18).

ETHICAL AND CONFIDENTIALITY CONSIDERATIONS

ETHICS

The ethical consideration, approval and re-approval process for this study were extensive and at times protracted however, Robson (2011) provides a timely reminder that "research is not a right but a privilege" (p. 224), ensuring that the robustness of the study from an ethics viewpoint has been well managed and appropriately considered.

Ethical approval was initially sought from two ethics committees, with the study intending to recruit participants from three main centres: Auckland, Wellington and Christchurch, with the possibility of a fourth site, Hamilton. Ethics approval was sought and obtained from the Multi-Region Ethics Committee (MREC) (Appendix A) and the Auckland University of Technology Ethics Committee (AUTEC) (Appendix D). Before approval to proceed was given, the MREC and AUTEC required modification. The initial requirements were to ensure a more secure website than Facebook, ensure Maori consultation for each site, remove reference to the Multi-region Ethics Committee, include a letter of access to AUT's counselling service, provide clarification of the interpreter's role and clarification of the length of the interviews. There was also a requirement to seek approval due to the change of sites for recruitment of participants (Appendix B and Appendix E).

Once ethical approval was granted, an expression of interest (EoI) form (Appendix G) was distributed through a number of networks that are known to be used by mental health support workers and others in this sector. The EoI generated significant interest throughout New Zealand, with a noticeable exception of Christchurch. No responses were received from Christchurch and there was limited interest from the Hamilton region. Unexpectedly there was significant interest from the southern part of the South Island of New Zealand; this area was not part of the original proposal. As a consequence of the response from the southern region, a further application was made to the Southern District's Ethics Committee and a Locality Assessment sought for both Invercargill and Dunedin. A variation to the initial ethics application was then made to the MREC (Appendix C) and the AUTEC (Appendix F) seeking approval to extend the geographical regions to include Dunedin and Invercargill. Some of the potential participants were employed by the Southern District Health Board (SDHB); therefore, prior to making this application

approval was also required from this DHB (Appendix U). The Southern DHB has an agreement with Otago University Ethics Committee through to the Ngai Tahu Research Consultation Committee as its iwi[7] partner to act on their behalf. "Ngāi Tahu are the iwi comprised of Ngāi Tahu whānui; that is, the collective of the individuals who descend from the five primary hapū of Ngāi Tahu, Ngāti Māmoe and Waitaha, namely Kāti Kurī, Ngāti Irakehu, Kāti Huirapa, Ngāi Tūāhuriri and Ngāi Te Ruahikihiki" (Ngaitahu, n.d.) for the geographical area comprising most of the South Island of New Zealand, except the Nelson-Marlborough region. Approval from Ngāi Tahu's Research Consultation Committee was also provided (Appendix V). As required, the consent forms and information form were amended to meet the requirements of the Southern DHB (Appendix W, X and Y).

Bi-annual reports were submitted to AUTEC, with annual progress reports being submitted to the MREC.

CONFIDENTIALITY

All participants were required to complete a consent form (Appendix I, J, X and Y) after they advised the researcher, through email or verbally, that they had read and understood what was contained in the information sheet (Appendix H); and that all questions relating to the study had been appropriately responded to. The signed consent forms (Appendix I, J, X and Y) were also kept in a labelled folder in a locked cabinet belonging to the primary supervisor. Electronic copies of the transcripts were kept on a data stick and stored along with a hard copy of the transcripts, in a locked cabinet in the researcher's primary supervisor's office.

Anonymised hard copies of the transcripts were provided to the supervisors.

At the commencement of the interview, participants were again advised that the interview would be recorded then transcribed by a professional transcriber who had also signed a confidentiality agreement (Appendix J).

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[7] Māori name for 'tribe'

Information that may have been able to identify individuals or organisations were removed from the transcripts, including any information relating to other health workers, organisations and certain geographical details that may have been mentioned during the course of the interview.

All participants were given a pseudonym and were advised of this at the time of interview; this process is in keeping with AI. This naming personalises the study and acknowledges the participants as people not subjects. Once the interviews were completed, an electronic copy of the transcript was sent to the individual participants via the email address they had provided. Participants were invited to make any changes they chose including deletions. Not all participants chose to make contact once they had received their transcript. While those that had not made a response to their transcript were followed up via email only one chose to make alterations. Participants maintained contact, with me as the researcher, via email long after the interview process was completed.

THE STORY TELLERS

The focus for this study is mental health support workers and their contribution to mental health services in New Zealand. As described in Chapter One, I disclosed my involvement with mental health support workers; that interaction has spanned many years. This placed me in the position described by Benjamin and Miller (1999) as 'experienced interpreter'.

RECRUITING THE STORY TELLERS

This study sought to recruit up to 40 participants from the regions where ethical approval and locality assessment approval had been given. Sandelowski (1986) agrees that the sample size in qualitative research is "typically small because of the large volume of verbal data" (p. 31). In order to recruit sufficient numbers for this study, an EoI (Appendix G) was placed on a number of websites including www.platform.org.nz (an umbrella organisation for a significant number of non-government mental health organisations), www.psa.org.nz (a trade union organisation that represents the industrial issues of many mental health support workers), www.careerforce.org.nz (an industry training organisation that has the responsibility to develop national qualifications for mental health support workers) and www.tepou.co.nz (mental health and addictions workforce development group).

A secure wiki was developed as an alternative way of generating discussion. In the initial ethics application, it was indicated that a social media site, such as Facebook, would be developed to have conversations with those people engaged in the study. However the MREC, while in support of utilising an electronic means to engage with participants, was concerned about the security of such sites. This was based on the fact that there was no on-going guarantee that the information (and therefore the comments of participants) would not get into the public domain. After some lengthy investigations, a site was set up through 'PB Works'. This site enabled me to establish a secure wiki-space. The site name was https://my.pbworks.com with mentalhealthai.pbworks.com being the workspace or wiki. People wishing to access the site were provided with the information sheet and were then required to sign the consent form for group participation. My role became that of a 'gate-keeper' and access was only provided once it was established that all the ethical requirements had been met. The wiki was structured in such a way that it resembled the semi-structured questions that were used to interview groups. This allowed participants to communicate with others involved with mental health support work. The feedback from the few participants who used the wiki was positive; however, the lack of uptake meant that the data for this study was drawn solely from the face-to-face interviews.

SHOWING INTEREST

Once potential participants indicated, via the EoI, that they were interested in taking part in this study, further information was provided as to the venues, nature of the interviews, duration and approach to the study. This information was emailed to all potential participants. If potential participants still indicated a willingness to be part of the study then the information sheet and consent forms were provided for completion. Participants were again assured of the ethical and confidentially considerations and the reasons for the need to complete a consent form prior to the interviews commencing. Potential participants were provided a stamped addressed envelope in which to return their signed consent form. However, a number of participants contacted me via email and advised that they would bring their signed form to the interview. Each participant's name, email address, telephone numbers and place of employment were kept on a spread sheet. Interviews were set up on a geographical basis with the time and venue negotiated with the participants. When

developing the group interviews, one of the participants undertook to organise the participants, venue and time for the group interviews. This proved a very successful process and again allowed the participants to be in control of the process.

SELECTING THE STORY TELLERS

For those that have services provided by mental health support workers: people that self-disclosed that they had a mental health issue and had previously had services provided to them by a mental health support worker. The nature of the mental health issue was not required to be revealed as my interest was in the interaction with the mental health support worker and not the nature of the person's illness.

Mental health support workers: those people employed as a mental health support worker by either a district health board (DHB) or non-government organisation (NGO).

*Employers of mental health support workers***:** a variety of services organisations. These included DHBs, NGOs educational institutes (universities, institutes of technology or private training establishments) or Crown Entities.

*Those who work with mental health support workers***:** registered nurses, social workers, peer support workers, cultural workers, registered occupational therapists and registered psychologists.

Other key stakeholders: those people that have a direct or indirect relationship with mental health support workers. This includes policy makers.

Fifty-six people responded to the EoI. Those that lived outside of the geographical areas where ethics approval had been gained were excluded. The exception to this was where interest shown by a number of potential participants from the lower South Island.

INCLUSION CRITERIA

The significant inclusion criterion for this study was that all participants would have a view on the contribution of mental health support work in New Zealand. One method of

identifying sampling in qualitative research is described as non-probabilistic. This type of sampling is referred to as 'convenience sampling' and is described by Bryman (2001) as "one that is available to the researcher by virtue of its accessibility" (p. 97). Individuals were approached to share their views and experience rather than seeking to have a representative view of an organisation or group. This type of sampling is used to identify cases that possess relevant characteristics for the question being considered. The other characteristics sought were that participants were knowledgeable and experienced in their field.

The role of the mental health support worker is wide reaching and intersects with other disciplines working in the health sector, although ultimately it is to provide services for mental health service users. It was this expansiveness that provided the richness for the data to be gathered.

Another important characteristic was that all participants would have a view on the contribution of mental health support workers in New Zealand. When using an AI approach, it is important to create environments that support participants to bring their viewpoints and experience to the study (Cooperrider et al., 2003; Reed, 2007) and to ensure there is no coercion on participants by providing them with as much information as possible, thereby enabling them to maintain power and control over their decision making.

Table 2: Categories of participants

Participant's self-description	Number of participants per category
Mental health support worker	26
Mental health consumer: *those that have services provided by mental health support workers*	2
Mental health managers: *those who employ mental health support workers*	2

Table 2: Continued

Participant's self-description	Number of participants per category
Mental health educators: *for those who work with mental health support workers*	1
Other health professionals: *for those who work with mental health support workers*	2
Family advisor: *for those who work with mental health support workers*	1

Table 2 sets out the categories of the participants and what they most strongly identified as. Many of the participants had a number of subcategories that they are identified as. As an example of the 26 who identified as mental health support workers, six also referred to themselves as peer support workers. While some mental health support workers did not see themselves as peer support workers (i.e. they identified as mental health support workers) they spoke of having experience of services being provided to them by mental health support workers. Similarly the Family Advisor's daughter had received services from a mental health support worker. Both the managers interviewed had either worked as a mental health support worker or had come to their role through another health discipline. The two consumer advisors identified as having a lived experience of mental illness but did not disclose if they had received services from a mental health support worker, although one had previously worked as a mental health support worker.

Focusing the stories

Participants were provided with options relating to the style of interviews these were:

- One-on-one interviews
- Paired interviews
- Group interview.

Preskill and Catsambas (2006) suggest that the rationale for the group or paired interviews when using an AI approach for data collection is that this provides a way for participants to be "insightful and energizing when there is the opportunity to hear other's stories" (p. 81). Providing a range of different interview opportunities assisted with the provision of a safe

environment for participants where their stories could be told and shared and they were empowered by being able to make those choices. Participants were able to self-select the type of interview they wished to participate in they were able to select via the consent forms.

The mixture of participants and numbers within the groups were not predetermined however it was anticipated that the total number of people interviewed would be up to 40; the final number being 34. In keeping with the findings of Preskill and Catsambas (2006), there is energy created in a group of mixed participants. The ability to manage such a group requires skill by the researcher. The researcher's responsibility is to ensure all participants are actively included and that all contributions are respected and heard. This places the researcher in the role of facilitator. As participants also self-selected, there is a presupposed assumption that the members of the group at least knew of each other and were comfortable with members of the group to undertake the interview. Due to the nature of the AI approach, participants are empowered to speak about aspirations rather than focusing on problems. This approach shifts the focus to an inclusive sharing activity.

Desire to be heard

The experience of active appreciative interviewing for this study was unlike that described by Carter (2006) where participants were said to be "reticent in talking about success and their achievements" (Carter, 2006, p. 58). Participants in this study were eager to share their stories, tell of their successes and describe what was working well. This willingness of the participants to celebrate success was a surprise as the characteristic of talking about success is generally not a characteristic evident in the New Zealand psyche. There is a Māori proverb "Kāore te kumara e kōrero mō tōna ake reka", translated as "the kumara does not tell of how sweet it is" (Maori Proverbs Whakatauki, 2013). The willingness by the participants to speak openly about their peak experiences is, in my view, an acknowledgment that the adoption of AI for this study created an appropriate environment for the stories to be told. Bushe (1995) suggests that most researchers approach research in a linear fashion and that in doing so they "have a tendency to want to generate abstract lists and propositional statements out of the interviews" (p. 18) and that "fresh images and

insight come from exploring the real stories people have about themselves and others at their best" (p. 18).

Limited reliable data are available on the demographics of mental health support workers. This study did not attempt to have the participants mirror the demographics of the general population or mental health consumers. When unpacking the data and acknowledging that this was not a comparative study it is of note that there were no discernible differences in the stories between geographical regions.

Acknowledging Christchurch

This section provides a tribute to the people of Christchurch, with the long-term effects of the earthquakes that first hit the region in 2010 still being realised. The initial ethics application only included one geographical region in the South Island - Christchurch; however, there were no volunteers from this region for inclusion in this study. While it is difficult to point to any definitive reason for this lack of uptake, it is possible that due to the trauma of continual earthquakes, people in the Christchurch region, had significantly greater issues to deal with and their focus was not on participation in research.

Later, when people from Christchurch heard that there were no participants from their region, several approached me saying that they were willing to take part in this study. While I thanked them then and do so again, it seemed that they had more important priorities of rebuilding their lives.

Respecting the story tellers

The validation of using an AI approach is acknowledged by Carter (2006) who suggests that takes good care of the participants as it acknowledges their contributions in an appreciative way, thereby respecting the participants and acknowledging their worth. The use of positive questions often reminds people of accomplishments and experiences that were surprising and elevating. AI "involves the mobilization of inquiry through the crafting of the unconditional positive question" (Cooperrider & Whitney, nd, p. 3). It was also this respectfulness for the participants that meant I assigned them a name rather than categorising them through a number. This humanises what can be seen as a mechanical

process and sits comfortably with the appreciative approach. Of the 34 participants interviewed for this study, none sought to withdraw, prior, during or after the interview process. All participants self-selected to take part in this study through the EoI. Contained in the information sheet were details about myself and my professional background. One of the rationales for providing this information was to establish my credibility with potential participants. McDonald, Cox, Paterson, and Lafrenière's (2008) research showed that participants had a higher level of trust in researcher if the researcher established their credentials participants had a higher degree of trust in the researcher and that "this trust derived from their status, and was associated with the authority, reputation, standards, and values of a health discipline, a university, or a hospital as well as information" (McDonald et al., 2008, p. 35).

Where it was necessary for people to travel to the interview, a koha[8] in the form of money (ranging in value to a maximum of $30) was provided to cover transport/petrol costs. All participants were also given a thank you card in appreciation of the time they gave so willingly and so freely.

ESTABLISHING THE INTERVIEWS

The gathering of information from the storyteller commenced during the second half of 2011. These were completed by the middle of 2012. The initial cluster of interviews provided the time to reflect on the stories of the participants. Thirty four participants were interviewed. This comprised four group interviews, making up 19 of the total number of participants. Only two participants chose to undertake a paired interview, with the remaining 13 participants requesting one-on-one interviews. Participants were advised that the individual interviews would take approximately one hour and that the group interviews would require approximately one and a half hours.

The process for gathering the stories took place in a range of settings chosen by the participants. The most challenging interview took place in a café within a garden centre; while this setting was unusual, it in no way inhibited the participants, which may have been because they chose the setting.

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[8] Koha is the Māori term for gift/donation

Table 3 provides a breakdown of the location, gender and ethnicity of the participants. Seven of the participants were from the Wellington region, 22 from Auckland and five from Southland (Invercargill and Dunedin). As there was only one participant from Dunedin, the participant has been aggregated into the geographical area of Southland, in order to protect their anonymity. There was 27 hours 7 minutes of interviews to transcribe and analyse (Table 4).

Table 3: Demographics of participants

Geographical Location	Number of Participants	Gender	Ethnicity
Wellington	7	3 female 5 males	1 Māori 6 Europeans
Auckland	22	Sixteen females Six males	10 Pasifica 3 Asian 8 Europeans 1 Māori
Southland[9]	5	3 females 2 males	5 Europeans

Table 4: Demographics of the type and duration of interviews

Participants (pseudonym)	Location	Length of Interview	Style of Interview
Alan		1hr:50min	Individual
Anne		55min	Individual
Tony		1hr:30min	Individual
John	Wellington	1hr:55min	Individual
Jane		1hr:35min	Individual
Ben		1hr:10min	Individual
Anaru		1hr:30min	Individual

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[9] Includes Dunedin and Invercargill

Table 4: Continued

Names	Location	Time	Type
Lisa Ashleigh Sue Linda	Auckland	1hr:10min 55min 50min 59min	Individual Individual Individual Individual
Mel Lynn	Auckland	2hr:55min	Paired
Dianna Jim Simon Karen Fae Tony Fiona	Auckland	3hr:20min	Group One
Toni Tina Paul Jordan Kath	Auckland	1hr:35min	Group Two
Cindy Ross Andrea Jo	Auckland	1hr:17min	Group Three
Gina George Julia	Southland	1hr:50min	Group Four
Andrew Adrienne	Southland	1hr:30min 1hr	Individual Individual

GATHERING THE STORIES

Central to the appreciative interview as described by Cooperrider and Whitney (2005) is "the affirmative topic choice" (p. 17). This positioning provides the cathartic space for the participants to vision the future which sows the seeds for the Dream phase and crafts the Design proposition which galvanises the action for the destiny stage.

A digital recording device was used to gather the data in the least intrusive manner. The information was then transcribed so that both an audio file and an electronic transcript were available. This information was transferred onto a data stick, with printed copies of the transcript providing another source of backup. This material, including the data stick, was kept in a secure drawer in my home office. The interviews were undertaken using a semi-structured interview process. This enabled the questions to be framed in an appreciative way following the appreciative cycle and ensured that participants had the opportunity to tell their stories.

Watkins and Mohr (2001) identify five generic processes for applying AI as a framework. They are:

1.   Choose the positive as the focus of inquiry
2.   Inquire into stories of life-giving forces
3.   Locate themes that appear in the stories and select topics for further inquiry
4.   Create shared images for a preferred future
5.   Find innovative ways to create that future. (Watkins & Mohr, 2001, p. 39).

These processes guide both the focus and the analysis of the inquiry. Common ideas were grouped and clustered and then analysed using the 4-D cycle, while seeking to uncover the positive aspects of research being undertaken. In keeping with the view of Clandinin and Connelly (1988), who suggest that the researcher is the eventual writer of the research it remained my decision as who I would interview (once all the ethical considerations had been taken into account) and what to include in the findings or discussion. Even advocates of the concept of 'leaving the data to tell its own story' acknowledge that we can never be sure that the story will tell all or tell well, and eventually admit that the researcher is the one that decides what is the data's own story (Carter, 2006; Mantzoukas, 2004).

HEARING THE STORIES

Semi-structured questions were formulated in order to guide the interview process. Robson (2011) suggests that the use of semi-structured questions provides an environment that supports free flowing conversation and the ability to follow up on the responses provided by the interviewee. According to Donalek (2005), the interview method is the most widely used method for collecting qualitative data. Creswell (2005) explained that open-ended questions allow open-ended responses due to the limitless possibilities afforded to participants answering specific questions.

At the commencement of the interviews, I reiterated my professional background as a nurse. Kvale (2007) states that "professional ethical codes serve as context for reflection on the specific ethical decisions throughout the interview inquiry" (p. 25). My self-disclosure resonates with the AI approach that suggests the engagement by the researcher is a way of acknowledging their world and my world and not (as suggested by other approaches) to research "that would see this as "contamination," to be avoided or minimized" (Reed, 2007, p. 65). By sharing my experiences, participants were able to judge my credibility to undertake this study and I was able to use the skills that I have through managing group processes to manage the group interviews.

The following questions provided a framework for the interviews:
For those who have services provided by mental health support workers:

- What difference has a mental health support worker made to your life?
- What is it that you value about the services you have had delivered by a mental health support worker?

For mental health support workers:

- Tell me a story about how you as a mental health support worker have made a difference.
- Reflecting on your experience as a mental health support workers, what inspires you most about you work?

For those who employ mental health support workers:

- What are the things that you most value about employing mental health support workers?

For those who work with mental health support workers:

- What are the things that you value about working with mental health support workers?

For other key stakeholders:

- What are the things you value about mental health support workers?

The intent on having separate questions for separate groups was to allow a focus on the particular inquiry; however, mixed groups required a more flexible approach while still ensuring the inquiry traversed all identified participants. The mixed groups comprised a mixture of mental health support workers, consumer advisors, family advisors and peer support workers. While the mixed groups were more challenging to manage and ensure all participants had the opportunity to be heard, this composition also created an energy where thoughts were verbalised and ideas were bounced off other members of the group.

TRANSCRIBING THE STORIES

At the completion of the interview each recording was transcribed. The transcripts were then read simultaneously while listening to the digital recording. Corrections by way of factual errors were then made to the transcripts. As already discussed, within two weeks of the interviews taking place the transcripts were sent to the participants for correction or deletion of any part of the transcript.

I did not undertake the actual transcribing; instead, I listened to the recording while reading the transcript. I noted the passion and the emotion that was expressed in the spoken words. When re-reading the transcripts alone, the emotion was not readily transferred into the written format; some of the passion and excitement was lost. This provided me with a challenge to ensure that these characteristics were not lost when it came time to interpret the data.

A FRAMEWORK USED TO INTERPRET THE STORIES

The analysis or appreciative interpretation of the data was undertaken using a thematic analysis and Immersion/Crystallisation (IC) interpretation of the data while remaining authentic to the 4-D cycle. Borkan (1999) suggests that the tool required to undertake IC is

"the self" (p. 181). Along with the use of 'self', Borkan proposes that six other elements are required: data, personality type congruent with the demands of the method, time and patience, reflexivity, process-orientation and a mentor and/or some experience. In order for the researcher to be immersed in the data while applying IC, Borkan (1999) identified "points of entry and exit" (p. 183) and suggests these are considered in a non-linear way. Figure 7 is a diagrammatic interpretation of the IC process and how both AI and IC were used in the process of data analysis. IC adds another layer of complexity to the application of the AI process; however, the outcome is all the more rich for ensuring all elements are considered.

THEMATIC HIERARCHY

In order to identify what the data were telling me, I undertook two processes. The first process was called thematic hierarchy or common and reoccurring ideas. This approach is where the researcher first typically selects transcript data from one participant in an effort to begin identifying meaningful and relevant passages of text that provide an understanding of the phenomenon of interest (Drisko, 2005; Giorgi, 2005). Tentative themes emerge from synthesising information from the texts (Giorgi, 2005; Patton, 2002). These themes are used as 'codes', which are applied to the analysis of data from additional participants. Themes are revised using an iterative process, in which on-going judgments are made regarding the importance of data (Drisko, 2005). The judgement used becomes that of the researcher's, in that they are now the one best positioned to recognise and order accordingly the importance of the data. This method of interpretation is not to discover repeated patterns; rather, its focus is on new ideas that are able to be transformational in nature. Mace et al. (2015) use the term "restorying the data" (p. 200) as a way of defining data analysis.

Common ideas began to emerge and the picture was painted, I had someone read some of what I had written and their response made me come to the conclusion that this study gave a voice to mental health support workers. The comment made by my critical friend was "there is some good stuff in here once you get past the PhD speak". This comment helped to guide the way I then viewed the data. I applied an appreciative interpretation to the

transcripts and emerging ideas keeping my supervisors as my mentors so remaining congruent to AI through the lens of IC.

IMMERSION/CRYSTALLISATION

The second part of the process used was the IC technique described by Borkan (1999). The IC process was considered as it suggests that the analysis of the data does not commence and finish with the data collection; instead, the IC process commences when the research topic is confirmed. This is based on the view that the researcher is continually reflecting on the study process. Shellman and Mokel (2012) consider that IC as an "interpretative technique is intuitive, more engaged, and more fluid during all stages of the research process" (Shellman & Mokel, 2012, p. 363).

Figure 7: The core process of Immersion and Crystallisation (Borkan)
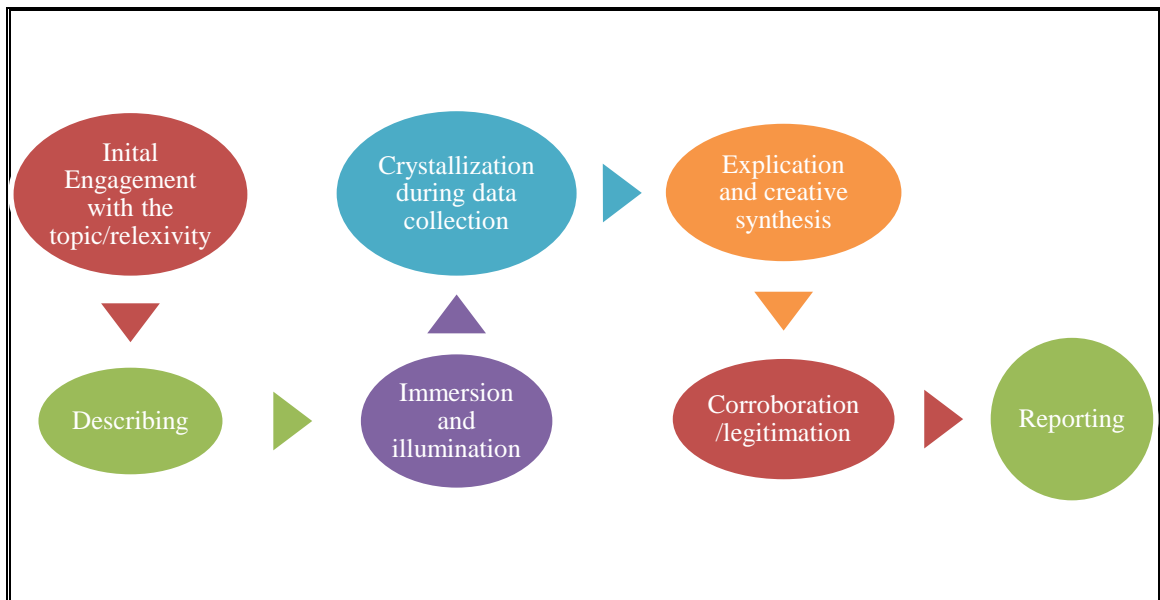
MANAGING THE STORIES

In order to make meaning of the data, I repeatedly listened to the recordings and read and re-read the transcripts. Each time I re-read the words, sentences and concepts, new meanings and understandings were gained. Themes began to emerge and the picture was painted. Kvale (2007) refers to this type of technique as 'bricolage', meaning mixed technical and conceptual discourses or an eclectic approach. This mosaic of themes through

language enables the researcher to build themes resulting from patterns and words. Caelli (2001) also suggests that this means of immersion in the data assists to understand the stories for not what is spoken but also "what was meant" (p. 274).

OLD AND NEW

Several methods were trialled to manage the data. Initially data were divided into four boxes, each named box was named as one of the phases of the 4-D cycle. As themes and key words emerged, they were placed in one of the boxes. The data in the boxes were then categorised into emerging sub-themes. Coloured highlighters were used on the transcripts, each colour denoting a theme.

The second method adopted was to utilise the software NVIVO 10. This software creates themes as described above. Instead of boxes, the data is collected and stored in nodes. One of the main disadvantages of using NVIVO is that it must be loaded onto the computer that the researcher is using which reduces its portability. The second disadvantage is that the data need to be set up in the same way, using the same styles for headings and sub-headings in order for the programme to recognise the data. The advantage of the software is that it allows the researcher to view the raw data in many different ways once the source documents have been set up.

It should be noted that the both systems are for management of the data: one being a manual system and the other one being driven by software. Whichever method is used the researcher is still required to undertake the analysis. On reflection, I did not need to undertake this two-stage approach; what NVIVO showed me was that the manual thematic analysis and IC process that I had undertaken was as valid and reliable as the software and also gave me the additional skill of being able to use NVIVO, albeit at a very elementary level.

THE USE OF LANGUAGE

As I interpreted the voices of the participants through my own world view, I have chosen to primarily use the word (mental health) 'consumer' when referring to people who have experience of a mental illness and access to services. However, at times I do use other

terms in response to the context and the words that participants use. The other words used to identify people that access mental health services are 'tangata whaiora', 'client', 'service user' and 'tangata motuhake'. Some of these terms are known internationally; however, 'tangata whaiora' and 'tangata motuhake' are terms that are used in New Zealand (Aotearoa) as they are words which come from the indigenous people of this land, the Māori. Deegan (1997) argues that "the names we call each other have certainly changed. But I would argue that the fundamental relationship between those labelled with mental illness and those who are not, has remained essentially unchanged for centuries" (p. 13). Wittgenstein (1958) suggested that language should be viewed "as an ancient city: a maze of little streets and squares, of old and new houses, and houses with additions from various periods" (p. 18).

TRUSTWORTHINESS

An important aspect of qualitative research is the recognition of the validity or *trustworthiness* of not only the data, but also the researcher's interpretation of the data. Williams and Morrow (2009) state that there are "three main categories of trustworthiness to which all qualitative researchers must attend" (p. 577). The three categorises they identified are "integrity of the data, balance between reflectivity and subjectivity and clear communications of findings" (p. 577). Whittemore, Chase, and Mandle (2001) caution towards a more balanced approach so that "creativity must be preserved within qualitative research, but not at the expense of the quality of the science" (p. 526). In keeping with the views of Whittemore, Chase, and Mandele (2001) a balanced approach was applied when interpreting the data. This balance was achieved through my own thoughtful interpretation and also through the guidance of my supervisors. Drawing on their collective experiences created an environment of positive challenge and gentle questioning. They helped draw out my thinking and watched for any times when my own experience coloured my interpretation in a way that seemed inappropriate. I would therefore add another category to achieving trustworthiness within qualitative research, that of moderation of interpretation of findings through the expertise of critical friends or academic supervision. Tobin and Begley (2004) suggest that "authenticity, trustworthiness and goodness" (p. 388) are the hallmarks for rigor in qualitative research and that there is a move towards a "more pluralistic approach as a means of legitimizing naturalistic inquiry" (Tobin & Begley, 2004, p. 394).

Managing the data when applying an appreciative approach allows the researcher to make strategic decisions about "whom to invite to take part in a study, depending on the experience, knowledge and understanding the researcher thinks they might have" (Reed, 2007, p. 71). In keeping with AI, when a group interview was undertaken it was the participants who controlled the invitations, guided by the information sheet. This inclusiveness and ownership by the participants is also in keeping with a recovery approach.

There are a number of approaches that are able to be used by qualitative researchers to ensure the integrity of the data. These involve triangulation of the data, management of the data and the wisdom and discipline of peer review by a senior researcher or external reviewer (Morse, 2012). My supervisors and a critical friend fulfilled these roles. Sandelowski (1993) postulates the view that qualitative research does not have to be valid based solely on the argument of reliability and that it is a body of knowledge in its own right (Sandelowski, 1993). The reader also has an important role in discerning the integrity of the findings, drawing on the congruence with their own understandings (Smythe et al., 2008).

BALANCE OF INTERPRETATION

Stories were gathered from participants spread across different geographical areas and disciplines. Both Shotter (2006) and Reed (2007) support the notion of 'withness' as being important as it "makes sure everyone's view is heard and respected" (Reed, 2007, p. 156). Reed (2007) argues that 'withness' provides equal status for all participants. It does not only hear the privileged or allow voices "being lost in the "noise" for others." (p. 158). The data collected from participants needs to be reflective of the participants' experience (Whittemore, Chase, & Mandle, 2001). The use of group and paired interviews meant participants agreed with and supported each other's opinions during the process of data collection. Morse (2012) cautions of being overly zealous in relation to unstructured interviews or interviews that you have done yourself and suggests that for the processes of inter-rater reliability keep the analysis shallow, obvious, and descriptive. The reason for this is that a segment of text has more meaning to the person who has done the interviews

and understands its full meaning in context than to the second "checker," who just sees a phrase or a short paragraph and takes it at face value (Morse, 2012, p. 137).

It is therefore the skill of the researcher, when applying an appreciative perspective, to ensure that an engaged, responsive understanding becomes available to us from within the unfolding dynamics of such relationships — a kind of understanding that is utterly unavailable to us if we adopt only a monological approach to them and treat them as dead forms (Shotter, 2006, p. 599).

I affirm that I have been immersed in the whole of this experience for the past four years. My supervisors have also had the opportunity to be exposed to the whole, albeit at a degree of distance.

SUMMARY

This chapter provides the detail of the plan of inquiry. It sets out the way in which the story tellers were selected and how their stories were respected, interpreted and protected.

Participants willingly gave not only their time but also a part of themselves. I hope I have done justice the stories told to me and respected the trust participants placed in me. Their stories have been reinterpreted from an oral form into a written form, which in itself changes how the stories are reported.

Ethical considerations, requirements and process have been described with the paramount consideration being to care for the information entrusted to me.

The AI framed questions were about the nature of, worth of, quality of and significance of certain situations (Preskill & Catsambas, 2006). Appreciative interviewing takes the participants through a self-reflection process and invites them to examine their successes and to identify ways of improvement (Preskill & Catsambas, 2006).

CHAPTER SEVEN: DISCOVERY – THE BEST OF WHAT IS AND HAS BEEN

Act the way you'd like to be and soon you'll be the way you act. Leonard Cohen

INTRODUCTION

This chapter reflects the stories of the participants that are at the heart of the Discovery phase of the interview. The first phase of Appreciative Inquiry (AI) uncovers the aspirational peak experiences, the 'best of what is' and the difference that mental health support workers make. The stories in an AI approach provide the opportunity to hear the positive as the "positive core of the organisation is what gives life to it when it is at its best. People start to appreciate themselves and their colleagues" (Seel, 2008, p. 6). The stories that describe the best of what is are heard throughout this chapter.

DOING THE WORK

ENDORSING THE WORK

Participants' stories revealed facets of the relationship between MHSW and mental health consumers and the belief that when this relationship works, support work works. Borg and Kristiansen (2004) suggest that a measure for defining the quality of the relationship is through the interactions, which in this study is between consumers and mental health support workers. The right environment is created when "services are less illness focused and more person-centred" which is achieved by "developing the roles and competencies of helpers and services in general, towards a more open perspective of what actually helps (and also what hinders) recovery" (Borg & Kristiansen, 2004, p. 501).

John, a consumer advisor employed by a district health board, supports the notion that central to the nature of this work is the 'relationship' with clients that works towards being an enabler and the need to ignore the illness altogether.

> *There seemed to be two main kinds of definitions or understandings of support work and one was that you more or less do stuff for the other person. If they haven't got anything to eat, you go and get them some food, you might not open their mouth and stuff it in, but you go and get*

them food, either because if they don't they will die or will become ill or will just sit at home all day and smoulder away or they will smoke and so on. So there is that kind of doing something for someone else, something necessary. The other kind of support and the word is sometimes used – endorsement. I think that is the real meaning of the support. Sometimes people need someone to bring them food or some clothes to wear or find themselves somewhere to live or something like that, but to confine support to that is not productive, one it is not productive and two it leaves out the most important part, it doesn't lead anywhere and doesn't put anything into context. It gives the person no particular future, it only means you have something to eat now for a day or two or a week and that's it. What happens next week? It doesn't lead anywhere, it just responds to the immediate or the mid-term at least. But the other kind of support work happens well, in a kind of paradoxical way, I suppose and idealistically, the support worker ignores the illness altogether, the value of support workers in the endorsement or the appreciation of the other person and the human relationship that comes out of that, because that's where the future begins because also there could be some discussion around those values of recovery like hope, and I think that comes in here. Whether hope ought to be a fundamental value of recovery, what it actually is and the understanding of hope and whether that is enough. And whether hope implies you actually do something about it or just sit there and wait and so on. I think the whole meaning of hope, so the role and values around support work I think are pretty important. We have to focus on the relationship, because I believe that when that works, support work works and when it doesn't work, it doesn't matter what else, you will be doing it forever so what have you achieved? If I come and cook your dinner every night this week, that's great, but if I am still doing it in 12 months' time, what has been the point of my work?

You have been fed. And that change where you are starting to cook for yourself, I believe comes through the relationship between you and I and as much about your trust of me as it does about your confidence or motivation to cook dinner. And that's why I think the relationship is important. I think we forget that when I am thinking about whether I've got the confidence to go out and do something or whether I've got the skill to do it or even if I can be bothered, a lot of it is my trust of you. I will be in a crisis obviously, but long term we are talking recovery and all of those strengths based models approaches then we have to think about not what I do but what you do. So we have to find some markers and they are kind of markers of satisfaction and they are markers of what that relationship enables me to do. Not what I do, but what it enables me to do and I think that's the difference and we need to fund for those.

John provides his definition of what he believes mental health support work is. He describes two main, but different approaches: one is what you do for people out of 'critical necessity' and the other is what you do for people as an 'endorsement'. In the former, he describes necessity support work as the 'doing for' and defines this as the tasks that are undertaken by the support worker in order to keep the mental health consumer alive. As an example, he suggests that the mental health support worker may cook for the person that they are supporting 'the doing for' in order to meet their nutritional needs. However, from John's perspective, he does not perceive these interactions as a productive role. John is able to take a pragmatic view of this approach by suggesting that these types of tasks may be necessary in order to sustain the person, albeit in the short term. John looks to the future. He does not see the future in the 'doing for': instead he sees the future in 'endorsement'. He uses the word 'endorsement' as a way to describe the human-to-human relationship between the mental health support worker and the consumer; he sees the essence of mental health support work is through the 'endorsement' of the relationship. From that 'endorsement' he foresees 'hope' for the future that brings with it 'hope for recovery'. John's value system views the nature of the 'relationship' as being pivotal; he considers that without the 'relationship', the consumer is not empowered to navigate an 'endorsed' future, because the mental health support worker will not have created the opportunities that facilitate 'skill acquisition' for the consumer. In John's view, the consumer will not have journeyed through their recovery if they only experience the 'doing for', although, as he suggests. they will be well fed. John stresses that the key to building the foundation of the 'relationship' is 'trust'. If relationships are built on hope and trust, recovery is what John sees as their future.

In John's view, he sees that the 'relationship' needs to be measured. He starts to define characteristics within the 'relationship' that could be used as a measurement. His first signpost explores what is needed to define what the mental health support worker has done that has 'enabled' the consumer to do for themselves (rather than what the consumer has specifically done). He views the enabling part of the relationship as an outcome measure. He further defines this by suggesting that it is the measurement of the 'relationship' that should inform how and which services are funded. John clearly sees that there is a difference between mental health support workers and generic support workers. As a way of defining the two groups, John describes the characteristics that differentiate them. He

suggests that both groups may need to undertake tasks from time to time: however, he deems that the task component of the mental health support worker role should only be of short term duration 'necessity' as the focus for the mental health support worker should be on the establishment of a long-term 'enabling' and 'trusting relationship' that is built on 'hope' for the future as it seeks *'recovery'* for the consumer.

What John proposes would provide a significantly different mechanism to what is in place for measuring the effectiveness of mental health services in New Zealand. Mental health and addiction services has a system in place to collect outcome data through activity-based reporting using the reporting mechanism Programme for the Integration of Mental Health Data (PRIMHD).[10] John is suggesting that the way in which to measure the effectiveness of the services provided by mental health support workers needs to be different to that which is in use in 2015. He suggests a future that is based on the nature of the relationship and not on the number of contacts. He believes that what is needed is a way to define the relationship, the nature of that *relationship* and how it *enables* the consumer into achieving their *recovery*. The need to revisit funding regimes that identify the important, but difficult to quantify, aspects of health professional and consumer relationships is supported by a study undertaken within the National Health Service (Hart & Dieppe, 1996) of Britain.

TANGATA WHENUA

E te Atua
Karanga mai te rangi o te whenua.
He whakawhetai atu he whakaaro e nga korero e whakatau tiaki manaaki ki rātou nga tangatanga ki tenei wā.
Mīharo ki mai kia rātou nga nā te me te nga tia te wa e mate ana, ko wai he nei rā ia maunga, ia waka, ia iwi, haere atu moe mai takoto, no reira e te Atua.
Kia piki te ora, te kaha, me te maramatanga.
Anei he kupu, he kupu ko te ora, he kupu ko te aituā he Raunga Rawa mai Karaiti ma ki to na tu.
Amene

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[10] Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers

Karakia[11] above is my way of acknowledging Anaru as tangata whenua[12]. When first greeting Anaru for the interview, I inquired as to whether there was a particular way that he wished to start this interview. My reason for doing this was due to my own experience of working in mental health services and in particular Māori mental health. Anaru's response was that he wished to say a karakia or prayer before the interview commenced. As a way of acknowledging the importance of karakia and as a way of acknowledging Anaru I have included his karakia. Generally a karakia is defined as a prayer; however another way of describing it is as a way of invoking spiritual guidance that creates a culturally safe environment.

Anaru introduced himself by providing his whakapapa[13]. This defines who he is in the Māori world; he honoured his ancestors that have come before him and his ancestral land, which includes the mountains and rivers associated with that land. He acknowledged his connections through his iwi[14], hapu[15] and whānau [16]. Anaru then defined who he is in the professional world; he did this by acknowledging his education in the area of social work. He also acknowledged his position as a manager within a Kaupapa Māori[17] service, which is also a NGO. These three distinct but overlapping worlds means that Anaru needs to weave his way through the Māori world, the professional world and the managerial world. I reflect on how Anaru walked these three pathways with apparent ease and how he shared his knowledge with the mental health support workers. In a study by Evans and Moltzen (2000), it is suggested that traditional ethnic groups are more tolerant of mental illness, providing them with a protective mechanism.

> *Sometimes because of life's experiences and trauma are very similar to their own experiences, we also have tangata whaiora employed within our organisation, so what I do experience and what I do observe is there is more empathy. The empathy comes with the understanding and unconditional care. In simple terms, you have a job description which is ok, but what I note is that they tend to work outside of that and that's why*

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[11] Māori prayer or blessing
[12] Māori term for people of this land
[13] Kaupapa in this context refers to his genealogy
[14] Māori word for tribe
[15] Māori word for extended family
[16] Māori word for immediate family
[17] Kaupapa Māori' is used popularly by Māori in a fairly broad way meaning any particular plan of action created by Māori, expressing Māori aspirations and expressing certain Māori values and principles. www.rangahau.co.nz/methodology

my role is really important to be able to consolidate some of those roles and responsibilities. Working outside of your job description has been a familiar theme that I note within the organisation.

I haven't had a lot of experience working with support workers; this is still pretty new for me, but again empathy and attachment and doing extra things in terms of extra whānau contact, wanting to bring whānau on site, asking them to facilitate hui and therapy. And then being mindful what my boundaries are around that, but then again staff coming up to me asking would it be ok to do this or would it be ok to cook this type of meal tonight? And just again having that time with those residents while they are with us but also being mindful that it is about knowing how you share your time with everyone that is in that house rather than attaching to one person, because everyone's needs are all the same regardless and because we are a small workforce, there are times where there is one to four.

So the practical things I see around how staff our support workers work with clients is that by bringing clothes, or bringing kai, they will bring their whānau in to introduce to their whānau, those types of things. They will have music with them. They will sit down and just do some little things with them even if it is reflection. You don't have to make a lot of comment around reflection, because this allows you just an ear just to listen. You don't even have to come up with solutions, but for them to be able to do that they need to have that therapeutic understanding of working. What I try and do, I try not to work in a way that is clinical because I suppose that's a part of my Māori, so what I try to do is I try to introduce some simple frameworks that will support them to be able to work with them. What I am talking about is your mini mental status, because some of the difficulties that staff have, is knowing what's right and what's to catch up. And then they are in there discussing and talking because what they have done in the past, tangata whaiora have given so much, but it is not reflecting and so it gets missed. So it is using status to be able to capture some of those core things, we don't have to put a lot of jargon down, it is quite evidence based in terms of what we do, I find that our staff now within the last 12 months have got a very strong robust reporting system and use their time lines and documentation.

The way Anaru described his many worlds and how he managed within those was by acknowledging the Western world of employment and job descriptions. What he suggests is that there are times when the mental health support worker needs to operate outside the prescribed boundaries and that in his role, he is there to support that when it is for the benefit of the tangata whaiora (mental health consumer). He defines what he means by the boundaries of the job description by using the words 'doing extra'. Anaru relates this back

to what he sees as the mental health support worker being empathetic which is grounded in their desire to provide 'unconditional care'. In order to do that it is necessary to be 'doing extra'. In describing the workforce of mental health support workers in his organisation he also reveals that many of his staff have their own lived experience of mental illness; this can also bring with it the quality of empathy. He expresses how the personal experiences of mental health support workers are visible in the way that they carry out their role. He speaks of the characteristics that he has observed; that those people with a lived experience of mental illness were more able to display 'empathy' for the consumers they supported. Anaru expanded on what he saw as the qualities needed to achieve these being: 'empathy' these being 'understanding, attachment and unconditional care'.

Mercer and Reynold (2002) regard empathy as being one the critical factors on which therapeutic relationships are developed; they extend on this view and suggest that this factor within a therapeutic relationship could even be more critical to the clinical outcome than psychological therapies. Anaru uses tasks that the mental health support workers do as a way of defining how they incorporate *empathy* and *care* into the *relationship*. While Anaru describes these in terms of tasks, it is not the tasks themselves that are important; rather it is the importance of the tasks and what they symbolise. While he describes this in the context of his own service, Kaupapa Māori, I view that what he is describing is about being human and the human connectedness that we have with various artefacts such as food (kai) and our family (whānau). Anaru describes ways in which mental health support workers with a lived experience of mental illness in the Kaupapa Māori service were able to connect 'empathy' with tasks and so used their own lived experience of mental illness as a way by which they could maintain the humanness of the support relationship. Anaru suggested that "it is the patient's perception of the helping relationship that determines the effectiveness of empathy". He sees the helping relationship as being well developed in his staff, believing this is a result of many of those staff having been consumers of mental health services and therefore able to show 'empathy', having walked in the mental health consumer's shoes.

Anaru describes the way in which the mental health support workers have connected their whānau with the whānau of the consumer; "they will bring their whānau in to introduce to their whānau"*,* an example of 'doing extra'. This ability to make those connections is

described by Mercer and Reynold (2002) as they suggest that in order for empathy to be effective, health practitioners need to be able to demonstrate that they are able to grasp what it is that a patient is experiencing and furthermore be "able to act accurately on the basis of this understanding" (p.10). Anaru sees that his professional background as a social worker adds to the richness of the service he is able to translate the jargon of mental health into words that are understood and therefore meaningful to the mental health support worker. In doing this, Anaru has provided a way by which he can support and grow his mental health support workers to better understand their role and to use evidence-based judgements to improve their practice, which gives them the skills to provide better mental health support work. Anaru is mindful that the need to provide empathy and care into the relationship also requires the practice to be evidence based in order for it to have the required status. Empathy as defined by Varcarolis (2006) is that "one understands the ideas expressed, as the feelings that are present in the other person" (p.157). The characteristic of empathy is used in order to progress the helping relationship and the nature of this relationship is part of the building blocks that aid recovery. The Māori world of mental health support work gives permission for a way of working that honours consumers' spiritual and cultural beliefs which may not sit comfortably in a Western model of healthcare. The crossover between the two worlds occurs with the nature of the interaction being based on relationships and how those relationships are defined and enacted. Just as Anaru used his whakapapa to introduce himself to me, he recognises the importance of whānau being involved with the healing of tangata whaiora; he acknowledges this in the way he introduces hui (meetings, usually involving family or significant others) as part of the healing (therapy).

THE USE OF SELF

This section provides insights and relates to Pasifika and as such warrants a section in its own right. I have however placed this section in close proximity to the stories told by Anaru as Māori and Pasifika share some cultural and ethnic links. Kath speaks about how she as a Cook Islander uses her ethnicity with consumers as a way of connecting with them by building rapport.

Kath, a mental health support worker, identifies as Cook Island. Kath speaks about how she uses her ethnicity as a way of connecting and building rapport with mental health consumers. She describes what she does from a cultural perspective, which shares similarities with the way Māori work with consumers. She identifies that time is a key requirement for building and maintaining a relationship. She also identifies that in order for the relationship to be enduring, it needs to be built on reciprocated and mutual respect.

> *I am from the Cook Islands and if it's a Cook Island client because the Cook Islands is small, I find out where they are from and about their family, so that when I visit them, I introduce myself, my family where I come from in the Cook Islands, just like the Māori do and I want the family to be there, just to build that rapport with them. Those first few visits and then as we go along I can identify their needs and work along with them to get with the doctors and nurses, but building a rapport with them on the first visit is very important. Sometimes they don't let you into their house. We only walk away and then we try again. Sometimes the doctors will go in first, like the Crisis Team and my work as a support worker, will help to fill the gap with the families because a lot of pacific islanders, Cook Islanders, they don't believe in doctors and they don't believe they have the mental illness. Where I come from they call mental illness, hearing voice is the ancestors telling you things. I have to build the rapport as some of them isolate themselves. We address the issues like a jigsaw puzzle so they can reach their goals of recovery and encourage them to come to the groups and that's why we run groups and sometimes some of the clients are New Zealand born and they don't know the culture, so it is quite difficult, but we get there. It is a slow process, not an overnight thing, it is a talking process, you get to build that rapport and get to know them and some of our bosses don't like it, but that's how we build that rapport. I feel that if I can respect, then I get respect back from my clients.*

Kath explains how she uses her own Cook Island ethnicity and identity as a means of connecting or as she defines it 'building rapport' with consumers that are of Cook Island descent. Kath describes the importance of engaging the family in a similar way to that described by Anaru. She has had to adopt strategies when the consumer does not want to be seen by her; she does this by continuing to return to the consumer. This seeming persistence is in part explained by Kath, based on her own cultural knowledge, that many Pasifika people do not recognise mental illness in the way it is described in Western medicine; therefore, there is a reluctance to be seen by a mental health support worker

because their cultural beliefs do not acknowledge Western views of mental illness. Kath provides insight into the dilemma she faces as what is described in Western terms as being psychotic and hearing voices is viewed by many Pacific people as voices of their ancestors speaking to them. Another role Kath describes is that of a cultural bridge between service providers. Kath articulates that this aspect of her role is to develop a cultural bridge to connect those New Zealand-born Pasifika people with an understanding of their culture. She views this as a way to connect Pasifika people to their ethnic origins and their people. Kath's broad use of the term 'culture' is similar to that used by Papps and Ramsden (1996), when they describe culture in broad terms but kept it distinct from ethnicity.

For Kath, time is an essential requirement in building the relationship. The time intensity of the relationship brings her into conflict with her employer. She suggests that there needs to be mutual respect in order for the relationship to work effectively. She believes that if she works in a way that respects the consumer the consumer will in turn respect her. The mutuality of this aspect of the relationship and the time given makes the relationship work.

John, Anaru and Kath place importance on the relationship and the characteristics of that relationship through its ability to nurture and support the consumer towards recovery. While they speak of the different ways to nurture the relationship and the different contexts they also have many similarities. All describe the 'doing with' as the way to support recovery, not the 'doing for', and view the role of the mental health support workers as one built on relationships, a non-clinical but mutually respectful relationship that seeks to walk alongside the consumer as they navigate their pathway to recovery. Empathy, trust and unconditional care provide the foundations for the relationship between the mental health consumer and the mental health support worker.

CREATING SPACE FOR CHOICE

Integral to establishing a trusting relationship is the commitment to facilitate real choice. Alan describes how in his role he was able to support the consumer's choice for spiritual guidance. Alan is employed as a rehabilitation assistant in a secure forensic unit. Into this role he brings with him his mental health support worker qualification. In many mental health services Alan's role would have the title of mental health support worker; however,

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the DHB that employs him uses the title 'rehabilitation assistant'. Alan spoke about an experience he had that was not only meaningful for him but also for the consumer he was working with.

We had a patient who was wishing to go to a church, to a Mormon Church and staff were saying it wouldn't be good for him and for his mental health and I utilized the Treaty of Waitangi as the pivot to actually allow him to get the access to go to the church because of spirituality. Just because staff didn't agree with where he wanted to go, it wasn't right to say no, so by utilizing the Treaty of Waitangi we were able to make progress for him to go. In the end he chose not to go on the day after we had arranged everything, but the thing was it was in place for him to be able to go.

Basically the other staff didn't agree with the type of church he was going to go and my argument was that we didn't have the right to say no and it was the fact that the Treaty of Waitangi, that although is predominantly geared toward Māori, I was using it for a European, they couldn't argue with it. That was the big thing. He was expressing his interest in wanting to go somewhere. That was the church he had been brought up in as a child and he wanted to go back to it. That was the leverage I used to allow him to have the option of going there.

What was important to me was that he should have the right choice of where he wished to go to for his spiritual beliefs and for the patient it was actually allowing him the ability to go if he chose to. Like I say, at the end after all the work we put into it, he changed his mind. Then about six months later he did go and he has only been twice in 18 months but the thing being it is all set up in place for it to happen again if he wishes. If I had not formed a case for him, it more than likely would not have happened.

It was annoying. The arguments that were going about were that he wasn't mentally stable, the type of church could upset him but the thing being was that on all our outings, because I work in a Forensic Unit, everything has to be approved for leave and those types of things and even at the last minute if the mental state assessment that has been done by the Registered Nurse, they make the decision on the day before they go out, so the thing being as long as everything is working for the patient – it happens. If he is unwell then it doesn't happen, but it doesn't stop it happening in the future.

I am a verbose person and I get upset and I make my point. Somebody else may have easily backed down on it. But it is my own personal belief that spirituality is important to every person and it is their choice where they wish to go for that.

Alan describes a situation where he provided support for a consumer who had a desire to attend a church, in order for the consumer's spiritual needs to be met. Alan recognised the connections that this consumer had with this religion, through knowing and therefore making the connection with the consumer's childhood. Alan's advocacy was based on supporting this consumer with 'their choice'. In taking this position, Alan calls into question the right of his colleagues to deny the consumer access to a place where he could have had his spiritual needs met and also able to connect back to his childhood. In supporting the consumer's request Alan considers a number of factors. His tries to understand why his colleagues are using the argument that the person is not mentally well enough to justify not taking them to this church. Alan interprets this as staff are really saying no just for the sake of saying no. He senses that there is more to the statement than just saying no. His highly-developed sense of fairness and desire to 'create space' for the consumers to exercise 'choice' places Alan in conflict with his colleagues. However Alan's ethical sense of 'rightness' is stronger than his need to conform to the view of others. Alan's ethical belief structure that includes where possible, supporting consumers to have 'choice', is being called into question.

The context that frames Alan's approach is important to understand. The consumer that Alan refers to is subject to a court order under the Mental Health (Assessment and Treatment) Act 1993. In order to meet the requirements of the Act, certain action (such as going outside of the unit) require permission by the Minister of Health through the Ministry of Health. The application to the Minister of Health is made by the consumer's Responsible Clinician, who is usually a psychiatrist. Stringent conditions are placed around requests to leave the unit, with additional staff being required to escort the consumer. The application has to include details such as the purpose of the leave, duration, locality, how many staff will be escorting the consumer and if there are any victims associated with the consumer's detention in a secure unit as they are required to be notified. Alan is aware of the legal requirements; however, his principled belief is to support the consumers to exercise their choice within an environment where choice is very limited. He recognises that this outing will allow the consumer to be connected with his childhood and spiritual wellbeing and, for him, it far outweighs the legalistic paperwork and views of his colleagues.

Alan states that he used the Treaty of Waitangi[18] (the Treaty) as a way to gain leverage to enable the consumer's spiritual needs to be met. Although he does not expand on which part of the Treaty he used as a point of reference, he does suggest that his argument was built around the right of individuals to have their spiritual needs met. Kingi's (2007) interpretation of the Treaty into the health environment suggests that the Treaty "can also be used to assist health service delivery and more focused interactions between health professionals and clients" (p.9). As recognised by Alan, the Treaty holds a special significance for Māori, in that it provides for certain rights for Māori. Alan also views that as the Treaty is about two peoples ie Māori and the Crown that the principles of the Treaty equally apply to non-Māori (including the consumer, who is European). He uses this knowledge as leverage for the consumer in order to support the consumer with their aspirations''. For Alan's, his short-term goal is for the clinical team to recognise the consumer's choice and enable him to access a church of his choosing in order to have his spiritual needs met. Alan has used his knowledge and his relationship with the consumer to ensure that the consumer is heard and this request is given the consideration it deserves.

As Alan's story unfolds, he reflects on this event; he recognises that while the processes had been put in place to enable the consumer to attend his childhood church, it was the consumer who made the choice not to attend. Alan created an environment that enabled the consumer to exercise their choice. In fronting his colleagues Alan supported the consumer's choice, which was contrary to that of his colleagues. He then identified a legitimate way, through the principles of the Treaty of Waitangi, to enable the consumer to be able to exercise choice. It was the consumer who exercised choice, not the staff. Alan's actions created, in a very structured and regulated environment, a way by which the consumer became the eventual decision maker.

Alan saw the positivity with the consumer exercising choice. He advised that at some time in the future the consumer did attend the church of their choice a number of times. In telling this story, Alan recognises the challenges for consumers who are in a secure, contained and structured environment. He called on a range of skills to work creatively with the consumer and the system to see a positive future.

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[18] The Treaty of Waitangi is New Zealand's founding document. It takes its name from the place in the Bay of Islands where it was first signed, on 6 February 1840. The Treaty is an agreement, in Māori and English, that was made between the British Crown and many of the tribes in New Zealand

Gina's background is that of a mental health support worker. The service that employs her provides services to families where a member of that family has experienced mental illness. She works autonomously within the community, using her skills and knowledge to provide support to families. While Gina's story is long, its power is in the connection and relationship that Gina has developed with the family member whose daughter is experiencing mental illness.

I worked with a family in 2009; it was a mum who had a 15 year old daughter who was going through the CAFS [child. adolescent and family mental health services] system and had been fostered out with CYFS [child, youth and family services], she had behavioural issues and the diagnosis of borderline personality disorder, so the mum came through our system my primary focus was to maintain the relationship between her and her daughter because the daughter through her behaviour had created a lot of anger within the family. The parents had separated and re-married so she had two sets of family – one family didn't want to know, the other one, the mum wanted to remove the anger and trust her daughter again and maintain a relationship. We worked alongside this mum mainly looking at why she felt so angry towards her daughter and educating her teaching her that her daughter wasn't doing it to hurt her personally. One of the issues was that this mum wasn't included with the process that was occurring down at CAFS and so they did a survey and I took the survey to the mum to fill in and then took it back to the service and they were really surprised, and asked if the mum wanted to meet with them but unfortunately the relationship between the mental health service and the family was of anger, because of that lack of inclusion, so I just said no she just wanted her voice put out there, if it helps any other family, then that's great. We got to a point where mum was going to the netball games on Saturday to watch the daughter, they were doing things one on one because the mum was also pregnant again. So got to a point where she was saying like "thanks Gina for everything that you have done, I have learnt so much and I'm really happy where things are going and they can only get better", I said "that's great and see you".

It was a year later, I was sitting at my desk and the phone rang and it was this mum and I was like "how are you doing" and she said "Oh Gina I am so glad you are still there", unfortunately her daughter had suicided a month before I was not aware of this. I was just said "oh my God, I am so sorry", she said "Gina I need to see you". I felt a bit out of my depth". When I hung up the phone I realised she was doing exactly what we talk about on discharge, if anything ever arises you can always make contact and so with it being so big, I started working with this mum who was now living rurally on a dairy farm. She now had two babies and another one

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on the way and going through this. It was more than grief for her; there was a lot of guilt, so we tapped into grief intervention, we tried to tap into the mental health service because I felt she was slipping into a depression, we needed to work out what was actually mentally going on for her. She shared with me that her daughter had described sexual abuse, and for her it brought up her own. And it was like "oh my gosh, this is huge, do you want to work with that?" We tapped her onto a psychologist and so she started doing that journey, we began weekly visits one day she asked "Gina the girls need to go to pre-school or play group" and because she wouldn't let her little kids go anywhere, she wasn't having time to herself and I said, "well is that where I can support you, would you like me to take the girls to play group once a week?". She just cried and she said "would you would you look after them?" I had to come back and talk to my boss about it. Because it was like a big responsibility so we did that process for around two months and it was coming up time for her unveiling. One day she said "look the girls aren't going to pre-school today, I have a really big request".

She said herself, her eldest daughter who was 18; the baby who had been born and her sister were going to Wellington to collect the headstone. She said "Gina, will you join us, will you come with us?" I was really blown away and I was just so honoured that this level of trust had been built, so I came back and spoke to my boss and it was like "do you expect to be paid?" Well I still had to have my presence of being a support worker and so they decided they would pay me for so many days and then I would have to take so many days – because would take a week to bring the headstone back – so for some of that time I had to take annual leave it was kind of like, OK I can still be me, I know what my boundaries and ethics. Where we were staying was about a 25 minute drive to my mother's house. I had not spoken to my mum for six years I hadn't seen her for eleven years. And I am like well what have I got to lose, so I actually made that connection and that family was really happy as they felt they could actually give something back and it wasn't like an unethical thing. We brought the headstone back down, and then we had the unveiling, that mum became complete and there was just this sense of a connection and without that time and that support, I think she would have become a member of the mental health service.

Gina begins her story by describing a situation that gave me a sense of foreboding as the intensity started to unfold. While I had no knowledge of how the story would evolve, I felt intuitively apprehensive about what this story would reveal. Although Gina did not reveal the name of the mother described above, I made the decision to provide a human face to this story through providing the mother with the name 'Louise'. I felt that this was a way in which to acknowledge the power of this story.

Gina describes how she worked with Louise through a very difficult period in Louise's life. These difficulties included her daughter becoming mentally unwell, her relationship with her husband breaking down and her remarriage and subsequent pregnancies. She saw her role in this situation as one of providing support and education while working alongside Louise. Gina brought advocacy into the support when it was required. In telling the story, Gina described how she provided support for Louise when Louise was excluded from her daughter's care and treatment by Child Adolescent and Family Service (CAFS). Gina was able to recognise the hurt and provided the voice for Louise to be heard when she was not able to do this. Louise is fortunate in that she has the support of Gina; however, Gina recognises that this may not be the case for all families. Under Louise's direction, Gina approached the mental health service as an advocate to remind the service that where there is a family member accessing the service there is a responsibility to involve those family members. She sees the role of 'advocate' as a legitimate activity for a mental health support worker.

By all appearances the family entered a period of stability following this initial situation. Louise got on with her life as a busy mother and wife. While concerns are frequently raised regarding demands for services outstripping the supply, a negotiated agreement was reached between Louise and Gina that they had reached a stage in their relationship where it was appropriate to withdraw support. An aspect of the role of mental health support workers, which Gina reiterates, is the provision of education. This is education about mental illness, medication and keeping mentally well. The impact of the education provided to Louise is evidenced when she again enters in another crisis. One year later Gina took a phone call from Louise who had entered into another crisis. Louise turned to Gina in her time of need as they already had established a relationship built on trust. There was no suggestion that the service that Gina worked for expected a referral from another service, nor was there a suggestion that Louise would have to go onto a waiting list. Instead, through Gina, Louise was accepted back into the service with no barriers to impede her access. In her role as a mental health support worker, Gina and the service she was employed by had created an environment whereby families in crisis could readily access the service. Louise had confidence and trust that the door would always be kept open for her if she needed support. Louise reconnected with Gina almost a year later, because her daughter had committed suicide. The shock of this situation is evident in Gina's voice on

the recording; however her professionalism allowed her to firstly recognise her own emotions associated with this dreadful news. Secondly she was encouraged that Louise contacted her support systems when she was experiencing a crisis in her life, as she had been coached to do. Subsequent conversations between Gina and Louise revealed that Louise's daughter had verbalised to Louise that she had been sexually abused. This information caused Louise to confront her own experience of sexual abuse. While Gina continued to offer support for Louise, she was also aware that Louise needed interventions from someone trained in this field; Gina had an awareness of her limitations. She asked Louise whether she wanted to work on the issues around her sexual abuse and, as a result of this inquiry Gina 'facilitates' access for Louise to an appropriate service. Gina's knowledge of other services ensured that Gina was referred to an appropriate service to engage in therapy.

Louise reached out to Gina for 'support' again when she needed someone she 'trusted' to be involved with her young children. These and the subsequent actions could be viewed as unusual. Some may suggest that the service that employs Gina is a mental health service not a childcare service, while others may see that the service is doing what is needed to keep Louise well. This raises the question of whether what is being requested of Gina is in the purview of the support worker role? Gina's employer clearly saw this request as a legitimate part of her role when she affirmed Gina's request to look after the children to allow Louise time for herself. Gina's employer gave Gina the mandate to provide the support that was requested. Gina described the 'trust' that Louise had in her by allowing her to care for her two children so that she could have some time to herself. Her employer recognised there is a need for 'flexibility' within the support relationships. Gina continued to provide Louise with the support she needed.

Later, Gina was again approached to undertake a role that may sit uncomfortably with the role of support work. She was asked to accompany Louise to uplift the headstone for the unveiling of her daughter's grave. Gina revealed that the headstone was being carved north east of Wellington. This required Gina and Louise to travel by truck from Southland, which is at the bottom of the South Island, catch the ferry across the Cook Strait and then drive another hour and half to where the headstone was being carved. This trip takes several days to complete. Gina's employer was agreeable for her to undertake this travel, but limitations

were placed on what the employer was prepared to pay by way of Gina's time. She was paid some of the time she will be travelled with Louise; however, for the rest of her time she takes a combination of leave without pay and annual leave for the remainder of the time. Gina took time to reflect on this situation and realised that she must maintain her professional boundaries even during very informal moments. She acknowledges that she was being paid for some of the time during her travel to uplift the headstone; however, there were times when she was 'off duty' but was aware of the need to maintain her professional relationship with her role being that of mental health support worker. She states "I knew what my boundaries and ethics were" but she also recognises that she can be herself, "OK I can still be me".

Gina uses this understanding of 'being herself' when she describes how she used some of her time away to visit her mother who lived relatively close to where she was staying. While Gina does not make a conscious connection or identify with the relationship between Louise and her daughter, Gina had not made contact with her own mother for many years. Louise has made the connection with her daughter through the uplifting of a headstone; Gina connects with her mother through proximity. This connection demonstrates that while she identified as a mental health support worker during this experience she also realised that she is a daughter. Gina has perhaps used this opportunity to understand the strength of the mother- daughter relationship and the results of what happens when that relationship is cut short.

Gina verbalised that she was humbled and moved by Louise's 'trust' in her and the fact that she turned to Gina at a time when she Louise required support and compassion that it was Gina she turned to. She describes how Louise sought to connect with her late daughter; for, Gina the connection was that Louise called out to her in her time of need. Gina believes that without providing this level of support, Louise would have not coped and would have ended up accessing mental health services. Gina's employer trusted Gina to allow her to be flexible in the support provided. In her role of mental health support worker, Gina continued to provide family support for Louise. The 'caring' nature of the relationship between Louise as a family member of a person with a mental illness and Gina a mental health support worker has, as defined by Pinch (1996), the "potential to change society"

(p.86). However, Pinch warns of the indiscriminate use of caring but also applauds the benefits that caring brings for those that practice and receive it.

KNOWING THE CONSUMER

During the interview, Lynn, a mental health support worker, revealed that she had also accessed mental health services for treatment of her own mental illness.

> *You know these people better than anybody else. You know these people better than their families do. You know these people better than families well, I'm not criticising that they become family, you become their family. They trust you. You build a rapport with them and they start to come and they trust you and you know it's taken a lot to build up that trust, when I left there [residential mental health service] it was the hardest thing for me to do. I felt awful walking away.*

Like Gina, Lynn describes the need to build rapport with consumers in order to gain *trust*. She also recognises that by acquiring trust, the relationship continues to develop; however, she also acknowledges that maintenance of the relationship is needed if the trust is to be sustained. Lynn also describes 'knowing' the consumers she is working with in the way that she defines the familial connection she has developed with consumers and the emotions she feels when she left them because she left the service. Lynn does not apologise for the 'closeness' of the relationship she had with consumers, however, it is the fact that she understands the closeness of the relationship in itself that helps to protect Lynn when she withdrew from the relationship.

CREATING ORDINARINESS

George, a mental health support worker, works for an NGO. He describes the changes that come about when trust is developed. He explains the relationship that developed with a consumer, but observed that it was more evident after he had returned to work following a period of annual leave. He describes how 'trust' and 'rapport' had been built up within the relationship over a period of time.

> *I had a wee break once, when I got back he was waiting for me, he said "did you have a good weekend, did you have a good break" he would not have done that a year ago, he would have sworn at me if I*

had spoken to him, there would have been a lot of expletives. I put a mirror in his room not too long ago because he didn't have a mirror. I said, "You need a mirror because every now and again when you are feeling a bit low, go and smile at yourself and say – it's going to be a happy day". So if he smiled, then that person will smile back at you and you can't be sad if you are smiling.

The relationship that is described by George suggests that it was not an easy relationship, but that a normality had been created over a period of time. In this instance, the consumer has developed an interest in George and George's life outside of work. A mutual relationship has developed between George and the consumer. It is the ordinariness of the conversation that suggests they both care about one another. The conversation is what many people have within their lives when they return for being away. For George and the consumer, they connected through that simplistic human contact and caring. Enquiring as to whether someone has a "good break" is a conversation that takes place in many day-to-day environments. The consumer acknowledges that George has been away for a period of time and this event has provided a space for the consumer to engage in dialogue in a way that suggests an interest in George's activities and more importantly, it enables the consumer to be connected to part of an ordinary world. This connection with ordinariness allows the consumer to experience and to take part in what is often seen as mundane everyday conversations. Many consumers in residential settings adopt a routine, as that is the way that large organisations operate in order to gain efficiencies. This means that many consumers do not operate in the ordinariness of our world; rather, they operate in an ordered environment.

The interactions between George and the consumer have power in that they are so ordinary. George has worked on this relationship in order to develop trust. He recognises that in order to gain the trust, he must first develop a relationship and in order to do this he must look past the 'expletives' in order to connect with the consumer. The building of the trust in the relationship is something that needs to be developed over a period of time, needs to be worked at and be nurtured. In describing trust, Illingworth (2008) suggests that there are similarities between "trust, hope and faith" (p.11); however, he suggests that there are differences in the three concepts with trust being built on past experiences. Within this context, mental health support workers need to be able to create opportunities that are built

on new experiences and which enable mental health consumers to seek recovery through hope. The effect of that investment of time creates highly rewarding possibilities, as hope is created by building trust which leads to consumer recovery. "In a user-led orientation, trust between mental health workers and patients is needed" (Pippo & Aaltonen, 2007, p. 2873).

SUMMARY

The Discovery phase shares stories from seven of the participants; stories told in this chapter are about the world of the mental health support worker and how the work they undertake intersects at multiple levels. Each of the interviews came from a different perspective and each interviewee had a different role to play within the mental health sector, yet each described the space that is created by the mental health support worker to work with those affected by mental illness. The stories illuminate the unique ways of working that are needed to enable the mental health support worker to work in such a way that promotes individualised support, advocacy and relationship development that works towards consumer aspirations. This chapter also reveals the breadth and scope of the support provided to consumers by mental health support workers. Attributes of mental health support workers have been uncovered revealing what it is that mental health support workers do that makes a difference. The Ministry of Health (1994) identified the need to develop services that are responsive to the "needs of consumers, caregivers and their families" (Ministry of Health, 1994, p. 6).

The connection between mental health support workers and consumers is through the ordinariness of the rhythm of everyday life. It is grounded in the mutuality of the relationship, based on the things that human beings do; the connectedness through an inquiry of caring and relevant self-disclosure.

Many of the mental health support workers spoke of the need to have a culturally congruent understanding of the consumer's needs, while also developing their own knowledge and insights for their own cultural confidence.

'Making a difference' has been raised as a challenge in terms of quantifying how the support for mental health consumers is defined. Mental health support workers work within

the confines of their employing body, which defines their scope of practice. This enables them to work in a way that transcends the normally restricted view of what it is support workers can do and actually do. The present measures do not delineate the nature of the relationship between the mental health support worker and the person they are supporting. This chapter provides the opportunity for a new way of viewing the work of mental health support workers and a way forward to begin to understand the nature of the work they do. The participants revealed that what they do makes a difference for mental health consumers. Mental health support workers in New Zealand work within our multi-cultural society, the knowing within ethnicities, according to Papps and Ramsden (1996) "does not lie in knowing the customs of ethnospecific cultures" (p. 493).

The common ideas, from the stories told in the Discovery phase, have been gathered together in Figure 8. These ideas provide the basis for the blueprint within Figure 18.

Figure 8: Discovery - The best of what is and has been
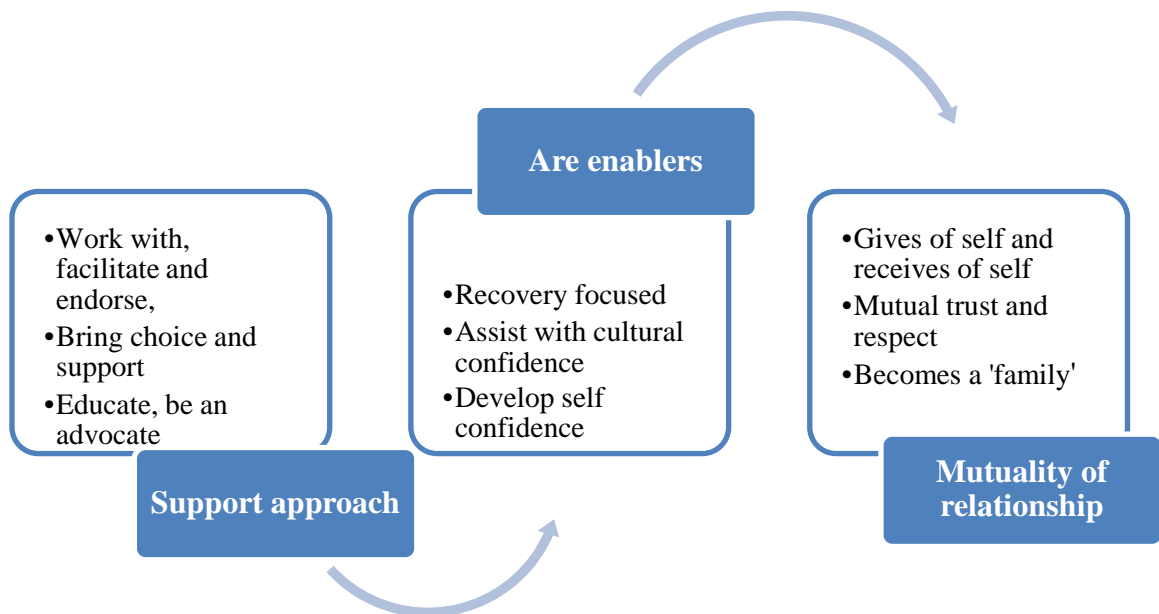
The stories told in this chapter begin to provide an understanding about the work that mental health support workers undertake and what it is they do when they try to make a difference.

The relationship between the mental health support worker and mental health consumer described in this chapter describes a relationship which is different from that of others in the health sector. That difference has come about because of the non-clinical relationship that is built on mutual respect as a result of the time being allowed for the relationship to develop and mature.

CHAPTER EIGHT: THE SHADOW WITHIN DISCOVERY

There is a crack in everything, that's how the light gets in.—*Leonard Cohen*

INTRODUCTION

Tensions when described in Appreciative Inquiry AI terms are referred to as the Shadow. This chapter explores the Shadow that has been identified within AI literature and discusses how it can be transformational. Fitzgerald and Oliver (2012) describe the Shadow as a "useful tool for opening up important areas of discussion" (p. 4). The Shadow's ability to be transformational is described by Verma (2012) as a 'diamond' in the 'coal-mine'. Verma (2012) developed a model called MARG which is a Hindi word for 'path with a direction'. When applying this model, Verma (2012) suggests that there needs to be a "non-judgmental and authentic acceptance of the Shadow" (p. 28) with the first step towards acceptance (of a challenge) being acknowledgement (of that challenge). This acknowledges that while there are perceived barriers to aspirations, it is the identification of those barriers that are important as this creates an environment that supports the Dream of AI.

Another way of viewing this chapter could have been through the lens of critical AI however I chose instead to use the Shadow. If critical AI had been adopted I would have needed to approach this study with the belief that mental health support workers are "traditionally subjugated within the institution" (McArthur-Blair & Cockell, 2012). This may have limited the scope for mental health support workers and therefore inhibited their ability to "participate fully in the dialogue of inquiry and the outcomes" (McArthur-Blair & Cockell, 2012). As this study was not confined to an institution, it had the ability for participants to create their own environment in which to have their stories heard. My view is that it is important to acknowledge the tensions that exist within the mental health sector and how this relates to mental health support workers.

When referring to the Shadow, I view this as a Dissonance rather than suggesting that the Shadow creates a polarisation, oppositional forces or barriers. The true Shadow within AI "includes the full spectrum of censored feeling and cognition, ranging from repressed strengths and capacities to fragilities and abhorrent characteristics. Thus, it includes

qualities and characteristics that may be judged as being positive and/or negative by self and/or others" (Fitzgerald et al., 2010). Bushe (2012a) suggests that it is the crafting of those inquiries to make them personally meaningful that provides power to the narratives. The Shadow as a Dissonance within the world of the mental health support worker acknowledges tensions that can be transformational in nature when viewed through the appreciative prism and attended to.

TRANSFORMING THE SHADOW

Ben works as a mental health support worker within an acute inpatient unit of a district heath board (DHB). At times he has a tendency to walk within the Shadow. He does this by applying negative words when describing himself, e.g. he defines himself as a retired social worker and a failed teacher. It is during these pieces of his story that Ben moves in and out of the Shadow. In applying Verma's (2012) interpretation of the Shadow, i.e. seeking to find the 'diamond in the coalmine', Ben struggles to give attention to the transformational nature of his experiences that would allow him to describe his 'diamonds'. The reasons for his struggle were not fully articulated; however, during the interview, it was evident that Ben does glimpse the sparkle of his 'diamonds', although he does not recognise them in a transformational way.

> *Just doing my job, doing what I am paid to do on an official level, making beds, cleaning up messes, providing some sort of emotional or intellectual support where it is appropriate. Hauling inexperienced nurse's nut's out of the fire when they get into trouble.*

Ben suggests that he undertakes a very task orientated role because he believes that he and others have defined this as his role. He begins to discover the 'diamonds' when he suggests that he is able to offer more than tasks. He describes how he supports his less-experienced nursing colleagues by using his own experience. Ben struggles to describe peak experiences and does not acknowledge that he has made a difference. However, the non-task-related acts that he undertakes do connect him with his less experienced colleagues in a positive way. Ben then reflects on some of the reasons that he continues in his role; he identifies that it is the hours and the pay that are the main motivators. The Shadow then shifts slightly and reveals that he actually derives a sense of enjoyment and connectedness

when he encounters mental health consumers in his neighbourhood; he enjoys the interactions he has with consumers outside of his work environment. This leads Ben to recognise that he has a world that operates outside of his employment; however, he struggles with the fact that it is that very employment that provides him with the lifestyle he enjoys.

> *The hours and money suit my lifestyle. I live in a suburb where there are huge amount of ex-patients walking around and quite often I can barely walk into [suburbs name withheld] without somebody coming up and tapping me on the shoulder and wanting to have a chinwag or $2.00 or a smoke or a can of beer or something, and by in large I enjoy that.*

Ben describes the tensions of being valued by colleagues.

> *With some clinicians and I also include registered clinicians, your input is highly valued and sought after. Others they wouldn't even know who you were and wouldn't want to know who you were and certainly wouldn't be interested in anything you have to say. And given the clinical staff turnover by in large every six months, with the rare exception, you can be flavour of the month one minute and a speck of dirt on the floor the next. It really depends on the mix. Because I have been around a lot longer than most and the reality is I have been around a lot longer than most of the nursing staff, your opinion has a certain amount of validity, a certain amount of weight given the individual circumstances, any different particular scenario, but then again given the highly transient nature of nursing staff, we are having a big clear out at the moment and I think four or five of our most senior nursing staff are flying the coup. They will be replaced by RN1s [Level 1 Registered Nurses] and I would anticipate the next six months my gravitas will be diminished accordingly. That is just based on the last 12 years' experience. I could be wrong, the RN1s haven't arrived yet, but we will wait and see in January.*

> *On the rare occasion we have had one psychiatrist who must have been on the ward seven or eight years, I knew him well, I socialised with him along with everybody else, he knew who I was, he knew my name, he knew my children's names and if we were in an interview before, during or after, he would ask my opinion. He would say "well you sat through that, what do you think?" Or "this is our plan, what do you think?" Or "I'm not feeling very comfortable will you come into the room with me or into the interview room with me, because you know this patient really well". I mean I was quite lucky with Steven [non-deplume] because he was there for a long time, but he has gone now. We have got other people*

who have just come in, nice people, clearly very clinically competent, but they don't know who you are, they sort of understand you are not a nurse, but because I am big and ugly they go "you're security – walk this way with me". It takes quite a while for them to actually work out, "oh this person might have a brain".

Ben suggests that there are many preconceptions about him and his role. These add to what Ben articulated as the lack of clarity and understanding of his role, which result in his role being frequently misinterpreted and defined by others. He suggests that some of the lack of clarity is related to high staff turnover, i.e. a "highly transient" workforce, resulting in him being one of the constant staff members on the ward. That leaves him feeling not understood as the role and the breadth and functions of his expertise are not recognised. His specific competency based on long experience within the role is not well defined or understood. Ben acknowledges that when the value of his experience is understood, then he is given recognition. When staff understand his role by way of working with him, they also understand that he has the capability to contribute to the total care of the consumer. He notes that when new staff members come onto the ward, he is required to prove his worth, as the ambiguity of his role title does little in determining the worth of the position. He measures his 12 years of experience against the experience of a new graduate nurse. The arrival of such new graduates brings Ben a sense of responsibility the need to ensure that they do not get themselves into trouble. He sees himself as protecting them although he is not acknowledged for this. Ben sees his worth ebbs and flows and is dependent on his establishing relationships with new colleagues. He would like to see consistent recognition of his worth and the work he undertakes, rather than having to continually justify his capabilities.

Ketola (2008) suggests that "the Shadow necessarily remains partially unconscious and carries out commando attacks from its secret hiding place" (p. 202). Ben's commando attacks manifest themselves as his having to justify who he is and what his role contributes to the health sector. This lack of recognition can manifest itself in many ways. Instead of acknowledging and acting on this undervaluing, people can often be labelled as disaffected, rigid or suffering burnout. Ben articulates that he enjoys his work and the interactions he has with past and present consumers, both in and out of the workplace. He implies that the relationship that he has with consumers is positive and recognised, but that this same

recognition is not afforded to him by his colleagues. Perhaps it is with consumers that he can more easily simply be himself and, in doing this, feel valued.

AUTHENTIC APPRECIATION

Cindy, a mental health support worker working in a large NGO, has been employed with the same organisation since she arrived in New Zealand. One of the areas she spoke about was the impact that personal gratitude had on her and the positive memory she holds about that interaction, even though such gratitude is sparse. Cindy's Shadow is that of lack of appreciation.

> *When you get a client that says thank you, when they are genuinely thankful. It has probably happened twice in the last seven months. I remember each of those days vividly and when you are having a tough time at work, that is what you think of, that time when that person told you that you are making a difference in their life*

Cindy is reminded of the aspects of her work that uplift her when parts of her work are less than satisfying. She is able to push the Shadow aside as she reflects on the rare times when her work is appreciated and the genuine authenticity of that appreciation. Those times, only twice in seven months, uplift her when she is having a "tough time". She reflects that while the quantity of appreciation is limited, its quality and appreciation provides her with her 'diamond in the coalmine'. For her, the impact of what she sees as *authentic gratitude* makes a greater difference and is more significant than the person who says thank you as a standard response. I would interpret from this that the impact of the paucity and genuineness of the gratitude makes the event more important to Cindy than the frequency. The impact of small but significant events is referred to by Borg and Kristiansen (2004) as "little things, but ones which for them had great meaning and impact" (p. 499). They suggest that these acts make individuals within the helping professions "more human and valuable" (Borg & Kristiansen, 2004, p. 499). This exchange examines the importance of the humanness of the relationship between mental health support workers and consumers.

Cindy uses the transformational nature of the Shadow to relish the rare acknowledgements of the work she does; this is her 'diamond', her brilliance which sparkles in times of her darkness.

CULTURE OF TOUGHNESS

Jane, a registered nurse, has worked alongside mental health support workers when she was employed by a DHB. One of the roles she held with the DHB was that of nurse consultant. She uses the term 'psych assistant' in place of the 'mental health support worker'.

> *If you think about some of the people who come into psych assistant jobs, where I worked, were known to staff, were family members of staff, so therefore the assumption was made is that they are kind of part of a mental health-wide community and so if they come in then they will just learn to be the way that the staff are and so they have kind of had exposure for want of a better word to the mental health world. So they think that they know and some of them do know and some of them come in and there is actually not too much that you need to do. We set up specific training for psych assistants to be honest, but it wasn't mandatory, if you know what I mean, so if you wanted to really understand what the skill base of that group were, I think that's when it makes it difficult to measure and what I wanted to do there was for it to be the essential. We had them working in our intensive psychiatric care unit. Now why would you have an untrained workforce providing care there, if you were physically sick in the main hospital, you wouldn't have an untrained workforce working with you. So that is kind of what I see the difference is and I think the risk of not having some qualification is heightened because there isn't the same regulation of that workforce in terms of professional boundaries and code of conduct, so they need to be managed in a different way. In fairness to them I think that having a qualification probably helps them more to do their job and reduces the risk of that group crossing boundaries or displaying attitudes that you really don't want and you have to ask the question where they got that attitude from. So that's where I think that if they are trained then the standard has been set.*
>
> *So the standard is not set by the environment they are going into and the staff they are going into. I recall an article called "The culture of toughness" and it was in the States and it was around unregulated workers who actually set the tone of the ward and so the registered nurses actually had to be nice to them and work with them because if some serious incident happened, your back might not be covered and so that raised some issues about how you deal with if you have a large*

group of unregulated workers, how much control they can have about setting the tone of the ward and if you think about the registered nurses – if there is a high turnover of registered nurses, who are the ones that know the most? It will be your psych assistants and there are some risks in that and there is some value in that, but if you have got the tone right and if they have got the skills right. So I was always interested in that article because it talked about how to do the right thing when standing up for what was right could put you at odds with the greater workforce and then in a serious incident you could be at risk really. And that's the culture I think that we need to balance all the time.

Jane reveals the aspect of generational mental health workers, where knowledge acquired is being picked up and passed on within the mental health community, from staff to staff and, in many institutions, from generation to generation within families. Large psychiatric hospitals were often placed in rural communities; therefore this became the main source of employment for those communities and it was not unusual to have many members of one family employed by the hospital. Jane raises the question of the *ad hoc* approach to delivery of care, which she explained as a complication related to non-mandatory training for psychiatric assistants. She uses the acute hospital setting as a way of questioning why psychiatric assistants with no or minimal training would or should be placed in an intensive care unit. She suggests that this would not be an accepted practice for a general intensive care unit so questions why it is an accepted practice in some mental health intensive care units. Jane uses this example as a way of explaining the accepted levels of practice and the expected level of qualifications. She suggests that having a qualification is one mechanism that can be applied to ensure staff understand their boundaries and that they have an appropriate attitude. She further suggests that having the trained workforce sets the required standard of practice. Jane then starts to move into an area of concern; she provides another perspective from that given by Ben. She shares the Shadow side and the inherent risks for other health professionals when the dominant group is an unregulated workforce or where there is a high turnover of the regulated workforce, creating an environment where the tone is set by the predominant culture. This can potentially create an unsafe environment for any new staff that question the way of working and may place them at odds with their colleagues who they depend on for support in risky situations. Jane and Ben share much in common and although they provide different perspectives, both

describe the need to reduce the risk within the mental health environment and to seek to address the need for balance between experience and qualification within that environment.

OUT OF EXPERIENCE COMES HOPE

Dianna lives and works in the Auckland region. She defines herself as a mental health support worker and peer support worker. When she speaks about the work she does, she speaks from the experience of having her own lived experience of mental illness. Dianna was interviewed as part of a group made up entirely of Pasifika people mental health support workers, peer support workers or family workers. Many of the participants in this group disclosed their mental illness.

> *I have heard of support worker but I am not really sure or clear the support they got from that person wasn't very involved or maybe it was because of my own experiences, maybe they thought "Oh Dianna doesn't really need that much support" and I think that because of that and adding on to what Simon has to say, I think that a lot of us with the transferable skills that we have innately with ourselves as a human being and specifically cultural as well is the love we have for our family that we care and we do support naturally our family at home and I feel that if you have a loving heart and you care then that's why there's a job as a support worker. You become a support worker because that's what we do naturally. Being specifically a peer support worker having your own lived experiences that right there is gold because that's where you draw from. It's that we have been through and relate to you in our own experience and that is a deeper understanding, a deeper respect, a lot of things we do without having to talk about it all the time and repeat the things through talking about it. Jim who is a champion in my eyes of peer support is holding hope for another person especially when that person isn't really feeling very hopeful within themselves. Jim has been that for myself personally and to be able to hold that torch and carry on, that is pretty powerful especially as Jim talks about when people living with mental health, that's when they are their most vulnerable. To have people alongside the most vulnerable who might for us have the same kind of skin, a friendly warm smile, a tone of caring, you maybe uplift or hold them in a very fragile state in their life at that time, that's gold.*

Dianna believes that the qualities she has and how she uses these in managing her family provides her with the necessary skills to be a support worker. She describes this as the need

to have a 'loving heart' and this will lead to 'caring'. While Dianna raises concerns about how she gets support, she expresses no doubts that her own experience of mental illness enables her to undertake her role. She describes her experiences that she draws on when providing support for others as "gold". She puts forward the view that having her own experiences of mental illness allows her to have a deeper understanding about what is going on for the consumer. She also sees this as a way of having a deeper respect for the consumer.

Dianna's own experience of mental illness has been used to enable her to gain an understanding about what is meaningful support for consumers and to use this knowledge to support consumers. She suggests that there is no need to articulate what it is she does, nor to justify how she knows that what she is doing is correct. She acknowledges Jim, another participant in the group interview, and refers to him as being a champion for peer support. She uses the words "hope" and suggests that Jim provides hope for consumers when they themselves are not feeling hopeful; he is the vehicle through which hope is channelled. Dianna understands the vulnerability of people with mental illness having experienced it herself. In the times when the consumer is at their most vulnerable she speaks about sharing the same skin; this provides connection through shared experience. Dianna also sees the need to reach out and connect through what she describes as a friendly smile, holding them, once more connecting all with an aim of uplifting, i.e. valuing their humanness. She suggests that the human-to-human connection through the shared lived experience finds the "gold" in the slurry. Dianna's own experience of mental illness has enabled her to use this experience, transforming it into skills that she can use in her role as a mental health support worker.

ACKNOWLEDGING THE TANIWHA[19]

In Chapter Seven, Anaru, a manager with a Kaupapa Māori service, described the attributes and the difference that he saw mental health support workers make through the support they provided for mental health consumers. He described that support as being channelled through unconditional care and the provision of a culturally safe environment where the support workers and consumers are able to the mental health support worker gains

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[19] Māori mythology for both a guardian and a malignant force

confidence and increases their skills that enable them to work alongside consumers on their journey to recovery.

In this chapter, there are data in which Anaru acknowledges the Shadow that is present when he discusses the sense of failure felt by mental health support workers when consumers they are supporting do not reach their recovery goals. As I uncover the Shadow in these stories, I do so within a transformational framework.

> *I have found them [mental health support workers] to get quite defensive and guarded when that terminology was coming in. And in terms of how they look after themselves, sometimes it is their families back home but also when you leave site, can you actually take that stuff home and do you actually burden your families with that. And so they tend to bottle it, they try to offload on some of their own colleagues, the skills around being reactive to the clients is a way of frustration, and that's not knowing, it's what they know in terms of how they operate or their own experiences or otherwise it's just avoidance. So when you are working in a facility like I am currently managing at the moment which is 24/7, trying to find time and capacity to provide training and supervision becomes very difficult because we are a small workforce and so you have to try and be creative in trying to support your staff and the way that I try to support them is having access and for them to have access to me. So it's about being available, so in terms of the most practical things of them supporting themselves, it's important they have access to people who will practically support them and provide a solution, but it is a collaborative approach. But someone they can speak to and trust and so I think access is really important for support workers. Again coming back to that supervision, it is actually really difficult to find people out there that want to supervise support workers so it tends to be other support workers from within the organisation who have similar roles, if that makes sense. And just trying to bounce off each other and sometimes in trying to do that is still hard because we are 24/7, operation still needs to continue, if a person is off the floor it is not that easy to replace that person, so there are definitely gaps.*

> *When they talk about what are we doing to measure and grow our workforce, sometimes there are not a lot of people resource that come in and do that. I think that with support workers they have an integral role and what I am finding now there is more of a push towards outcomes and recovery and everything tends to be measurable now and so just trying to provide some thought about what it is we do differently to make a difference in their lives for the short period of time that they are with us and now when you are looking at the recovery model and outcome focus, I have to reinforce with my staff that these are the simple things that we can do to achieve an outcome which is about just*

the interaction, treatment compliance is always important because they have come to us because something has happened, because if everything was alright then they wouldn't be with us and looking at some practical outcomes while they are with us. Anything from a day to three weeks because now there is a reporting system where we actually have to be looking at evidencing our practice right across the floor, whether you are clinically based or your core business is support work, both from a residential prospective or community prospective. So the whole sector in general is changing. I think the powers that be – I am not too sure in terms of how they view support workers – I suppose for them to be able to experience that is for them to be on the floor and see how they operate.

They put all this unconditional care into them [mental health consumers] and their goals in terms of meeting their recovery sometimes doesn't happen and they get disheartened by that. Everyone has to set goals, treatment goals and now I am doing some training with another team at the moment and I am just getting them to think practically if you had ten goals and if you achieved two goals out of your six month time with them [mental health consumers] that's awesome. I think that what happens when you are trying to achieve everything that won't happen.

Anaru uses the skills he has as a way to engage with mental health support workers. While acknowledging the Shadow, he strives is to focus on the 'diamonds'. He seeks to create an aspirational environment for his staff by supporting them through the periods where they see failure and turning that into times of aspiration. Anaru recognises the challenges faced by the support workers; however, he creates space for them and provides them with access to support. He describes the service he works for as a small service, with unique challenges as a result of its size. Anaru has used this as an opportunity to create a collaborative way of working which he also sees as yet another way that Māori culture is used to support the workforce.

Anaru describes the burden of responsibility felt by the mental health support workers when they are working with mental health consumers. He describes his concern that the support workers are not adequately prepared for the emotional and at times frustrating relationships that develop between the consumer and support worker. His concerns centre around the support workers not having the skills they need in order to keep themselves emotionally safe; instead, they deal with this burden of responsibility offloading it at home or onto their colleagues. What Anaru suggests is that support workers do not always have

an appropriate reference point, *"not knowing"*, from which to interact with consumers. Therefore, there is a risk that they will use their own lived experience of mental illness as the main mechanism to support the consumer or more concerning they will avoid the interactions entirely. Anaru knows that he needs to provide support, training and supervision for his workforce; however, as a relatively small organisation these things are limited. He also raises concerns that there is not always the funding or the people that are willing or able to supervise mental health support workers. Anaru has had to reflect on and transform this situation by using the resources he has at hand his staff. He describes using group supervision in terms of how his staff "bounce off each other", recognising that this is not ideal but is a way of addressing frustrations and the need to off load.

Anaru raises concerns about the limited workforce and the challenges this provides in being able to deliver a service and keep support workers safe by up-skilling them and providing supervision. He reaches out to "the powers that be" and challenges them to understand and see what it is that support workers do. He sees his involvement in this study as another way that will assist with providing a way of viewing the contributions of mental health support workers in a way that has never been done previously.

THE BUSYNESS

Sue is a mental health support worker based in Auckland and employed by a large NGO.

> *They are just so flat out and you have to wait a month and a half to get an appointment and then on that day the doctor will be sick. They just always seem to be running. It seems like that. So if you ring a clinical worker because you have a concern, quite a few won't get back for four or five days but I know they work four days on, three off. But it seems like I am always chasing them. And I think that if I have an issue or a concern with a client overall, eventually they will get back and they usually are really responsive in a positive way when they do but yeah, it's short and sharp until next time.*

Sue speaks about what it is like for her and the consumer she supports when they are reliant on the secondary mental health services. She observes that services appear to be under pressure, which results in a considerable wait for an appointment that can become elongated when the appointment is with a psychiatrist who then calls in sick. She observes

that the clinical services appear to be under constant pressure "running". She also raises the fact because the clinical staff in the DHB work different shift patterns it may be three days before a response from the service is received. Sue acknowledges the clinical staff, as well as the support workers, appear to be under pressure. She appears frustrated by these issues; however, she also acknowledges that when the service is provided, it is positive. It is barriers such as shifts and lack of resources that create tension in the relationship.

SERVICE USER AND SERVICE PROVIDER

Tony is employed as a mental health support worker. He works for a large NGO which provides home-based support services as well as residential services; he also has his own experience of mental illness. When Tony tells his story, he explains some of the strategies that he has needed to put in place to ensure that the work he does is seen as professional by others. Tony has insight into areas of his work that require development and has adapted this into his employment.

> *We have a social worker at work and a strategy that is suggested that I use with him is if I have an email that I am unsure of before I send it out, I make sure before I send it out and I may forget to put it in draft form to send via him so that he can proof read it on my behalf and that's been particularly useful. I think I have got better at being more confident in writing emails and so there has been a few I have let slip before, sending them on to him and also a manager that I wasn't comfortable with, seeing him have a particular look through my email with a fine tooth comb, she is not very supportive, but went into different positions so that is pretty OK as well.*
>
> *I haven't completed my driver's licence and that has been quite an issue for me. As its part of my role, I have appreciated the flexibility of my employer with the issue because ideally I should be able to take clients to psychiatrists and attend appointments in the work car when it is needed. So that is part of the reason I work part time.*

While Tony describes his lack of confidence about his ability to send an appropriate email he also recognises that his limitations are in part accepted by his employer (although he does not feel this level of acceptance was shared by one of his managers). In order to compensate for this Tony has developed strategies to enable him to continue with his employment. These strategies are to have someone he trusts proofread his emails before he

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sends them and to only work part-time due to not being able to undertake his full responsibilities if he worked fulltime. Tony speaks frequently, about how he is hindered in his role because of his inability to gain his driver's licence. While many Shadows exist for Tony, he has been able to push aside the curtain of uncertainty to create appropriate strategies for coping.

> *There is a peer consultant at Ward XXX at the moment I think he is very well known within the industry, his first name is Steve [*non de plume*]. He started a service in another city. I would actually like to see more similar roles to what he has been doing for some time and not have the DHB stereotype a person like him and say that because he has started up a company and had all these years of experience, that he would be great in this role. I think there should be a few more roles of that type. So if there are some workers out there who have slipped through the cracks due to skill gaps with their licence and that's not something I have not been working with, I certainly have worked on it. I have had a number of driving instructor lessons, there has been an issue of a number of factors, so I would like to think that there are people out there that would take advantage of people who have the skills and experience and just because I don't have the licence thing, and obviously can't take full advantage of my role that there might be similar roles out there that a peer consultant, which is what Steve is and I would probably throw 100% of myself into that. I have an immediate obligation to deal with my responsibilities to have a drivers licence within my current role.*

When Tony describes the work that Steve undertakes in the DHB, he suggests that there is a need to have more mental health consumer consultant roles. Most DHBs have employed mental health consumer advisors or consultants to provide a consumer lens through which to view service development and delivery. He also suggests that there are many people who could gain employment where their lived experience of mental illness would be recognised as a skill. The issue of Tony's inability to gain his driver's licence once more breaks through into the conversation. This is seen by Tony as a major factor in his ability to take up or even consider other career options.

While Tony understands that there are personal barriers that prevent him from fulltime employment, he is able to identify other barriers that also exist such as the words that are used to define people that access mental health services. He suggests that financial imperatives are focused on with the person being forgotten.

For the sake of the recording, the only reason I use the tangata whaiora[20] word more often than consumer or client, is to me I was a European and no blood connections to the Māori population is that tangata whaiora to me doesn't have a dollar figure attached to it, whereas if I say client or consumer, it is normally by accident and is generally because it has Ministry of Health attached. Whether it be through the certificates that I have done or through my work at work on documentation they have got those things, those words whether it be client or consumer, it is not personal to me. Yes and maybe if it had a clash then sometimes another word "person" instead, would be nice. I always think it is a bit excluding in some regards. Because obviously many people are in job for also to pay the necessities as well, but I don't see that tangata whaiora as being a dollar figure for me. There is a dollar figure for my employer obviously, but not for me. Yes labels are so powerful that when I was in care I had a couple of issues that maybe I took out of context and so I got representation from the Mental Consumer Union just to get some clarification on some issues. I had to apologise to my mental nurse but in general she was there and did a brilliant job of representing me and I didn't have to apologise, I needed the support at the stage I was going through. There were other issues that I needed to clarify and get her support. It was nice to have that. Where often you will get a general community nurse who may say something and not mean to and stirs up tangata whaiora. Or my employer, to be honest, more that case than the community nurse in that situation.

Tony has an internal struggle with the labelling of and terminology used to describe a person who has services provided for their mental illness. He suggests that much of the terminology used has loaded interpretations. Tony reveals that there are financial imperatives associated with mental health services and suggests that some of the terminology used assist with continuing to maintain a financial model. He suggests that it would be useful to be constantly reminded that it is a person who is receiving services and that the personal nature of those services should not be forgotten within the institutional language with which mental health consumers are labelled.

At times I struggled in my attempt to unpack Tony's words, when he spoke about the loaded terminology used to describe people that access mental health services. That was because I did not have alternative words as much of the terminology in everyday use in this field could be suggested as being negatively loaded. For example do I suggest that services

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[20] Alternative word for mental health consumer

are provided to or for? While the term 'patient' had been replaced with 'client', 'service user' or 'consumer', are these appropriate definitions? These terms suggest that of an equal relationship based on wants and needs. This interpretation may not be the view universally shared by those that access services. Other terms to define the relationship have been developed; however, as Tony suggests, these terms are already pre-loaded with stigma. It is difficult to define services and those that access them, as there is still the issue that not all those within the mental health service are able to exercise choice; instead some have services imposed on them. Tony speaks of the load that words place on the intent of the service. I tread carefully on the edge of the Shadow to ensure my words are not loaded with misinterpretations. McArthur-Blair and Cockell (2012) view inclusive spaces, from what I describe as the appreciative prism, to transform social structures as part of their study into how to create inclusive spaces. They suggest that AI practitioners "must recognize the socially constructed inequities that impact those which come together in an appreciative inquiry" (p. 5).

Tony also speaks about the need for those involved with mental health consumers to understand what they are doing and the support that they are providing. He suggests that there is a skill in communicating with mental health consumers and these skills are not always held by all health professionals. He also suggests that there are times when even those who have the skills need to be clear, as confusion may put the relationship between the health professional and the consumer in jeopardy. While Tony suggests that there can be confusion in the relationship within mental health, he is not so forgiving when he speaks about health professionals that do not have a mental health background and suggests that they risk escalating rather than de-escalating a situation due to their ignorance. Tony provides an insight into his experiences as a mental health consumer (i.e. service user) and as a mental health support worker (i.e. service provider). Through his own admission his illness has limited his abilities, reduced his opportunities and placed barriers to full participation in many areas.

PROFESSIONALISM WITHOUT REGULATION

Lisa is employed as an educator of mental health support workers. She spoke with passion about the work she undertakes, and also expressed strong views that related to public safety.

Lisa is a registered health professional. As such Lisa has a scope of practice under the Health Practitioners Competence Assurance Act (2003) and therefore has a regulatory authority which regulates practice through attestation of continuing competency.

Cheap labour, my memory of the time when we moved quickly to community support, neglect, was the consumer movement wanting support but not professional support –meaning not wanting clinical support. But this was misconstrued as meaning cheap labour, unskilled support people with good hearts which is fabulous but is not enough.

Danger of it going under another health professional group as it is a role that has strong similarities to all of the professional groups above, but not one of them.

More acknowledgement and valued, career path, accountability, for mental health support workers for people receiving the support needed for regulations under scrutiny such as HPCA (Health Practitioners Competence Assurance Act. 2003) so that there is accountability for mental health support workers and they can be supervised or even forbidden from being employed as are other professionals. But we have many professional groupings at one level; we need another health profession like a hole in the foot. But we have got this situation now of "someone being dismissed and then getting a job down the road". But now that we have mental health support workers I think they need to be regulated for the benefit of people using the services. Self-regulation is not widely carried by the group. Second level social worker. Employer/employee regulations are not enough. Interrupted biography, times in people lives when they are diagnosed with a mental illness, then that is where the support worker role comes in to assist the person to find their way through the effects of the illness, what happened in the lead up to using the services, to make sense of their life experience, work through the issues of medications, self-stigma, how to use the services. Some of this is done by nursing OT and social workers in particular. I do believe that is happening, but not as strongly as it should. It is a significant part of helping people back into their life and community and therefore the role of the mental health support worker.

Lisa exposes the issue of the development of the mental health support worker workforce as being undertaken with haste as a result of government policy which saw people with long term mental illness being moved from a hospital setting into the community. While she does not offer an opinion on this policy what she does ask is has sufficient emphasis been placed on what the consumer wants. She describes this in terms of what the consumer did not want; they did not want more clinical support; what they wanted was more appropriate support. Lisa feels that instead what happened was the development of a cheap labour force created

from the people with the hearts of gold but generally unskilled, the people that are referred to as mental health support workers. Lisa recognises the need for mental health support workers to have a good heart, this I re-interpret as being a caring person, but Lisa suggests this alone is not adequate. Having a good heart is not a quality that generally has high value in our society, although it is a value that many of us would like to be labelled with along with our other skills and qualities. The level of remuneration is one way in which skills are valued, yet Lisa suggests that while the mental health support worker has well-meaning and well intentioned qualities these skills are not the skills that command high salaries. She continues with this thread when she expresses the view that she does not believe that mental health support workers are not seen as a valued part of the mental health workforce. This lack of valuing is a complicated position to untangle. Consumers wanted to be able to have support provided by a group of workers that were non-clinical in nature i.e. not a duplication of existing health professionals. This she suggests has been through economic imperatives translated to mean an unskilled and poorly paid and undervalued health sector worker. A good heart is not sufficient to secure a good salary.

Lisa expresses concerns about the lack of regulation within the sphere of the mental health support worker related to:

- Lack of regulation of mental health support workers
- The lack of self-regulation of mental health support workers
- Limited accountability of mental health support workers

She poses what is for her a dilemma as to how mental health support workers can be seen as professional if they are not a regulated group of health professionals but argues the sector does not want or need another regulated health professional. The question she poses is around how the mental health support worker can be viewed as professional for the work they undertake without being regulated. She recognises that the act of regulation in itself poses issues, adding yet another group of health workers to the health professional arena. Would the regulation of this workforce pose greater risks? To regulate is likely to mean a clearer definition and monitoring of the scope of the work against the risk to the public of receiving care from non-regulated health professionals. The Health Practitioners Competence Assurance Act (2003) provides protection for the public for those

professionals whose scope of practice sits under this act by way of a regulatory authority. Section 3 of the Health and Disability Commissioners Act (1994) provides a definition of health care provider by way of section 5 (a) i or iii. The other relevant Act is the Health and Disability Services (Safety) Act 2001. It is of note that this Act provides references to service providers only, not individual practitioners. The more substantive analysis of this matter will be examined in more depth in Chapter 10. The area of regulation poses a Shadow for support workers. O'Brien (2005) suggests that it is the knowledge and power which is held by professional groups that provide them with the ability to develop professionally and to have their profession legitimised. The unexamined issue is whether the public is better protected through regulation. The purpose of the Health Practitioners Competence Assurance Act (2003) was to provide public protection in high risk health occupational groups. Vernon, Chiarella, and Papps (2011) discuss the complexities within the regulated health sector through evidence of current competence and regulation with each part of the sector including regulatory authorities, individuals and employees having a part to play with the ultimate aim being to ensure public safety. Vernon et al. (2011) poses the question as to whether all the requirements for regulated health professionals in place has just shifted responsibilities from individuals to service providers.

YOU DON'T WANT TO PAY FOR THAT WORKFORCE

Jim is a Pacific Island mental health support worker, with his own experiences of mental illness. He is employed by a district health board, but has had many roles in the mental health sector.

> *I remember being employed as a CSW in 1995 and starting on either $23,000 or $25,000 and I have nine children, come on. You know you want validity and you want a competent workforce but you don't want to pay for that workforce. So what we have heard is that a lot of that workforce has moved on, not because they want to, they really love their work and they want to be CSWs but the money is not there and you can't live on that kind of money. We know with Pacific and our big families and you simply just can't afford to stay there. So now you have got people working in mental health but not in jobs that has got their passion. Now that to me is just so frustrating. You have people where their gifts and their talents are in CSW work but they are not able to use it. To me, it just upsets me. And so now you have people without passion and in jobs that don't quite fit them or the other way round. So I am*

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happy these days to look at the value of CSWs. This is why I think CSWs have been so undervalued and you don't hear much of them, because a lot of the feeling has been that it is a stepping stone to another career move, but they didn't really want to make that career move, but it is kind of forced on them because when you get your pay packet it reminds you that "oh yeah, I got to move". It's as simple as that. The workforce itself, a lot of rigidity and a lot of this is systemic of unfairness or even what you would call stigma was that around what do CSWs actually do that's is different from social workers? What is different and now it has become a bit of a threat to other already credentialed occupations and even to this day you still get people scrapping "What are they doing, that's my job". We talk about these things sometimes and then it disappears in the busyness of things. I think this is the right time that somebody actually needs to be talking about and looking at the actual fit of these services. We are all about workforce. This group that you see here that you are sitting with have become the first Pacific peer support team in the country and this is because the workforce valued enough to give one person a full time job. I have been quite humbled and ashamed sometimes when I pick up my pay packet even to this day, when I am working with people who are voluntary 0.2 or 0.5. How do you get 0.1 or 0.5? And you expect people to be totally committed and on to it and do their thing.

Jim raises the issue of the monetary value for mental health support work and poses the rhetorical question about the lack of valuing of mental health support work. He suggests that as they are undervalued in the work environment that this is probably another reason that there is not a lot of documented evidence about what mental health support workers do and the contribution they make. He further suggests that as a result of the undervaluing of mental health support workers they have had to follow other career opportunities which have a higher societal value. Even though they had a career they loved this was undervalued which has led to it being underpaid. Jim implies that one of the reasons he agreed to take part in this study was so the voice for mental health support workers would be heard. He questions the value of the work that the support worker does and compares it with the work social workers undertake. He uses this comparison to raises the issue that he sees as professional patch protection.

Jim suggests that while services get busy and under pressure, which could be a resourcing issue, rather than addressing the resourcing issue the focus is often placed on the overlap of roles. This again raises the issue about whether there is a need for better role definition between the health professional groups so that the resourcing is used more effectively and

efficiently. There is no suggestion by Jim that there is an overabundance of resourcing rather his comments are attributed to the need to use existing resources more effectively. Beddoe and Duke (2009) argue that by a professional group having a registration this provides the profession with legitimacy and authority. Jim offers an alternative to the view suggesting that mental health support workers can be valued and therefore seek legitimacy through credentialing rather than registration.

Jim recognises that the employment he holds places him in an ethical dilemma as he recognises that in his role he is adequately recognised and remunerated appropriately, however he knows that there are many others that do a similar role but the way their role is constructed if they are paid they are only recognised for a limited number of hours per week. He suggests that many mental health support workers undertake more hours than what they are paid to do.

SUMMARY

This chapter uncovers and explores the Shadow within mental health support work. Some of the Shadow experiences relate to structures while others relate to the value that is placed on the work that is undertaken. By identifying the Shadow this action by itself is transformational and incorporated into the next three phases of the AI cycle to plan and envisage the future. The ability to use the Shadow as a transformational force is shown in Figures 9 and 10.

What is described in this chapter is that the relationships support workers maintain with the mental health consumer and the work they do within mental health care team adds value. Many of the stories told about mental health support workers were told not only through the eyes of mental health support workers but through the eyes of those who are also service users.

What has been heard is that the role of mental health support worker at times operates in the Shadow and that Shadow is a result of the role not being well understood and lack of role definition. The issue of legitimacy of the work of mental health support workers was

explored in terms of valuing this workforce for what it contributes and to obtain legitimacy through some form of regulation.

In taking an appreciative approach into viewing the world of the mental health support workers the transformational approach I have taken with the introduction of the Shadow in this chapter illustrates that in order "to appreciate means to be fully aware" (McArthur-Blair & Cockell, 2012, p. 83). The awareness and acknowledging the obstacles allows for them to be considered and turned into future opportunities.

Figure 9: Acknowledging the Shadow

- Defensiveness
- Busyness
- Fighting between services for resources

Culture of bullying

Legislate in order to professionalise

- Restricting the practice
- Public protection
- Vulnerability for others in the workplace

- Interprofessional tensions
- Feeling economically undervalued
- Services under pressure

Tensions within the role
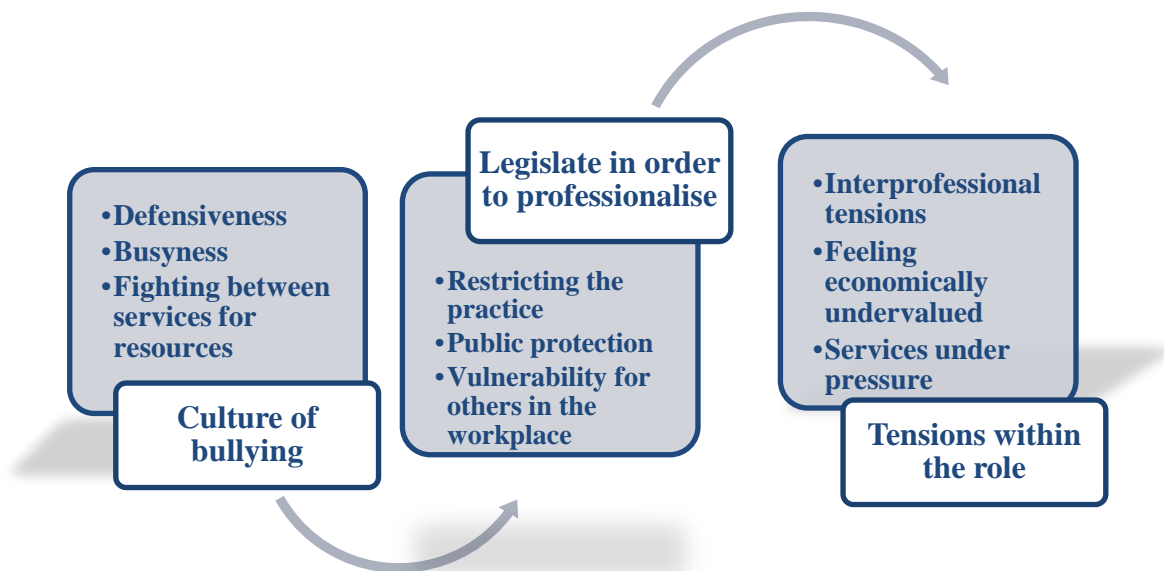
Figure 10: Transforming the shadow
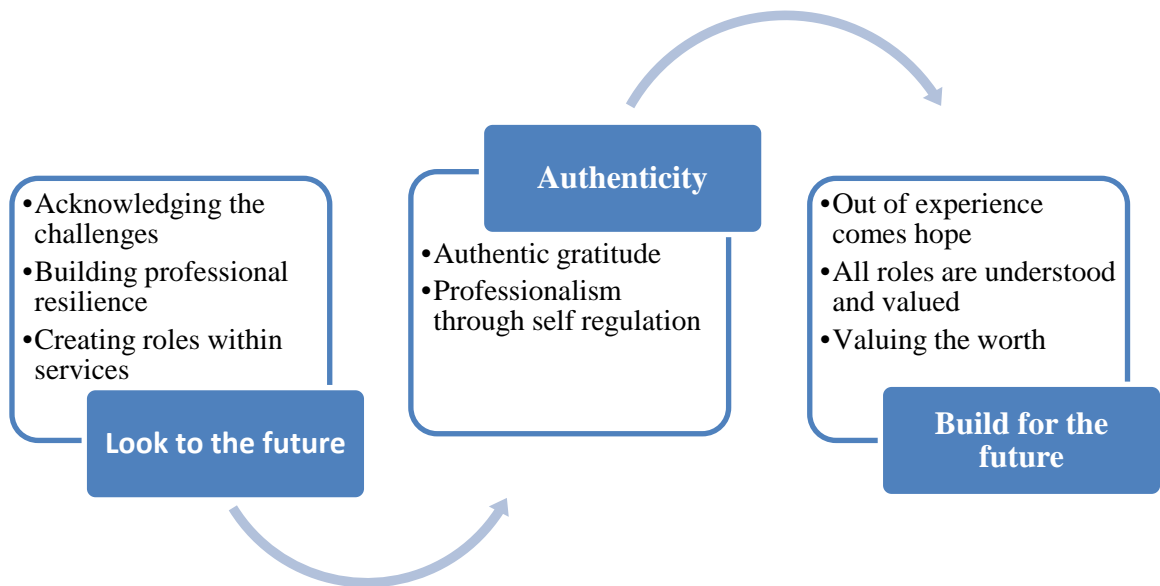
As this study moves into the next phase of AI, the action phases, the Dream, Design and Destiny work is discovered and revealed. The Discovery phase and the discovery of the Shadow provides the foundations on which the ideal future is based, strategies to develop the future and ways to sustain that future for mental health support workers.

CHAPTER NINE: DREAMS – DISCOVERED POTENTIAL

The future belongs to those who believe in the beauty of their dreams. Eleanor Roosevelt

INTRODUCTION

Chapter six provided the opportunity for the peak experiences of mental health support work to be heard. The Shadow of the inquiry was introduced in Chapter seven. This chapter uncovers the aspirational contributions of mental health workers by creating the Dream for the future about what could be. The contributions to the stories were provided by mental health support workers, those who educate support workers and those who work with support workers. The Dream phase gathers up the themes generated within the Discovery phase and utilises them to push the boundaries for visioning "what the future might or could be" (Reed, 2007, p. 33).

DEFINING THE DREAM

Within the world of the mental health support worker lays the ability to inform the future through uncovering 'peak experiences'. This chapter reveals the discovered potential and how that potential can be harnessed to create the vision. It is during the Dream phase where "participants work together to develop ideas of what the future might or could be" (Reed, 2007, p. 33). This phase also acknowledges the existence of the Shadow/dissonance but adapts the way it is viewed in order for it to be transformational.

Watkins and Mohr (2001) describe the Dream phase of AI as being where "shared images of what their organizations would look, be, feel and function like if those exceptional moments and the life-giving properties in the system became the norm rather than the exception" (p. 25). The Dream phase provides the opportunity for the "desired future from the collective, imaginative, and innovative capacity based on past successes, current strengths, and future possibilities" (Stratton-Berkessel, 2010, p. 33). Participants in this phase are encouraged to resist barriers and boundaries as they seek to vision 'what might be'.

Carter (2006) defines the Dream phase as being "focused on an affirmative exploration of 'what might be' through thinking outside of the usual boundaries and by envisioning positive futures" (p. 54).

Cooperrider and Whitney (2008) suggest that it is when we hear and how we interpret the words that have the potential to generate change. The stories about mental health support workers continue to be heard, "within the context of Appreciative Inquiry, this narrative-rich environment creates data that provide(s) the means for analysing high points and successes" (Preskill & Catsambas, 2006, p. 61). The Dream phase of AI creates the opportunities for an appreciative interpretation when inquiring as to what is the discovered potential of mental health support workers. In the Dream phase innovative solutions to perceived barriers are created.

Dream: the staff who supposedly work together connect with each other in such a way to make that work they create a shared energy

SEEN FOR WHO THEY ARE – TURNING LEFT

Jim primarily describes himself as a support worker. While this is how he identifies himself he also brings to that role his own experiences of mental health issues. He described that he has worked for a variety of mental health providers which included district health boards and non-government organisations. While Jim clearly identifies as a mental health support worker he is equally proud of his Samoan heritage, which adds another dimension to his contribution. It is the uniqueness of these mixtures which brings added dimensions to the role of mental health support worker.

> *My observation is that I haven't seen the inclusion of a CSW in clinical interview. You will have clinicians, cultural advisors etc. and if it's clinical, the DHB, but you won't have CSWs and yet the CSWs are the ones that we know have the relationships with the clients. You don't see them actually interviewing for clinical positions. Things like that to me are crucial because they bring that difference to that interview. But when they start to look at attitude skills and knowledge, that's what the CSW should bring to the interview and look at who should get that job.*

One of the things that I see is the opportunities to be able to participate better and even something just like accessing resources. I am forever seeing DHB internal trainings where there is like about 8 or 9 vacancies. Why can't you get the NGO sector to fill those in, to utilize those spaces? You have got to create things to make the relationships happen between them. You don't get anywhere by forcing people into things but there needs to be a better way to co-exist between the NGO and the clinical sectors. I still see that as not being as smooth as it can be and we all know systemically how we, nobody is saying we have got a right or couldn't approve, but we still have to come up with an answer and that's it. We are all saying it, we know it can be better but we aren't connecting and that's the point we are trying to make, we aren't connecting, we might end up getting busy and it drops off the radar again and we get on with the busyness of the day to day stuff. So maybe things like training and there have to be other ways to make the groups, we hide behind our computers a lot of the times and because of that it takes away our visibility and our ability. I am one of the worst culprits, I don't even know half the staff on the same floor and I have been working at the service for how long because that's the main-stream team over there. I always turn right to come to my team and I never turn left to say hello to our mainstream team, it's like that. How do we create the energy so that we don't end up, I am looking at anybody else, I am just looking at me. How do I shift my attitude so that I have got a better relationship? You can bet that I will come along tomorrow and I will turn right.

For Jim, the answer to his being part of a team is simple within its complexity; if he turned left when he gets to work instead of turning right he would connect with other members of the mental health service. While it could be interpreted that Jim provides a simplistic solution, he does suggest that his Dream is that the non-clinical services and the clinical sector will work together to bring a wholeness to the care and support of mental health consumers. Jim has belief in his ability to influence this desired change. He suggests that his aspirational world would be an 'inclusive' world which 'connects' up the various parts and values the contributions from all that make up the whole. Jim describes mental health support workers as working seamlessly between the various organisations, being able to access each other's services and resources. In Jim's world there are no barriers whether they are real and visible or imaged and invisible which divide services. He describes an environment where staff will want to work together, where there are no divisions nor are there directives that require staff to work together. Jim sees this as staff taking control of their work environment including the way in which they work and that this occurs in a co-operative way. Jim sees a world where services work together and share resources, where

the opinion and input of the mental health support workers is sought out and respected. He sees a future where there is interaction between services, staff know each other, not just know of each other. Jim's new world values the sharing of resources such as training, access to which will be open to all service providers and all service providers will be welcomed to operate within each other services as if they were all one and the same; there will be no barriers actual or perceived.

Jim describes another role for mental health support workers, which is them being utilised for staff interview panels. This input would be valued because it would bring a different perspective when interviewing potential employees. The mental health support worker will look for attitudes and values in staff that may not be what has traditionally been explored through the recruitment practices.

Jim is able to see a future where there is shared responsibility for developing the relationship between mental health support workers and other health professionals. His future is where there is a natural ease within these relationships with an equal responsibility for developing and maintaining them.

Jim's vision is a world that is significantly different from the world in which he now operates.

MENTAL HEALTH SUPPORT WORKERS ARE MADE TO FEEL PART OF THINGS

Dream: mental health support workers are able to advocate for their clients in team discussions to ensure clients get the best support relevant to their situation

The following transcript was gained from a paired interview. Preskill and Catsambas (2006) consider that paired interviews allow the sharing of success and for others to hear the stories and the success. Mel and Lynn enjoy a respectful working relationship although

they came to mental health support work on different paths. Their transcript has been managed as an integrated story.

We had a team from the DHB we had a really good relationship actually, we would meet weekly and it was also one of the things about our team is that we didn't have the traditional clashing of conflict that were meant to be the way that things were, yeah it was a clinical team we had problems with the clients we could ring them directly and they knew us by name and if we ever had anything going on we could always ring them and they would always come. It was definitely a unique situation. I hope that there are more services going on like that now.

Well, the service that I worked for recently wasn't like that. When you took the client to the clinical meeting and more often than not the support worker didn't even go into the meeting, let the client sweat. They didn't always see anyway it was just different. I think that came down to the fact that sorry I came from something that was quite unique and my expectations were probably slightly high, I don't think the group of people I work with there were good just the actual DHB wasn't as good as we had in other places. There was a lot more collaboration now. Things that could make it more so now that clients can make those things themselves, so I don't know if it's like that over this side. Yeah absolutely, remember back at Block Hill it was the done thing that everyone sat together and that's quite an institutional way of doing things. I sort of think when you are in a residential setting and you are being supported by somebody and that support person really should have an idea of what's going on with their wellbeing as well really.

I think it was more of an automatic thing where people would just, well it's clinical review day, we are just going to take you there. Whereas what I have learnt more true autonomy being the person can say who they want in their meetings. Yeah a lot of clients because of the set up that I was in, they used to meet weekly in the community more often than not they didn't want anybody in there but we didn't give any feedback either.

Yeah, so you wouldn't know if there were any medication changes, you wouldn't know what was going on, so you know communication again. Communication breakdown in the community setting was huge. Then it comes down to client rights doesn't it? That's where the contact with the clinical team for letting you know, but not necessarily, they do eventually but not always straight away, it might be a few days. It's just typical, normal. That's what I mean as a support worker you have no control.

Mel and Lynn have a shared vision for the future. That future is about mental health support workers being valued members of the multi-disciplinary team; they will be sought out for their views and opinions. They have been able to base their future on their past

experiences, enabling them to articulate what it is like for them when their voices were heard. Their future is a world where it is accepted that they will be part of the decision-making team. They will not have to be invited; it will be an accepted part of how the world will operate. It is the coming together and being together that is important and the active collaboration 'travailleurs de soutien en santé mentale sans frontiers' (mental health support workers without borders). Professional borders, in their future focused appreciative world, are deconstructed for all mental health services, irrespective of whether the borders or demarcation lines are imagined or real.

CELEBRATE OF THE DIFFERING ROLES OF THE MULTI-DISCIPLINARY TEAM

Dream: each mental health support worker has their own specific role that is recognised and valued by the team

Andrew is a mental health support worker employed by a DHB. He describes what it is like for him to be part of a team and to be valued by the health professional team. Andrew suggests that if mental health support workers are to be an accepted and valued part of the care/support team then it is important that members of the team understand the work that mental health support workers undertake. In gaining that understanding, mental health support workers will be acknowledged for the differences in how they work but also what they bring to the team and, ultimately, to the treatment and support of mental health consumers. The future for mental health support workers within Andrew's vision is a worker that is valued by colleagues, that their contribution is sought and that members of the health professional team are aware of the role.

> *No problem at all. The doctors are totally supportive I have doctors referring regularly to myself and support the clinical staff refer, we are involved in all the IPMs [interdisciplinary planning meetings], you feel valued as a team member. I think the majority do, there will still be a percentage that probably don't but I think the majority do and they understand what we do and they use it well and we are certainly not that good in telling them at all.*

The essence of human nature, seeing people living their lives to the best they possibly can that's what we do and if you can help somebody with their quality of life, what more can you do? It's adding value, making their life a lot easier, taking some of the stress out their lives and as long as you aren't taking the stress on board yourself. It's good because you have to have programmes in place so you don't take it on board too.

In some instances if you have a specific goal with a person, if they achieve a goal and it has made life easier for them. I think as a whole, it is only as a team that we move forward. Like if you try and think of the things you do yourself, you are not going to go anywhere in a hurry, it is teamwork that makes a difference, not individual work.

Yes. Like the team has their own specific roles they do with medication that makes a difference, social worker and also ourselves we have our own specific roles that make a difference but bringing those together and it's a nice wee combination for the person. Because everyone is different so you are tailoring different needs to different individuals.

Andrew describes the work he does in terms of the human contact he has with mental health consumers and with other members of the team. For Andrew, the most important factor is being part of the team and being valued for the skill and experiences he brings to the team. He emphasises that each individual contributes something to the team, as the goal is to support mental health consumers to reach their goals and ultimately their recovery. Andrew sees the acceptance and valuing from the other health professionals that he works with as the future for mental health support workers. He sees the ability to work in a team and be accepted by that team as the future. For him it is important that all members of the team have an understanding of each other's roles, as this would ensure that no role overlaps or underlaps.

Andrew sees the relationship that mental health support workers have with mental health consumers as different from that enjoyed by other health professionals. Some of that uniqueness occurs because of the nature of the relationship and where that relationship takes place. Many mental health support workers enter the homes of mental health consumers; they are a guest in that home. This changes the nature of the relationship. Mental health support workers have time to build and sustain these relationships and to use their skills and knowledge which come from life experiences. For the majority of mental

health support workers, their training is focused on being able to engage with consumers, whatever the consumer's environment is.

A RESPECTED MEMBER OF THE WIDER HEALTH TEAM

Dream: my professional opinion is respected by the team

Mental health support workers and others spoke about the work and the value of the work which is undertaken. However, a sense of isolation from other health professionals and because of the nature of the work they undertook was expressed by mental health support workers, which would not be present in their ideal future world. Many mental health support workers operate independently of the wider healthcare team. Their isolation magnifies their wanting to be a member of the team.

> *I think they should be considered part of the MDT [multi-displinary team], so they should be valued and recognised member of the MDT. I think the building block pathway to the career as a registered health professional should be open to them.*

Jane is a registered nurse and has experience of working with mental health support workers. The comments made by Jane suggest she clearly sees the future where the support worker is valued and is part of a team. Jane also opens another door for mental health support workers; she not only sees that they should be part of the team and valued for their contribution but that she also sees this as a way in which they gain professional recognition. When discussing professionalism amongst social workers O'Brien (2005) suggested that claiming to be professional only occurs when practitioners work within "broader structural dimensions…with individuals, families, groups and communities" (p. 20). The possibilities for broader structural dimensions are discussed within the concepts of heterarchy later in this chapter. Jane sees the future opportunities for mental health support workers and their contribution to the multi-disciplinary team, a voice that in many instances has been silent, but will now be heard.

GETTING THE RELATIONSHIP RIGHT

Dream: the right match of mental health support worker and mental health consumer leads to an engaged relationship, with time for the mental health support worker to 'be on the ground' and advocate for consumers

Anne is a social worker employed within an alcohol and drug service of a DHB. She has also worked for an NGO. During the interview, she described how she saw the benefits of mental health support workers once she came to work for the DHB. The Dream phase provides the environment for what Anne has identified to be the aspirational future for the mental health support worker.

> *I think that in my experience they seem to easily engage with clients really well. Support workers that I work with come from such a varied range of backgrounds, life experiences and I have observed that sometimes they engage better with our clients. They seem to be able to do it more easily and more quickly perhaps than professionals, so that is the kind of thing that when it has worked well it has been really easy to facilitate a good working relationship for me as well because support workers and I have worked well together and they have engaged with the client, then we can really focus on achieving outcomes with the client, so there is something about the diversity of their backgrounds maybe. They seem to have more time than case managers, and in my experience case managers have massive caseloads in this service about 48 people on a caseload, and so I just can't spend as much time with people doing things that need to be done, so having support workers who have much smaller caseloads and the capacity to be out there and mobile and meeting the client where they need to be and advocating for them and the other agencies and being there on the ground in ways that I can't be.*

Anne acknowledges that the mental health support workers come from an expansive background and with a wide range of life experiences. She sees these characteristics are what make the mental health support worker unique in the health setting. The acknowledgement and valuing of bringing those characteristics to the relationship is a significant difference with mental health support workers and it is this difference that is valued as a contribution to both the team and the type of work that mental health support workers are able to engage in with consumers.

Anne is able to see the benefits that mental health support workers bring to consumer care and voices those benefits as being the way mental health support workers are able to spend time with mental health consumers. This valuable commodity called 'time' is something that other staff working in mental health services do not have. This allows the opportunity for more positive interactions, which changes the nature of the interaction creating the opportunity to provide a unique relationship. The value that that time allows within this relationship is recognised by Burti and Mosher (2003) as the non-medicalisation of these relationships, which need to be acknowledged and valued as they "are labour intensive, relationship-based and non-technical" (p. 228). Mental health support workers have the benefit of time to spend in developing relationships with mental health consumers; the insights they gain from this can be brought to the mental health team. The labour intensity of the relationship through the use of time provides another perspective for the treating team, which will be sought in the future. Case Consulting (2003) also identified that there was a direct correlation related to the frequency of contact between the mental health consumer and the mental health support worker that created the environment for the development of positive relationships.

VALUING THE PERSON-SPECIFIC EXPERTISE OF THE MENTAL HEALTH SUPPORT WORKER

Dream: other health professionals recognise that mental health support worker is the person likely to know the client best and to appreciate the whole picture of their lives; that this person-specific expertise is valued.

This section reflects on the desired future that mental health support workers will be seen as professionals by other workers in the mental health sector. The Dream is that the work that mental health support workers undertake and the way they engage with mental health consumers in a range of environments will be valued as a positive contribution to the treating and planning team.

Linda is a mental health support worker employed by a large NGO in the Auckland region. She has been working as a mental health support worker for the past 18 months. Linda brings a range of other experiences with her from her previous roles outside the mental health sector. She sees the role of mental health support worker being unique to that of other professionals in the mental health sector. She describes this difference as the mental health support workers being able to work with mental health consumers in a holistic manner. This holistic way of working is not confined by the rigidity of regulation and allows the support worker to get close to the feelings of the consumer. Linda sees that the role has opportunities within it that are not stifled by the regulations and legislation associated with other health professionals. She sees the future as the mental health support worker being able to work in this flexible manner unrestricted by regulations and legislation.

> *In my experience so far, I would say I find it quite hard sometimes to work with clinical because we work holistically, so we deal with the feelings and we see clients on a weekly basis so we have the one to one time and we get the whole picture, the whole holistic picture and we deal with their feelings and the stuff that goes on for them week to week. And with clinical they have to be very rigid and get their job done in that specific time, so they don't go on gut feelings the way that we do and they see that client in a window. Sometimes it is quite hard to get them to listen to you because you know the client in a really different way and sometimes you have to battle a bit to kind of go "I need you to listen to me, I know this client really well and I don't know quite what it is, but something is not OK or something is not right". Sometimes you feel that you are looked down on as a CSW because they are more qualified than you. But there are others who work collaboratively and really in order to get the best for the client, we need to all be on the same page because that's how you get clients playing you off against each other and it's really good for us to know that their meds have changed. So I would like to see more of that because the bottom line is we are all trying to work for this client and we shouldn't feel that there is a hierarchy. It should be "look use my expertise in this way and I really respect your expertise, so let's share" and it's not always like that. I can only say that from a CSW's perspective.*

Linda further sees that the future will see the benefit of the freedom of time. This freedom has been curtailed for most other workers in the mental health sector; 'time' is measured by

contacts, with a pyramid effect. Due to the funding model those with the highest level of education, i.e. psychiatrists, spend the least amount of time with mental health consumers, whereas mental health support workers with the lowest level of qualifications spend the most amount of time with consumers. Therefore, as a support worker, Linda has the luxury of spending time with the consumer in a variety of settings. She sees a future where other health professionals have this opportunity so that they may well be able to interact with the consumer in a holistic manner. Linda sees the future where other workers in the health sector will be able to act on intuition "*gut feeling*" rather than having to engage with the consumer in rigid algorithmic way where interventions only occur if they are based on research and evidence.

Linda sees the future where the mental health support workers are able to be translators between the world of the consumer and the world of the constrained health professional. By seeing the consumers in a range of settings, the information and knowledge that the mental health support worker has is shared and respected by other members of the team. Linda sees a future where the contribution of the mental health support worker holds equal validity to other health workers. Based on the enduring relationship that mental health support workers have with mental health consumers and the nature of that relationship, mental health support workers are sought out to provide their insight and contribution to the care of the consumer. Linda sees the mutuality of the relationship within the team as adding another dimension.

In a study by Borg and Kristiansen (2004), one of the human characteristics that consumers found most helpful when working with health professionals was *respect*. This aspect of the relationship described by Linda has been defined by Borg and Kristiansen (2004) as being a relationship that is built on equality and collaboration. Of the relationship is built on these values then this may be more important than those built on an "intellectual comprehension" (Borg & Kristiansen, 2004, p. 496).

SEEKING MY OPINION

Ross is employed into a large NGO in Auckland as a mental health support worker. He is a mature male and spoke of his varied life experiences.

Yes different like that. And because they have been in this field for a long time they need that support which support workers can give. There are professional boundaries the doctors; they don't want to take our comments as such. For the assessment even, there has been the increase in the medications for two or three of my clients because there are more medications, we have come to know that there are changes in the behaviour of clients, not always positive ones but because of some things and the medications. So the doctor says that because this has happened, but as staff, we should be asked how is it, is it because of some problems inside them, family issues or something or is it about their job. The approach to drinking is different to what our thinking is. We can look at the problems with good behaviour and they but we are getting examples of ok the person has lost the job, he is looking for a few days but now he doesn't have the funding. Or the cancer, he has cancer and he is also smoking and he is still doing the same things change that is very minimal because they have been living in this house for a long time. So we need to support them, so how can we without taking the risk of doing something without the medication thing. But he is working he is coping with everything in life and he always says just like this, it has been like this I wouldn't be here because nobody is coming, nobody comes to visit me so what is the quality approach what we could give even though he is working that he could work but he doesn't want to go and now increase his medication because he is not smoking for three years. Different people are different. So how can we be friends, I tell them and I tell the doctor that sports or something politics they are interested in all these topics.

Ross speaks about the relationship that he has with mental health consumers and how that relationship is different from other health professionals. That difference is defined as a long-term relationship where he observes aspects of the consumer's life that are invisible to other health professionals. Ross sees a future where his opinion will be sought out as he can provide a mental health support worker's perspective on the world of the consumer outside of the times that the consumer is seen by the medical staff and other members of the treating team. Ross imagines a future where there are no professional boundaries and where his input will be valued because it is unique to that of other members of the team. Ross is able to provide a wide perspective of the consumer's life, which is as important as the medical treatment, as it provides insight into how the consumer is responding to the treatment and what that means for the consumer's ability to re-integrate or re-engage with their world. Ross sees a world whereby calculated risks in treatment management can occur. He is suggesting that the mental health support worker would support the consumer through visiting them in their home and reporting back any concerns. This is a relationship built on trust that extends beyond the relationship with the consumer to trust from other

health professionals. He sees this as a way of improving the quality of the service while continuing to support the consumer.

HETERARCHY

Dream: the mental health support worker's expert knowledge about the client is drawn on in clinical decision making; for their knowledge not their relegated position

Many of the mental health support workers spoke about a future where hierarchies did not exist. While this study looked at the contribution of mental health support workers, the stratification of hierarchies between the various health professionals was not an unexpected finding. However, this study identified that there was also stratification within mental health support work. What had not been initially obvious but was then discovered is that there is an invisible hierarchy between community support workers and residential support workers. This study also identified differences between support workers employed by DHBs and those employed by NGOs.

Mel is a mental health support worker employed by an NGO in Auckland.

> *Remember it was a little bit elitist, if you were a community support worker you were better that a residential support worker.*
>
> *The thing about our team is that we didn't have the traditional clashing conflict we would ring them directly* [clinical team] *and they would come. It's being better valued and being made to feel valued by the clinical services.*

Mel and other support workers spoke about the differences or stratification within mental health support work, with the community support worker considered to have a more important role and therefore at a higher level than workers within the residential setting. While this stratification was spoken about by mental health support workers, they also spoke about envying peer support workers. This was based on the perceived luxury of time

that peer support workers were able to spend with consumers as a result of reduced caseloads. This aspect will be examined in more depth later in this chapter under the sub theme of 'time'. While mental health support workers enjoy less pressure on their time than other health professionals, they dream of the future as being able to have caseloads similar to peer support workers and a valuing of all the aspects of the work that support workers undertake, irrespective of the setting.

The ability and legitimacy to shift power that can be created through "the concept of power, heterarchy" (Aime, Humphrey, Derue, & Paul, 2014, p. 346) is the mindshift for creating an environment for mental health support workers' contributions to be welcomed and celebrated and expected.

> *We work under the supervision of a case manager, I was very fortunate*
> *that the case manager allowed me a lot of autonomy.*

Alan is a support worker within a DHB who is positive in his outlook as he is "allowed a lot of autonomy". He speaks in positive terms about the way that he works with other members of the team particularly the case manager. The emancipatory intent for mental health support workers is that their work will be valued, they will work autonomously and they will utilise the skills they have to provide another aspect to the treating team.

Aime et al. (2014) suggest that creating an environment that supports individuals ensures that what they contribute to the team by way of resources and expertise is of value. What Alan describes is a way of working that saw him valued by his colleagues. In the envisioned world of mental health support workers, the level of autonomy afforded Alan would be the accepted way of working. Permission to work this way will not have to be 'allowed', it would be the shared expectation.

WORKING CONDITIONS

> *Dream: are paid a realistic salary with conducive working conditions and are seen for the value of their contribution*

Sue is a mental health support worker employed by a large NGO in Auckland. She has been in the role for the past five years and would like to see her role as a mental health support worker being paid what she believes it is worth.

> *Money, and then there wouldn't be such a high turnover and even though you have a lot of knowledge and experience after five years but I am looking at getting out in the next 12 months and taking that knowledge and experience with me and maybe not even staying in mental health because of the pay. I am really ready for a change, mainly because of the money. I love what I do but I can't do it forever. I think I do a really good job and it aligns with my personal beliefs but it just doesn't pay enough to live off. It is the money that is driving me away, which is kind of heartbreaking in a way because I think this is my niche but I can't live on what I am paid for much longer and because I am in conflict with management because they are always saying there is not enough money and you can't do that, we haven't got the resources which is incredibly frustrating. We are crammed into a room upstairs, seven people – it's about double the size of this room and its absolute hell when we are all in the same room and so just having better working conditions. Because we are supporting people but who supports us. No-one really supports us and I guess if we belonged to some sort of organisation for support workers that recognised what we do and how hard it is, then that provided us with information and resources that would be useful. We are sort of the unseen people in the community, very unseen.*

Sue recognises her personal beliefs align with the work she does; however, she sees a future where her salary is also reflective of the challenges and responsibilities that the role brings. Many of the support workers employed by NGOs expressed concern that their salary was insufficient for them to be able to live on, whereas those support workers employed in the DHBs did not raise any concerns with their salaries. While Sue deviated away from her concerns about salary and focused on the resources she has to work with, she sees a world where she is supported by her manager and that the environment in which she works is appropriate. While the issue about what was appropriate was not fully explored, Sue

described a cramped, undesirable work environment. She expressed concern about the physical conditions in which she works. In Sue's future world, she would be housed in an office that is pleasant and spacious. She argues strongly for the visibility of mental health support workers to be raised up and recognised. In Sue's aspirational world, the employer would not determine the pay scale; this would be determined by the work that the support worker does. The funders of mental health services would not make a distinction between the clinical and non-clinical services; instead (as has already been discussed in Chapter Seven), they would review the funding model and move away from an input model with volumes to a model where the consumer's individual needs and requirements were considered.

Mental health support workers undertake a variety of roles and have a range of responsibilities. Across the sector, mental health support workers described a varying salary distribution. Those within DHBs tended to focus on the work they undertake with very little reference to salary although they did disclose their salary range. Support workers employed in the NGO sector described their salaries as low. This provided a diversion for the work they do and gave them a sense of not being valued for that work. The mental health support workers saw their role as valuable and that the future would see them being paid a salary that was reflective of their role and not determined by the organisation they worked for. By being paid a realistic equal salary, Sue sees the future where there is less turnover of staff and more valuing of the role.

RENAMING SUPPORT WORK

Dream: having a title that defines who we are and what we do

Bourdieu (1992) argues that the use of titles provides a means of maintaining the social hierarchy. Titles become another form of social stratification and limit change, therefore maintaining "the power of social taxonomies" (Bourdieu, 1992, p. 162).

I would prefer MHSW [mental health support worker] because support worker could be physical support, it doesn't really define the area of health you are working in, it's just the rehab assistant it used at the DHB before that they were called psych assistants. Because we are not RNs [registered nurses] we don't do the pills. I read a study that talked about the relationship and rapport in an inpatient unit that the support worker has [with the clients] because they don't have anything to do with the medication.

Alan is employed by a district health board and is able to recall when the work he now does had the title 'psych assistant', which I am interpreting that to mean 'psychiatrist assistant'. In Chapter Eight Jane also used the title of 'psychiatric assistant' when describing the position of mental health support worker with the DHB. Alan also uses the title of 'rehab assistant'. Just as there is no one term used for people that access mental health services, there is no one term used for people that provide support work for people accessing mental health services. Careersnz (2014), the New Zealand government website for careers, defines the role of the mental health support worker as to "carry out a supportive relationship with people who have been or are experiencing mental illness" (Careersnz, 2014). While this website describes the national qualification, it also goes on to say that the national certificate "is not designed to qualify people to be clinical mental health practitioners" (Careersnz, 2014). A search of titles using the words 'mental health support' brings up a number of variations including 'peer support worker'. Other definitions suggest that the worker is a supporting role for other health professionals such as nurse assistant, occupational health assistants. Given the importance of titles to define who we are and to ensure role clarity, consideration needs to be given to the role title to appropriately define the role and to ensure that the role is not considered an adjunct or subservient to another discipline. The future lies in identifying an appropriate and fitting title for the role that is not a subset of another professional group, but is a respected title for the valued work that is undertaken. By re-branding the title, role clarity will occur.

THERE IS ROLE CLARITY

Dream: each person working to their legitimate capability

Jane, a registered nurse, has worked in a variety of settings with mental health support workers. Jane demonstrates throughout the interview that role clarification for mental health support workers would contribute to their aspirations. In Chapter Eight, Jane articulated through the presence of the Shadow that she was able to speak about the dreams for the future for mental health support workers.

> *Those principles of the right task for the right person with the right skills, so if I was new to a ward and was working with a psych assistant or mental health support worker, I should be able to understand that role and know exactly what they are capable of, and because of the mixed workforce in terms of trained and untrained, it is hard for me as a registered nurse to actually think – like if it was an enrolled nurse, I would know what they are capable of, if it was a student or a new grad nurse I've got some sense of where that is – where there is kind of a mixed bag out there. Having confidence in that role that they know what they are doing, they understand what they are doing. I probably have seen some roles develop – it's a terrible word – but have quite a bit of status in the ward and have particular roles within the ward and sometimes that's helpful and sometimes it's not.*
>
> *I think it's having all the workforce trained, so they would all be trained. That role confusion I think is around how you work as a team. So you are making sure that as a team you are all working within your scope but there is that kind of sharing as well and when you think about the service users, sometimes I wonder how hard it is when they go to people for different things and you say "if you want a shower you go to the psych assistant or support worker", so it's how to frame that in a way that is more responsive, so that people don't get into that patch protection. I think the training is quite key and how they are included in that MDT [multi-disciplinary team] really. I am not always too convinced that nurses know how to push that scope up a bit. Maybe that's about patch protection or not. If you were in an ideal work and setting up a team, that's when you would look around what's the capability of all of those roles really. Then sometimes looking at the capability of a particular staff member. So there is sort of your basic qualifications, but then that*

person's strengths or weaknesses, so if you think about the male gender and the Māori thing then those are the things you might think about.

Jane explores the issue about the lack of clarity for people in the sector regarding the scope and breath of the role of the mental health worker. She suggests that there needs to be a clearer definition for the role. As part of the valuing of the work that mental health support workers do, it is important that there is shared understanding about their role, what their contribution is and how they can be part of the mental health team. Jane identified that one of the mechanisms to achieving role clarity is through mental health support workers having a consistent education/training programme and by being part of the team. This leads to all members having a greater understanding of the breadth of the support worker role; and with that greater understanding comes greater clarity and therefore other members of the team will have confidence in engaging with support workers. Jane sees the future widening for mental health support workers and that this will occur through other health professionals raising their scopes of practice with the mental health support worker filling the gaps that will be created. In raising the need for role clarity, Jane shares the view of Lisa in Chapter Eight who discussed the lack of role clarity from a regulatory point of view and warned of the danger of developing another health professional group.

GOALS ARE ACHIEVABLE

Dream: the mental health support worker is equipped to effectively help clients meet specific goals that lead towards recovery

The valuing of time and the continuity of time spent with mental health consumers by support workers has been discussed in this chapter in relation to roles of other mental health professionals. In this section, Anne, a registered social worker employed by a DHB, also raises the issue of the value of time. She described her previous experience of working within an NGO; she had also worked in the United Kingdom and Australia before coming to New Zealand. Anne provided information on what she termed 'floating support workers'

in London but suggested that their role was more focused on housing issues than holistic support.

They seem to have more time than case managers, and in my experience case managers have massive caseloads in this service about 48 people on a caseload, and so I just can't spend as much time with people doing things that need to be done, so having support workers who have much smaller caseloads and the capacity to be out there and mobile and meeting the client where they need to be and advocating for them and the other agencies and being there on the ground in ways that I can't be.

Maybe they are less directive than case managers, but I don't know if that is really the case actually. When I am seeing somebody and because I only have limited time, I don't have any time for pussyfooting around, like my agenda for today is this, this and this and is there anything you would like to do so it is quite structured and maybe a bit overwhelming.

A support worker that I work with usually has a specific goal when she is seeing my client but because she is seeing him several times a week; I imagine she could probably afford to be more directed by the client in terms of the patient things, so maybe that has something to do with it.

Together with the needs assessor, we had identified this bloke's massive range of health and other needs this man had. I knew that if it was just left up to me to try and address, it was going to be a really long term process and I didn't have the time to focus on him whereas getting a support worker involved – she has been making sure the client gets to all the appointments he needs to get to which previously he hadn't been getting to and if he had, with his deafness he had been refusing to wear a hearing aid for ten years so communication was really massive and the way that he presented, I think a lot of people were quite put off by that because he looks quite bohemian, has long dreadlocks and hadn't been washing himself well and changing his clothes. So his interaction with other health services often didn't get any outcome for him because they just kind of dismissed him as an alcoholic and they couldn't talk to him anyway. So Lisa has been able to make sure he gets to appointments and be there to advocate for him. So he has gotten all his entitlements sorted out and he is now being supported to get to all his audiology appointments and had a hearing aid fitted last week and it works so now he can hear, so that has been huge and probably the most significant thing so far. She has gotten him to see the dentist and so just being able to get him to appointments and she has spent a lot of time making sure that she knew what he wanted so that he could speak on his behalf. She would communicate with him before the hearing aid was fitted by writing stuff down and then he could speak perfectly well for himself. So that kind of facilitated the communication between the agencies and the client. She

has been prompting him at home to stay on top of cleaning and make sure he has food in the fridge and make sure he is feeding himself, so he is keeping on top of all of that self-care stuff, which again being based here and not seeing him at home, means we are pretty limited really in being able to make sure that he is actually looking after himself. I think she has actually identified that he needs more support than what she can provide herself, so I think there is a four week more intensive package going in from this week where there will be another team of support workers that will go in once a day to make sure he is keeping on top of his self-care.

Anne recognises the importance for mental health service staff to be able to spend time with mental health consumers, with the time being 'goal orientated'. As a clinician, Anne sees the value of the support worker being able to have the ability to be mobile and meet with consumers in a place other than an office. Consumers can be engaged within a variety of settings, many of which are negotiated between the consumer and the support worker. Anne describes how the mental health support worker is able to do the things that many other clinical staff cannot do because they have the time and smaller case-loads. Anne is able to articulate the value of the work of mental health support workers sees that they are able to look into the world of the consumer and undertake those roles that assist the consumer to live a life they may not have been able to do so if there was not the *time* allowance for the mental health support worker. Protecting 'time' and 'caseloads' for mental health support workers is key as it allows other health professionals to feel confident that the consumer is having many of their needs attended to through the involvement of the mental health support worker. Anne values the observations of the mental health support worker and the fact that the support worker has more 'time' to enable a more longitudinal relationship than an-office bound health professional. An aspirational future would mean having the 'time' to be mobile and being able to spend time with consumers. This time would build rapport to create a relationship with consumers and bridge the life of the consumer in the community. Further, it would change how the consumer is seen and assessed by the health professionals.

SUMMARY

"So it's closing the gap and with the help of the role of the mental health support worker working alongside the team, community mental health, DHB, we can actually get that support system in there." Alan mental health support worker

This chapter tells the stories and uses these to create the shared vision about future possibilities. The information gathered from participants provides a richness of data so the possibilities to redesign and enhance mental health services with mental health support workers to create a new way of working. The hopes and dreams within the stories of the participants that have been harnessed create a vision for the future of the mental health support worker that could ultimately redefine and positively change mental health services.

Watkins and Mohr (2001) postulate that change begins when the Discovery and the Dream phase are articulated. The appreciative interpretation of the data commenced in Chapter Seven with the Discovery phase – stories about peak experiences were told. The dissonance or Shadow that is transformational in nature was discussed in Chapter Eight. This chapter – the Dream phase has heard the stories and interpreted these in a way that weaves the vision for the future. Chapter Ten is the Design phase, where the proposition of the ideal is expressed and conceived, with the positive core being magnified by the opportunities of the future.

The ultimate aim for the Dream phase is to create a better future for those that access and use mental health services. Erikson, Arman, Davidson, Sundfer, and Karlsson (2014) suggest that "relationships are co-constructed, and the experience of the service user depends on what happens between him or her and the professional" (p. 111).

The world of the mental health support worker and the way they work enables them to provide a significant contribution to the treating team to create a better world for

consumers. Each health professional sees the mental health consumer through their own world view, frequently based on their own theoretical framework and education.

What has been described in this chapter provides an aspirational outlook for the mental health support worker, enabling the curtains to be drawn back from the windows and see the appreciative prism creating a world of opportunities for the mental health support workers.

Being a valued member of the team creates the support and opportunities for the contribution of the mental health support worker. It enables them to bring to the team a vision for mental health support workers irrespective of the organisations in which they were employed.

Figure 11: Dream: Discovered potential revealed

- Seen for who they are and the specific expertise they offer clients
- Right mental health support worker matched to right client
- Autonomy
- Consulted with regarding their clients
- Recognied as the 'ones that know'
- Others understand the role

Valued

Uniqueness

- Time to build relationships
- Bringing own life experiences
- Able to build long-term relationships
- The human contact
- Expansive background

- Have the available resources
- Work seamlessly between organisations
- Condusive working enviroment
- Adequate remuneration
- Active engagement with others in the sector
- Extending the role

Environment

Mental health support workers have carved out a unique role in the mental health landscape. They bring with them their life experiences and their ability to engage with mental health consumers. Having these qualities recognised and acknowledged by their fellow health professionals and employers opens up many more worlds and possibilities for the future. The interrelated nature of Figure 11 illustrates the intersected future possibilities of mental health support workers; that one sphere of aspiration overlaps with the other spheres in a non-hierarchical manner. Mental health support workers see their role being celebrated and acknowledged by others for the uniqueness that they bring to the relationship with the consumers and to the mental health team.

For the aspirational future the world will understand the breadth and scope of the mental health support worker, all disciplines working in mental health will know what the support worker does and will seek them out and ensure that mental health consumers know about support workers and that they are a valued part of the wider team.

The plans needed to "craft the future" (Reed, 2007, p. 33) will be addressed in the Design and Delivery chapters of this study.

CHAPTER TEN: DESIGN-DETERMINING

If I can dream, I can act and if I can act, I can become. - Poh Yu Khing

INTRODUCTION

The Design phase is future focused, positioned to create the *preferred future* based on "*provocative propositions* which act as challenging value statements" (Chapman & Giles, 2009, p. 298). Chapter Nine, the Dream phase, heard stories that provided the aspirational future for mental health support work. The Design phase is a collaborative approach to design a "possibilities map" (Seel, 2008, p. 6). Preskill and Catsambas (2006) suggest that the emerged themes can also be referred to as "design statement, opportunity or possibility statements" (p. 20). Additionally Reed (2007) suggests that the statements in this phase of the cycle are positioned to start with 'Everyone will' or 'There will always be'. In this phase, themes that emerge from the interviews are developed into 'future-focused' ideals that "stretch, challenge, or interrupt the status quo" (Preskill & Catsambas, 2006, p. 21). This approach to the data analysis ensures authenticity with the 4-D cycle and allows Dissonance to be acknowledged and transformational.

Throughout the preceding chapters, stories have been told by and about mental health support work and mental health support workers not only about what they do, but also what they could do. This chapter gathers those stories together to propose a future where the provocative propositions are acknowledged in order to capture the Dreams (aspirational futures) through the Design phase and tell what mental health support workers could do. Chapter Eleven will discuss the required environment in which the preceding chapters created what could be the reality of the Destiny.

The Design envisaged by participants is that the mental health sector will:

1. Have an understood educational pathway
2. Negotiate an agreed national salary scale
3. Create a title that describes the role more appropriately
4. Establish the mental health support worker as a distinct professionals group

5. Build an understanding of the role of the mental health support worker amidst related health professionals and the wider community

6. Initiate strategies to ensure that the mental health support worker is an integral part of the health team

The statements position the aspirations of mental health support workers. These aspirations will be gathered up in Chapter Eleven to provide the action plan of the Delivery phase of the cycle. This study, by maintaining the Appreciative Inquiry (AI) authenticity applies Chapter Eleven: the Delivery phase as the means for drawing together the "actions and making commitment to tasks and processes" (Reed, 2007, p. 33). These actions are then developed into a 'blueprint' model, which provides a framework for capability development.

HAVE AN UNDERSTOOD EDUCATIONAL PATHWAY

Andrew is employed as a mental health support worker within a district health board (DHB); he has also worked in the non-government organisation (NGO) sector in New Zealand as well as overseas. He commenced in the mental health field in 1991 having come from a background of a freezing worker, meat inspector and a shearer.

> *I don't want to over-emphasize the qualification as opposed to losing what we have now, it's a balance. I think the diploma sits quite well at the moment because a lot of it is on the things we are doing, it's everyday stuff that we do. It depends on where you are taking it, with the bachelor, what is the area that you are taking it into. Is it more of the managerial type roles or running a service? At this stage I don't think you need to be over-educated on the ground floor, there will come a time I suppose, the authorities will probably call for it, we have a degree in OT [occupational therapy], we have a degree in social work, we have a degree in nursing, so obviously if support work stays around then it will be the next step as well to work in the area.*

> *When I was up at Careerforce there was talk of this core level 2 course, I think it was, they were looking at that stage and I said you don't want to make it too easy for people to get in either. You have got to have a standard of education required to get in but, like level 4 certificate level and I thought that worked quite well but they were saying a lot of people were pulling out from courses because it is too difficult, that was what Careerforce were saying and they are not*

finishing the courses. I said well that's no reason to lower the standards, I don't think you lower the certificate because people are pulling out of the course; it seems to me to be the wrong way to go about it. I just seemed to me to be the wrong way of doing things. Throwing the baby out with the bath water sort of thing. When things had been established and seemed to be working well. We have more and more people doing the certificate, why change, why reduce it.

Who is going to want to employ a support worker level 4 if there is an extra cost associated with that when they can get a cheaper support worker level 2 on the basic level. There was going to be a criteria at the Ministry at one stage, you had to say the support worker was completing certificate training to attract funding and I don't know if they ever carried through with that or not.

And I think there was an increasing level they had to attain too as well in in some regions, I don't think they put anyone at all through the certificate course. They may have changed, you would think if there was some pressure on them to do that, it would have happened, so I don't know if it eventuated or not.

It is one way of raising the standard, making it part of the contract, without that you are going to go for the lowest common denominator if it's the cheapest option. I think support work is better than that and we deserve better than that.

I would like to see more streams in support work, more areas that we can move into, perhaps the work environment where there could be a role for support workers, work areas like that. There are a whole lot of levels where support workers could move into and a lot of employment opportunities.

It gives you something to achieve and something to aim for as well. I think if you are in a role you have got to have something to work towards all the time. That's my thoughts, I guess support work has only been going for, if you look at support workers plus respite as well, support work has probably only been going since the late 80s.

It is an area that needs developing I think. If you have 4,500 out there at this stage. There is going to be a certain percentage of those people who are going to want to achieve more than what they are doing.

The qualification is developing all the time too, I can't think of anything else to be done to be honest. It is nice to be able to have some role in the development of it as well, even if it is at a local level. The other area is support working closer to all services as well as mental health services.

Andrew articulates the value of the existing educational pathway for mental health support workers. He identifies two main areas that require further debate in the sector. The first discussion to be had is focused on the level of entry for a mental health support worker The first national qualification for the mental health work sector was set at Level 4 on the National Qualifications Framework (NQF); this places the qualification at sub-degree level. It is this qualification framework that Andrew refers to when he suggests that there needs to be a balance as to what is the right level of qualification for mental health support workers. He views the introduction of the National Diploma in Mental Health (Mental Health Support Work) (Level 6) as just another way of validating the work that many mental health support workers already undertake. Andrew seeks to explore the issue of qualification 'creep'. He clearly sees that once the support worker qualification steps into degree level preparation this would be the domain of managers and not the domain of those people that work on the 'ground floor'. Andrew cautions against qualification creep and does not believe that this is relevant for most mental health support workers.

Just as Andrew has raised concerns about qualification creep he has equally raised concerns about lowering the entry qualification level. He does not share the view held by the Careerforce (an industry training organisation) that the rationale for lowering of the level of entry would allow those people that have not achieved at Level 4 to be able to enter at Level 2. From Andrew's perspective, the Level 4 qualification is at an appropriate entry level and raises concerns about the introduction of a Level 2 qualification from an educational perspective and also from a pragmatic view. If a mental health support worker enters the field with a Level 2 qualification, this may then become the entry level at which salaries will be set. Andrew then questions the value of having a Level 4 qualification, as he asks why services would employ (and have to pay at a higher rate) someone who holds a Level 4 qualification when they could employ someone with a Level 2 qualification. The setting of qualifications is one of the ways that those receiving services can have some assurances that the level of care and or support provided is at a standard expected within the New Zealand health system. The multiplication of qualifications within the NQF in this area has the potential to cause confusion for the public, consumers, employers and policymakers. Andrew advocates for a Level 4 qualification as being the entry qualification and is supportive of specialist strands in a range of areas being developed. He suggests that this then addresses the issue of qualification creep while allowing mental health support

workers to gain skills and knowledge in a range of areas, thus increasing their marketability.

Andrew sees a designed future where mental health support workers have developed specialisations within the field of support work. He sees that the future is about giving support workers more specialised knowledge at the same level rather than pushing to a higher level or reducing to lower levels. Andrew sees a future where the organisations that contract services, the DHBs and the Ministry of Health work together to ensure that staff employed into mental health services have as a minimum Level 4 certificate and that this is monitored. By undertaking these steps the public, including consumers, gain an assurance that those people delivering the services are appropriately qualified. This mechanism would also contribute to this sector being able to establish a process to self-regulate. Andrew's vision of his preferred future is one where the role of mental health support work is understood by other health professionals, mental health consumers and the public at large. He sees a future where there is no confusion or lack of understanding about the role. Andrew further sees an expansion of the mental health support worker role. This expansion is seen not just working within the mental health context but going beyond that into other service areas.

The views articulated by Andrew were also verbalised by other participants. Many of the participants including Anaru, Jane, Gina, Jordan and Andrea saw the value in education, the need for clarity of the role and the need to obtain skills across the different fields within the mental health sector.

NEGOTIATE AN AGREED NATIONAL SALARY SCALE

In previous chapters, many of the mental health support workers working in the NGO sector raised the issue of salaries. This section considers the stories related to remuneration and what could be the possible future. Chapter Eleven will then examine what is required to make this possible future a reality. Chapter Twelve gathers up the future possibilities to create a blueprint for that future. The story told by Ashleigh (below) has a focus on remuneration. Hers is not the lone voice; Paul, Jordan, Jim and Sue all raised concerns regarding remuneration.

Ashleigh works as a mental health support worker within an NGO service based in Auckland. She describes working for an organisation in which she feels supported. Ashleigh believes that the work she undertakes needs to be recognised and appropriately compensated in terms of salary. She seeks recognition for her skills, which she believes are as good as those of others in the mental health workforce, although others are paid a higher salary. Ashleigh describes the work she does in terms of *"doing good for people"*. For her, the "doing good" provides her with employment satisfaction however, she sees that her role is as valuable as other health professionals in her sector and seeks a remuneration that is commensurate to others as a way of recognising the value.

> *We have huge support in our office. It is an amazing place to work. The staff are really amazing. We wouldn't be able to do it without our colleagues*
>
> *We are very low paid for this because even if we are on holiday, we always think of work. We think we should be paid like a social worker. They are paid high and we are paid low. We are doing more than them. Only thing is they are social workers and we are support workers, but we are doing the same thing. We are only paid sixteen something dollars an hour. When you do something good for people who are really suffering, you will have good deeds for generations to come. If it's a referral for us, they come here. We get referrals from them and we also get to see the doctors and nurses because we are taking clients there. We have meetings there. So we often go there, so we often get to see them. Sometimes there is a difference of opinion. They think that support workers that we don't do anything, but we do heaps of things. I feel that way, but I don't know how others feel. Sometimes I feel really frustrated, and say why are we paid for less and why we have to take more. Sometimes I feel frustrated and tell my colleagues.*

Ashleigh uses the terms "them" and "they" in this part of her interview, referring to social workers. When she refers to "there" she is referring to the DHB. Ashleigh is able to articulate her preferred future, this for her, is "us". For her, the "us" is the DHB sector and the NGO sector working collaboratively, with each service acknowledged for what they bring to the partnership. One aspect of this partnership that she sees as positive would be to have some equality in remuneration. The issue of inconsistent remuneration places a barrier between the professional groups, as well as the DHBs and NGOs. Remuneration is one of

the ways by which staff measure their value to both the organisation that employs them and the society in which they live.

Unlike other groups of workers in the health sector, there is no national collective that provides a collective contract for mental health support workers. Other professional groups in the health sector are covered by a range of nationally negotiated collective agreements. These types of collective agreements ensure that staff employed throughout the country have similar terms and conditions for the coverage of the role. For example, nurses employed by DHBs have a Multi Employment Collective Agreement with the roles clearly defined under a national job sizing and job scoping agreement. This agreement has coverage for nurses that choose to have the Public Service Association or the New Zealand Nurses Organisation as their bargaining agent.

The Employment Relations Act (2000) sets out legislative requirements related to employment, including employment agreements, in New Zealand. While this Act allows collective bargaining, to which mental health support workers could be a party, this is only allowed for registered unions. The dispersed nature of mental health support workers means that they do not have national coverage. While the legislation can be seen as enabling, as it provides protection for employees, it also allows for two types of employment agreements, either individual or collective agreements. The need to obtain equity of salaries across organisations and across disciplines is something that the mental health support workers aspire to and for them is a future proposition.

EQUALITY

Participants suggested that employment of mental health workers within the DHBs was better than NGOs in terms of salaries, conditions and general recognition for the work they do. Those mental health support workers in the NGO sector spoke about their salaries are low compared with other disciplines as well as what the support workers in the DHBs are paid. Equally, staff from the DHB acknowledged that they were paid an adequate salary.

Stories from participants that were mental health support workers, told of a role that was greater than just being about a job. Greater understanding of the role would provide a more

cogent argument to advance in the equity for salaries of mental health support workers thereby recognising that the role is more than simply a job. Figure 12 shows an advertisement placed by Platform (2014b) which appeared in the Wellington daily newspaper, The Dominion Post, was on 5 July 2014. This advertising campaign would support the claim by Ashleigh and a number of mental health support workers employed in NGOs that they do not enjoy parity with their DHB counterparts. More investigation is needed to define the roles in relation to the size and scope. Mental health support workers in the DHBs spoke about the support they had from their colleagues and the ability to access backup from clinical services. The support workers in the NGO sector did not have the same level of backup and spoke about being very much on their own when working in the community.

Figure 12: The Dominion Post advertisement

The concern raised by the NGO sector in relation to its funding levels has a direct correlation with the ability to provide services including paying staff. The recent campaign by the NGO sector in seeking more equitable funding is part of the Shadow that exists for mental health support workers within the NGO sector. A website established by Platform to highlight this issue suggested that "DHBs need to fund NGOs fairly so they can meet the true cost of delivering services - including fairly remunerating their staff" (Platform, 2014a). The DHBs have been established as funders, planners and service providers. The concerns raised through Platform highlight not only the inequity of the funding but also the potential conflict of interest that may arise when the same organisation not only funds services but also provides services.

Ashleigh states the hourly rate for mental health support workers in the NGO sector is approximately $16.00 per hour. The minimum adult wage in New Zealand in 2013 is $14.25. The numbers of mental health support workers employed in services across New Zealand is significant, with Te Pou (2014b) reporting that there a reported 2,631 full-time equivalent mental health support workers. If their collective strengths were to be harnessed this would provide an opportunity for them to seek equity and equality.

A TITLE WHICH DESCRIBES THE ROLE

Nishikawa (2011) introduces the term 'knowledge worker' as a way of redefining care workers. This definition is built on two platforms, the first being that knowledge workers are constantly involved in knowledge acquisition and the second being that the "productivity of their work and their organization depends very much on their knowledge" (Nishikawa, 2011, p. 115). Anaru a manager of a Kaupapa Māori[21] NGO, service has articulated his views on many aspects of mental health support work and support workers in the preceding chapters. He speaks positively about mental health support workers and the part they have to play in providing services within a Kaupapa Māori service. Anaru uses affirming language about how the mental health support worker's basket of knowledge (kete o te wananga)[22] can be filled so that they are better equipped to provide services; however, he does question the appropriateness of the title, 'mental health support worker'.

There is no expectation that they do comprehensive assessments but again this all comes back to the kete o te wananga, being able to fill their kete[23] with more tools and knowledge to be really a smart practitioner and the words support workers is displayed out there, I would love to actually change that.

I am not sure but with tangata whaiora and tangata motuhake[24], something that is special, I think support has a demeaning title, perhaps coming back to whānau and think about what is an appropriate title for those particular roles and responsibilities they really are roles that have a lot of responsibilities, so if there's an issue, we can't always make contact with those clinical staff to come in straight away and deal with it. Sometimes it may happen today and it may not happen until tomorrow or the next day, so the reality

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[21] Services that are based on Māori models of care
[22] Māori term translated as translated as 'basket of knowledge'
[23] Māori term for basket
[24] Māori terms used to described mental health consumers

is that those particular support workers – I would actually call them kaitiaki – are there to manage that particular issue at that time.

Perhaps in another time if there is option to explore that title of support workers with another title name, I would be interested.

It has sort of a stigma around it. So when are you coming to clean my house today? Will you make my bed? Will you do my dishes? It's that support. And I have to say also some of our clinical teams out there actually get that all confused around roles and responsibilities in terms of whether they are likely to do this, this and this. And that's why I try to reinforce with our community team – "if you are speaking to those particular teams out there, talk about what it is that you don't do". So there is more transparency. "Don't worry about what you do do". So there is more clarity.

Stories relating to labelling and titles for mental health support worker have also been described by participants in Chapter Eight. This related to the lack of clarity about the title and with multiple titles for similar roles. However, for Anaru, he considers the title to be demeaning and not valuing of the work of this group. His preferred proposition is for a title which is more encompassing and is special. He uses the word kaitiaki [25] and suggests this provides a more appropriate title as this word brings with it the mana[26] of the role. The literal translation of kaitiaki from Māori into English is 'guardian'. Anaru's belief is that the renaming of the title will more appropriately define the work undertaken and provides the role with the mana it should rightly have. He suggests the 'mental health support worker' title is not correct in describing what the role is and that a clearer role definition will bring role clarity. This need to have clarity through a title for the role and the need to have it defined was also raised in Chapter Seven by John, when he described in his view of what the role is not.

Anaru also believes that in order to title the role, it is important to define and agree on the characteristics of the role. Anaru and John have started to define the characteristics of the role including the responsibilities. The difference in roles and responsibilities are across different services, different regions and different funders. Anaru believes that if there was greater transparency around the role and the role was retitled then there would be less confusion, less role overlap and less cracks in the system. This would then provide a

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[25] Māori word used to define a guardianship or holder of knowledge
[26] Māori word for power

mechanism to identify the services gaps within mental health. Anaru suggests that there is confusion between physical care e.g. cleaning the house for consumers, and mental health support work. The area of support work he suggests is not doing the cleaning but creating an environment so that the consumer is assisted to gain the skills of daily living through the mental health support worker walking alongside side them.

TITLES ARE IMPORTANT

Titles are important as they define who we are, provide a value statement about what we do and describe what our relationship is with others. As has been discussed, the title of 'mental health support worker' requires revisiting so that an appropriate national title can be agreed. Those people that interacted with the health system were previously referred to as 'patients' and in many instances still are. Like the 'mental health support worker' title this brings with it predetermined thinking. The move towards words such as 'consumer' or 'client' was an attempt to develop a more equal relationship between the two parties where there was less of a power imbalance. The Mental Health Commission in New Zealand used the term 'consumer' in its Blueprint for Mental Health Services in New Zealand (1998). A mental health consumer was defined as "a person who experiences or has experienced mental illness, and who uses or has used mental health services. This document also refers to services user, survivor, patient, resident, client and turoro (Māori person who engages with mental health service)" (Mental Health Commission, 1998, p. 110). Equally the words that are used to define people that access mental health services and those that provide support work in mental health services need to have a title that defines them.

ESTABLISH THE MENTAL HEALTH SUPPORT WORKER AS A DISTINCT PROFESSIONAL GROUP

One way of describing a professional is to describe what it is that they do that is different from what other professionals do. There are many aspects of the work that mental health support workers do that has developed organically over time. There are aspects of this development that have been described by mental health support workers and others.

John, a consumer advisor employed by a DHB, interwove the relationship that support workers have with consumers as being both a human and humane relationship that is built on mutual respect and 'doing with and not doing for'.

> *So support work provides the context of the person in response to the person.*
>
> *I think that support work happens well, in a kind of paradoxical way, I suppose and idealistic, the support worker ignores the illness altogether, which of course they can't do that, but ignore the illness as much as possible so that what you are doing is a relationship between two people and it is a certain kind of relationship, it's not a relationship or a friendship or anything like that, it is a professional – in some sense – relationship between two people, and that relationship works – the support worker relationship works, when that relationship doesn't work, support work doesn't work. I think that is true of clinical relationships as well, but they are different kinds of relationships. It is a working relationship and when works, support work works. It's not just a respectful relationship – that is obviously fundamental – but it is also to use your word, it's an appreciative relationship in that the support worker doesn't need to know about the illness because the support worker doesn't need to understand the illness because the support workers doesn't really have much to do with the illness. I mean it sets limits, that's it.*

John suggests that the support worker is able to look pass the illness and sees the mental health consumer as a person. He agrees that the illness cannot be ignored, but nor should it be seen as a barrier to the professional relationship that the mental health support worker builds with the consumer. John holds a strong belief that it is the nature of that relationship between the support worker and the consumer that is of most value. John is clear that the relationship is a working professional relationship but it is not a clinical relationship. It is this creating of the relationship that makes the role of the support worker different from other health professionals.

EXPLORING BEING A PROFESSIONAL BODY

Paul is a mental health support worker employed by an NGO. He sees the benefit of exploring ways to have a professional body that supports the profession of mental health support work.

We do similar things as key workers and CSWs [community support workers] and yet the remuneration is so different. I think that is the frustration. I do understand that they are registered health professionals and unfortunately we are not, we don't have a professional body, which is the other thing. Although I have a degree, people that are registered health professionals, social workers or OTs [occupational therapists] in my organisation get a higher salary. They come in as health professional at $21 an hour and we come in at $17 and yet they are doing the same job, although they are registered health professionals, so it is very frustrating.

I think it would be good to try and develop or put something and get an association and make it a registered body. Because there are so many support workers out there, not just in Auckland but the entire New Zealand.

When you say health professionals, we could say health practitioners or something like that, but I am curious and it is interesting to know about the people who have done the degree especially because my 10 year plan is hopefully that people who have those degrees and those qualifications can work from home, from a mobile service of delivery. Those opportunities that are there to deliver community support services from home. That is my 10 year plan. That is what I hope to see, because it makes sense. It may sound far-fetched but if you have the degree, you are already focused and you have got all those skills on board to be able to work from home.

Paul speaks about creating a ten-year plan that would see mental health support workers practising more autonomously. Paul understands that being seen as professional brings with it a higher salary. In his view, the work that the mental health support worker undertakes is as professional as the work that others undertake in the health sector. The difference is that one group is regulated and the other group is not. While the intent of regulation of the health sector was to ensure public protection, it has had the unintended consequences of putting in place a hierarchy that has become value-based by way of remuneration. Therefore, in order to be awarded the status of other in the health sector many of the mental health support workers in this study believe that it is important to develop a professional body and therefore self-regulate. In order to do this, mental health support workers also need to have their scope of practice clearly defined.

In considering the impact that regulation has on many health practitioners, the National Support Workers Summit (2007) deliberated the issue of regulations and identified that

mental health support workers have the ability to be able to operate in a way that is not possible for the regulated health workforce as it is "statutory requirements that bind clinical services" (Platform, 2007a, p. 2). However, many support workers believe that they lack the credibility and the perceived professionalism that is awarded to the regulated health professional by not being regulated.

Platform (2007a) also described mental health support workers as "a new emerging workforce without traditional professional or union affiliations" (Platform, 2007a, p. 14). When examining the vexed issue of regulations of a professional group, be they imposed or self-regulation, it is important to consider why a profession seeks regulation. O'Brien (2005) suggests that key to the discussion on professionalism is the "between 'the professional' and 'the user'"(O'Brien, 2005, p. 20).

The Health Practitioners Competence Assurance Act (HPCA) (2003) became law on 18 September 2003 (Ministry of Health, 2014b). One of the main functions of the Act was to provide public protection through the monitoring of on-going competence of practitioners. The Ministry of Health states that "not being regulated under the Act does not imply that a profession lacks professional standards" (Ministry of Health, 2014b).

The Ministry of Health website outlines the conditions and reasons why some health practitioners are not regulated under the Act. These include:

- A low level of risk of harm
- Practitioners work with, or under the supervision of a regulated, profession
- Employment arrangements provide an appropriate form of regulation outside the Act to minimise risk of harm to the public
- Self-regulation by the profession can provide an appropriate form of regulation.

EVERYONE WILL BENEFIT FROM MENTAL HEALTH SUPPORT WORKERS BEING PROFESSIONAL

Adrienne, a manager with an NGO, spoke proudly of the support workers within her service. She spoke positively of the work they did and was complimentary of their professionalism.

I don't know if I influence, other than saying it to people and I think it is just finding that value in what they do and to be recognized as a professional body rather than they are not clinicians but they don't claim to be, but it is still not a professional body but they still have qualifications around support work and some have got diplomas and that so it is just being valued as a professional body of people.

I know there has been talk about seeing it sitting and I know they have talked about NZASW [New Zealand Association of Social Workers] being the sub link into that, but I don't know if that is going to happen but to have a body that is nationally recognized is a way of recognizing whether it be something different.

Some social workers saw it as maybe taking their professional away, I don't know, when it came to vote, it just didn't happen, I don't really know why.

Probably not, a lot of directions set up and that's one good thing about NZASW there so something similar would need to be delivered I believe before all because that was all part of so maybe similar or around that could be implemented but it is definitely doable but who can actually, I think all that stuff would need to be done at the top before you go and to have that recognition nationwide.

Adrienne does not see herself or support workers as influencers. She does recognise the value of the work that mental health support workers do and the professionalism they bring to the role. She articulates the difficulties that mental health support workers experience by not being seen as a professional group or having a professional body. She understands that mental health support work as it is known is a relatively new occupational group. Adrienne raised concerns about the support workers trying to find their professional voice and not allowing it to be subsumed by another professional group. The mental health support worker's role is different from that of other roles in mental health services. That difference, once articulated, could allow it to work with another occupational health group to develop its own identity and to ensure that it can be self-regulating within the existing regulation and legislation. Adrienne sees this as the possible vehicle for gaining national recognition.

When the HPCA Act (2003) was first proposed, it set up a framework so that those disciplines that were considered to pose the greatest risk to the public were placed under a regulatory body. All other disciplines not under the Act were to be self-regulating. The issue for the mental health support workers is that they are not under the Act even though

they are required to provide services for and work with vulnerable populations. They have not been successful with establishing a way to self-regulate. The exisiting regulation for mental health support workers, in 2015, is through their employment contracts and other relevant legislation. The medical profession argued strongly for their continuation of self-regulation. Their reasoning being that for doctors "self-regulation is justified and necessary because the complex level of skill and knowledge they possess means that only those within the profession are able to regulate them" (Rogers, 2004, p. 21). This justification of why self-regulation as a valid means of protecting the public provides a cogent argument for mental health support workers to self-regulate.

In a report on regulation, undertaken by North East Education, the need to establish regulation for health workers/professions that would be future proof so as to allow for the "emergence of new healthcare worker groups" (Illing et al., 2008, p. 14) was identified. The issue relevant to mental health support workers, was that the healthcare workforce is changing, as are traditional roles within the health sector. Staff groups who have traditionally carried out limited and low-risk functions now have extended responsibilities, which may previously have been the sole domain of other professional groups. Cross-over and blurring of roles between staff groups make it increasingly difficult for a future regulatory system to be based purely on job title. A new system needs to "protect the public but also be flexible and able to address such changes in the workforce and healthcare delivery" (Illing et al., 2008, p. 12). The extension of professional regulation was discussed by the Extending Professional Regulation Working Group (2009), who identified cost to the employer by way of time and money as being a barrier to regulation, as well as the cost of achieving higher education. The Working Group considered that "respect, respectability, status and legitimacy was earned from the public rather than conferred by statutory regulation" (Extending Professional Regulation Working Group, 2009, p. 27).

BUILD AN UNDERSTANDING OF THE ROLE OF THE MENTAL HEALTH SUPPORT WORKER AMIDST RELATED HEALTH PROFESSIONALS AND THE WIDER COMMUNITY

Jordan is a mental health support worker employed by a DHB. He speaks of the challenges he faces in his role in particular the difference in salary paid by the DHBs and the NGOs. This difference may not be a reflection of the role or the understanding of that role, rather

as a result of difference of understanding. Jordan does not see that the challenges are with the clients he works with; rather, he believes these sit with the organisations.

> *For me, not so much a challenge with the clients, I think there is a disparity in terms of remuneration, in terms of wages that community support workers get, especially when they are over-qualified. At the moment we have got all these qualifications and I am just making comparisons between the community support worker from the NGO and one that works at the DHB. I just wanted to raise that because it is timely that some of these budgets should reflect the good work that our community support workers should be getting. It should be across the board. When I say that, my evidence is that – I don't know if I can identify the organization – but I know there is an NGO that really pay their community support workers, their vocational support workers really good remuneration for their staff.*
>
> *Well you would get over $36K or $38K, that's with the minimal certificate. I don't want to get into it any further than that but probably that's one of the challenging issues that I have. It is never with the clients, it is always with the organizational structure and the budget that doesn't reflect how it should be in terms of, especially the outcomes, in the work that the community support workers do with their clients, the time they spend, I am sure that you would have heard this so many times, hopefully we don't have this conversation in our group in another 10 years time and still talk about the same things and issues. This kind of thing should be done, we could talk to the cows come home but some things have to be actioned and addressed.*
>
> *To bring these people, peers support workers, to know and to hear these are the challenges we have. You want to stay working in the DHB as long as you can because the remuneration is really good. So I know exactly the benefits of working for the DHB, but I think it should be across the board with NGOs too.*

Jordan has the view that the health system and, more importantly, the mental health system has a tiered approach, with the mental health support worker at the bottom. Jordan verbalises that the NGO sector funding is lower than the funding paid to the DHBs. This means that the NGOs are unable to pay mental health support workers the same salary ranges that are paid as the DHBs. This was also raised by Ashleigh and is supported by Platform, Figure 12. His view is that the work of the mental health support workers is worthwhile and that there should be no difference between the organisations because all the work is of value. Jordan seeks equality of salaries.

Jordan touches on the challenges that he and other support workers have with the system. For him, the greatest challenge is the system because of its structures and budgets. Jordan has a desire to have the work he does acknowledged with appropriate remuneration. His future proposition is to not have a similar conversation through another study in ten years' time; he would like to see action taken on the issues he has raised.

CREATING TRUST IN RELATIONSHIPS

A study undertaken by Verhaeghe and Bracke (2011) showed that mental health consumers have a distrust of mental health professionals which is "due to stigma expectations and self-stigma despite an absence of any concrete negative reaction from other people" (p. 300). The study then went on to say that this sense of distrust is one of the identified factors that "impedes the positive relationship between stigma expectations and satisfaction" (Verhaeghe & Bracke, 2011, p. 300), suggesting that the stigma related to having a mental illness is a barrier for mental health professionals (including mental health support workers) even before they engage with a mental health consumer. Trust within professional relationships is seen as important as it helps to define the relationship. By labelling the mental health support worker role as non-clinical, it is the nature of the relationship and not the illness that becomes the focus.

John, a consumer advisor with a DHB, spoke about the need to understand the relationships and the aspirations of mental health consumers.

> *An appreciative relationship doesn't need to understand the person, just appreciate that this person is a human being living or attempting to live in the only way that seems possible at the time, a human life, and to appreciate that.*

What John, values as key to the relationship is the need to value the mental health consumer and not to understand them. He remains firm in his views that mental health support workers should treat mental health consumers as people rather than as a diagnosis and work with them to achieve their dreams and aspirations. He views that the recognition of the person and what they aspire to achieve provides a greater depth to the relationship rather than attempting to analyse it. The value for John is that type of relationship as it will seek to

acknowledge and celebrate that for what it is. John does not limit his views that the relationships are only between consumers and mental health support workers; he allows his statement to be open for interpretation. It is the humanness of the relationship and appreciating the differences is something that John considers to be fundamental to any human interactions.

While the literature found very little written about the relationship between mental health support workers and mental health consumers/clients, numerous studies have been undertaken regarding the relationship between other health professionals and patients. Brownie and Horstmanshof (2012) identified that "at the core of person-centred care is the relationship between the nursing staff and the resident" (p. 783). While research about the nursing profession provides a proxy for mental health support workers, this study describes peak experience of the mental health support worker and their relationship with mental health consumers.

In his critique of Aristotle's ethics, Bostock (2000) describes the relationship between two people of unequal status as deserving of "special treatment" (p. 170). Bostock's interpretation of the 'special treatment' is a result of the inverse proportion of the status, although he describes these unequal relationships as more akin to a father son relationship where this is a natural inequality. The end conclusion is that friendship can only be between two equals and that this can then only be between 'good' people, as to love someone for himself is the same as to love someone for their goodness and therefore their virtue. In his own words, John supports the notion of equal relationships between mental health consumers and mental health support workers and mental health support workers and other health professionals. The equality of that relationship John termed an "appreciative relationship". John recognises that the mental health support workers have the opportunity to provide a different type of relationship with consumers and this relationship should not be modelled on existing relationships with other health professionals.

ALTRUISTIC ASPECT OF THEIR BEING

Ashleigh is a mental health support worker based on the North Shore in Auckland. She holds a Bachelor of Arts degree from an overseas university as well as the National

Certificate in Mental Health (Mental Health Support Work). English is not Ashleigh's first language.

> *If you do good for some people, you will be having your family and your generation will be having good deeds. So I believe in that. Yes that is a value exactly. Now I am getting that in my mind. When you do something good for people who are really suffering, you will have good deeds for generations to come. I believe that very much. Because I have seen that with my parents. They haven't done no harm to anyone, they are still having a good thing going on, so thank God for that.*

This altruistic view expressed by Ashleigh of the work that mental health support workers do was shared by many of the participants as being what inspired them the most about their job. What is being described is the internalised gains that mental health support workers get from the work they do. However, in many of the stories told by the support worker employed with an NGO, this did not bring with it the salaries enjoyed by their counterparts employed by the DHBs. While there are many factors that motivate people in employment, "workers act in the interests of their employers for a host of reasons. Sometimes money is the motivation, but often it is because they care about what they do" (Prendergast, 2008, p. 201). Is the role of the support worker in both NGO and DHBs paid at the same rate and, if this is the case, does this allow the DHB to cross-subsidise from one funding category to another? Ryan and Deci (2000) suggest that intrinsic motivation is an aspect of what makes us human; however, they also suggest that in order to maintain this motivation, humans require a supportive environment in which to operate. Intrinsic value is an important aspect of the work environment and something that is highly valued by mental health support workers, and this may lead to "enhanced performance, persistence and creativity" (Ryan & Deci, 2000, p. 69) but by itself is insufficient. A striking theme that emerged from this study was the significance of intrinsic fulfilment and how this was referred to by mental health support workers and others. For the mental health support workers this characteristic was as their raison d'être although it was not a substitute for other aspects of their role that were not so gratifying. Ashleigh has a valued-based approach to her work ethics that relates to the "doing good". In providing an interpretation of the meaning for "doing good" I have reflected on Bostock (2000) interpretation of the works of Aristotle when he commented that "it is not the role of politics to adjudicate but rather to create the conditions in which each individual may pursue his own conception of the good" (p. 10). 'Good' in this context

is defined by Bostock (2000) as "a life which well exemplifies the particular kind of life appropriate to that species" (p. 17).

Lynn, a mental health support worker, raises the issue of care and caring. While it could be suggested that she is discussing professional boundaries, she is describing 'caring'. She describes a connectedness between mental health support workers and those mental health consumers that they support. She is concerned and worried about the mental health consumers she works with because she 'cares' about them:

> *I mean you still take your work home with you. Of course you do and worry are they going to be ok and that sort of thing. If one of them goes AWOL [absent without leave] or something you go home and think you hope that they find them, hope they are aright. I came back in (to work) even though I wasn't working there at the time I still got involved. It's a human connection. There are professional boundaries but it's still hard not to, it is, but you have got to still learn to look after yourselves as well.*

When commenting on caring in relation to nursing Finfgeld-Connett (2007) suggests that caring and social support are intrinsically linked concepts. She does however describe the precursor to caring as 'professional maturity', which she further defines as a protective mechanism that provides the nurse with the ability to "cope with the routine stresses of clinical practice" (p. 60). Finfgeld-Connett (2007), suggests that there is no evidence to suggest that social support requires 'professional maturity'. It is for this reason that she defines social support as being provided by lay people and may include family members and that social support is provided by 'healthcare professionals only when lay providers are unable" (p. 60). Millet (2011) extends the concept of care that occurs within a professional relationships and suggests that "a living thing ought to be looked after or cared for simply because it exists as a living thing" (p. 272). Lynn sees the caring as part of what the mental health support worker does because of the relationship. In Lynn's future, the caring aspect of her role will be valued; it will not be seen as the blurring of professional boundaries. The nature of the relationship will be understood and valued.

Many of the mental health support workers raised the issue of being part of the wider team. Mel and Lyn, employed as mental health support workers, discussed in Chapter Nine what it felt like for them when they were valued as part of the wider team. For them, that acceptance as part of the team felt good. Jim, also a mental health support worker, spoke of the need for all parts of the health team to work together as a team and that this responsibility sat as much with support workers as it did with other team members. There is a need to examine the barriers to this some of which have been raised in this chapter and the previous chapter. Mental health support workers spoke about a future where they are able to work seamlessly across services to provide better outcomes for consumers. If this is to be the goal then the real or perceived barriers need to be deconstructed. The Dream chapter highlighted the desires of mental health support workers, Chapters Eleven and Twelve provide recommendations as to how the suggested barriers can be addressed.

SUMMARY

This chapter builds on the previous interpretation of the data and looks towards the created future. The mental health support workers' role needs to be better defined so that there is role clarity, not only for the mental health support worker and the consumer but also for other members of the clinical team. This will then allow service funders and service planners to identify the service gaps and develop and fund services to fill that gap so as not to have the mental health support worker undertaking areas of support that would generally be associated with home care workers. In doing this, it allows other members of the health team to fulfil their own responsibilities and to work to the top of their scope of practice.

The title of 'mental health support worker' needs to be revisited so that it not only better defines the role but also gives mana to the role. While Nishikawa (2011) uses the term 'knowledge worker', Anaru suggest '*Kaitiaki*' is a more fitting title.

A collective voice will provide power to this group of workers to bring about and actualise the many desires raised in this chapter, as the collective voice is stronger than that of the individual.

The written word provides a challenge to capture and reflect the passion that was articulated by the participants in this research. This cycle of the four phases is where mental health support workers and others describe their contribution to mental health services, what inspires them in their role and how they make a difference to the lives of people with mental illness. The characteristics spoken about in this chapter were given with selfless, open honesty and enabled me to gain an insight into the world of the mental health support worker.

This chapter describes what drives mental health support workers to undertake their role, how they work with mental health consumers in an aspirational way in order to make a difference, and what are some of the characteristics that employers and trainers/educators need to seek and build on.

Once more, the intersecting circles stylise the inter-relationship of the main themes that have emerged from the Design phase (Figure 13).

Figure 13: The intersecting relationships of the Design phase

An established professional
- Self regulation
- Professional body
- A title that reflects the work
- Creating an identity through uniqueness

Established career pathway
- Entry level: support worker
- Senior: support worker
- Manager: support work
- Educational opportunities

Valued
- Role understood and renumerated
- National pay parity
- Be a part of the team
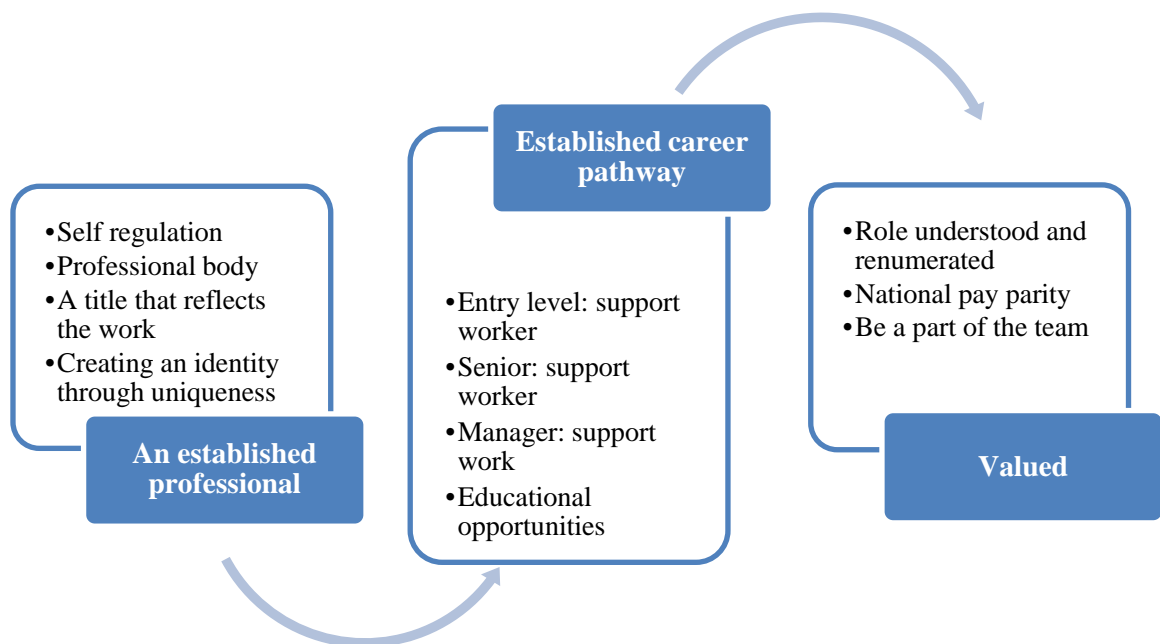
Chapter Ten draws from the previous four chapters and take the findings into the Destiny phase, consciously acknowledging the Dissonance. The next chapter will close the circle of the 4-D cycle as it builds a reality based on the Discovery, Dream and Design phases.

CHAPTER ELEVEN: DESTINY – CREATING WHAT COULD BE

Turn your face to the sun and the shadows fall behind you. Charlotte Whitton

INTRODUCTION

The Destiny phase of the 4-D cycle is considered part of the cycle where actions are taken based on the provocative statements posed in the previous three phases. The themes gathered from the preceding chapters and added to this chapter provide a plan that recognises the actions required. Some may suggest this is the final stage; however "most proponents of Appreciative Inquiry suggest that it is critical to keep the conversations going even after an inquiry has been completed" (Preskill & Catsambas, 2006, p. 25). In order to maintain the critical conversation, the Destiny phase is also about creating a sustainable future, the context for this future is mental health support work and those who undertake this role.

This chapter provides the plan for designing the future. The stories told in this and the preceding chapters provide the information that, when developed into a plan, provides a sustainable future for mental health support work in New Zealand. The future design is predicated on:

1.   Creating future services through mental health support work
2.   Developing the uniqueness of mental health support work
3.   Taking the best and developing those roles
4.   Mental health support workers playing an integral part for service change
5.   Creating a self-regulating profession.

As discussed in Chapter Five, the Destiny phase focuses on strengthening the affirmative capability of the whole system, enabling it to build hope and sustain momentum for ongoing positive change and high performance. The end goal for this study is to inform policy, education and service providers as to the current strengths afforded by mental health support workers and the innovative possibilities for the future.

CREATING A FUTURE OF MENTAL HEALTH SERVICES THROUGH MENTAL HEALTH SUPPORT WORKERS

Cindy is employed as a mental health support worker in a large non-government organisation (NGO) in Auckland. She migrated to New Zealand because she had viewed New Zealand as having a progressive mental health service. Cindy is one of a number of young mental health support workers that were interviewed.

> *The difference I think I make now is a lot different to what I thought I would be able to make when I came into this role. I moved to New Zealand in September because of the mental health system over here and because it said on paper that progressive and to what is going on in the UK and home. It is moving away from the institutionalized way of working. I was really looking forward to being able to make a difference because I don't think years and years of learning and years and years of this, that and the other, I think you need to have a certain sense of personable qualities to be able to work with people and I have personal experience of my father going through a diagnosis for us. So I came over here with all these fantastic aspirations and the difference I find I make now is providing company. Maybe a little bit of self-esteem, compliments boosters. I don't feel we are doing as much as we can – point blank. I feel that the difference I make now is absolutely minimal to what I wanted to make, but hey that was maybe a just my perspective. None of the clients I work with have gotten to that point of wellbeing where they feel independent and that's I suppose a little bit frustrating because I feel that we have such amazing resources. The staff here are dynamic, multi-cultural with diverse background – everything but there has not been one specific framework targeted. We use the strengths model here but it is too ambiguous and not specific enough. If we think we can just look at the positive it's gone too far the other way I think in terms of differences I think if we could focus a little bit more we could see the differences that maybe I think that I hoped for when I started in this job, like seeing different stages in their wellbeing fluctuating, that's all part of recovery, going up and coming down again, but gaining independence in the real sense of the word and gaining recovery in the real sense of the word and not just a buzz word that we put in personal plans and goals and things like that.*

Cindy describes life-long learning and her experience of someone who has a family member who has experienced mental illness; she believes the learning gained from this is as important as her formal learning. Cindy recognises the importance of gaining qualifications to work in this field but she also argues that this is only successful when it is

augmented with the appropriate personal qualities. Cindy is comparatively young and enthusiastic. She has a vision of an aspirational future for support work.

Cindy disclosed that she was drawn to New Zealand because of its enlightened policies for mental health services. She saw this country offering something that was different from what she and her family had experienced. She speaks about New Zealand having an aspirational future for its services and that she, as a mental health support worker, is one of the keys in determining that aspiration. Cindy's view is that New Zealand had the fabric from which to create a future for its mental health services. Her view is that there are excellent resources in terms of people, their skills, and a multi-cultural approach, all of which she describes as "dynamic".

Cindy articulated her views on the strengths model. She puts forward a view that the operationalization of this model leaves room for it being too ambiguous and non-specific. She is suggesting that in order to strengthen mental health services, there is a need to have a clearly-defined services framework based.

Cindy is reliant on her own self-reflective processes as she does not know what others think. She believes that she is making a difference but she needs feedback from others to have this validated and her contribution acknowledged. She views wellbeing as the ultimate goal for mental health consumers and voices concern that she does not know if she has made a difference because she has not received that feedback.

She views the foundation for services is to achieve "fantastic aspirations". This would require services to realise opportunities for both staff and consumers that are not so evident in the current mental health service structures and delivery. Cindy believes that a different future can be achieved if those who stop the "fantastic aspirations" from being realised could be recognised and addressed. She sees the future as being achievable, although she recognises that there are areas that requiring addressing. Cindy speaks of the need for a reality check for what is to be achieved. She sees a future that is real for the mental health consumers and challenges the current dominant view that is driven by "buzz words". Her concern is that services and care delivery are being determined by ticks and boxes rather

than by understanding that recovery is a fluctuating and individual experience. For recovery to be meaningful, Cindy believes this must be framed in "the real sense of the word" and not simply be affectation.

Cindy challenges much of the thinking within mental health services including the way that mental health consumers receive services. Her thinking seeks an aspirational future based on the realities of consumer's individual cycles of recovery and not on hollow words that are meaningless. In order to achieve that future, Cindy advocates for a review of the existing service delivery model and the philosophies that underpin the model, and to have New Zealand once more as an international leader of mental health services. Harnessing her passion and drive to make those changes can make those aspirations a reality.

Create an aspirational service framework

National employment collective

GROWING THIS UNIQUE WORKFORCE

As a registered nurse who has worked with a number of mental health support workers, Jane sees this group as a significant future workforce, not only in terms of numbers but also what the future could be for mental health support work.

> *It is certainly a workforce that I hear is expected to grow. And if you think about that kind of unregulated health workforce, it is a huge workforce in New Zealand. I think you get that sort of skill-shifting, so you will get nurses who – in a language I am hearing at the moment – nurses working to the top of their licence. So with nurses being able to prescribe, I think you will get the shifting up. So this workforce skill level is going to shift up a bit really. How do we say as nurses, no is that support worker a safe person to delegate care to. That's the thing that we need to think about. So that workforce, whether it is mental health or just the unregulated health worker, it is that delegation, so there isn't any standards around that, which I think could do nursing out of a job maybe. I think that is a reality really, for want of a better word, maybe it's a cheaper workforce going to do some of the things that traditionally we did as nurses. That is probably a challenge for us.*

In terms of the sustainable future for mental health support workers Jane clearly sees they have an increasing role for the future. Jane suggests that the shift will be in terms of the changing roles of other health professionals. She references this back to the role of registered nurses and how they have now taken on roles such as prescribing, which allows them to work to the top of their scope of practice. As other health professionals lifting their scopes ever upwards, Jane suggests that the mental health support worker's role will bridge the gap with that push to lift the scope of practice. She sees this development occurring as an almost natural progression and she also sees the skill of the mental health support worker also lifting. Jane also sees the possibilities for the future of mental health services through mental health support workers. She acknowledges that they are a sizable part of the mental health workforce and sees a future mapped out where other health professionals expand their scope upwards thus creating a real gap for the mental health support workers to fill. She does caution on the need to have standards in place for the mental health support workers. She suggests that there are some economic imperatives within the health environment that could be partly addressed through support workers, provided it is through the creation of standards of practice. Her view is that it is possible to expand this workforce's role, provided it is done in a way which protects mental health consumers. Jane realises that this change in practice would be a challenge, in her case to nurses; however, she does not suggest that this should be an impediment. Jane's view is that there is sufficient under-resourcing in mental health services, which would allow all roles to expand upwards. What Jane is stating also resonates with Jordan's views which are expressed later in this chapter.

Jane poses a question about the need for delegation and defining whose responsibility it is to ensure that the mental health support worker is a safe health professional. Under legislation in 2015 there is no legal requirement for nurses or other health professionals to take on the responsibility of delegation or direction for the mental health support worker. Although there is a requirements within the standards of practice for registered nurses to provide direction and delegation for health care assistants (Nursing Council of New Zealand, 2012), this does not extend to mental health support workers. Jane raises the question as to the correctness of this matter and places this within the context of safety.

Jane also raises the spectre of professional 'patch protection' and the view, held by others in the health sector, that mental health support workers could take up some of the roles that nurses in mental health have traditionally performed. Jane also raises this as a potential opportunity for nurses to look at their role and asks about the need to define and redefine roles as new workers enter the healthcare arena. Jane poses some questions and suggests that there is a need to redefine the mental health services workforce which she suggests is very striated and confused. If roles and skills were more clearly defined, access to services may in fact be improved. This way of viewing the expanding role of the mental health support worker may be challenging but also provides opportunities for other health professionals.

Succession planning for mental health support workers –
career planning

Code of ethics and framework for competency be
developed

TAKING THE BEST OF ALL

The following transcript is a conversation between members of a team employed by a large NGO based in Auckland. Cindy, Ross and Jo are employed as mental health support workers; Andrea is employed as a peer support worker. The interactions of this blended group provide some insights into the similarities and the differences between peer support workers and mental health support workers.

> *Cindy: Yeah, I think you are right about having that time for self-care and I am very strict about it with myself. I make sure I am doing things throughout the week to keep myself well, but when you are on a rotating roster and I am sure you guys are. Well we are not providing 24 anymore - 12, 7 – 7 days a week. So you can get into a routine of having your weekends as work time and that is a frustration. And you guys also get one-on-one supervision as well don't you.*
>
> *Ross: Yes we have group supervision and we can talk. There are benefits also. I don't think bring any outcome, it all depends on what we speak*

about but at the end of the day it is up to our management as to how they are dealing.

Andrea: Is that when you talk about clients themselves though and what you could do?

Ross: No that is what we do, it is for staff.

Andrea: Group supervision is like that thing where we brainstorm about clients; do you guys do that in your morning meeting?

Ross: No that is different.

Jo: We do group supervision with external supervisors and you guys do one on one and we do group.

Cindy: One on one is better.

Jo: One on one is awesome because you can have the time to focus on yourself. You can have what you want to achieve and you have that support that is unequivocal whatever happens in your week or month or whatever it is wherever the group is completely dependent on what other team members are going to be there and it is completely dependent on that.

Ross: And the time for discussing, it doesn't happen.

Cindy: Yep it is not the same freedom.

Jo: I think that when you asked what inspires us, well part of it is having a good team leader and good colleagues is really cool.

Ross: Yes, the whole team working together and accepting each other and supporting, that is the important aspect of our work very, very important.

Jo: We wouldn't be able to do it without our colleagues.

Ross: Because it is not working sometimes some staff not supporting us especially with peer support and the community because different staff come and go. The salary is a very important factor that we can look forward to, where are we going from there. Financial constraints and then giving up your time, you can't do that type of stress, having a family plus work, not possible.
Cindy: I don't know where else there is to go at the end of that bracket in terms of career changes, like do you guys see yourself in this role in 10 years?

Jo: No.

Cindy: I would hope not. Yeah 10 years is a long time.

Jo: I mean would you see yourself in a team leader position is that something you would?

Cindy: Not at the moment, I couldn't imagine doing what my team leader does.

Jo: So many changes in mental health, in the whole system itself. The models that we work with are like 10 or 20 years ago, so something has to change.

Cindy: Yes we are recovery focused but there is more than just recovery and we get clients coming through with no accommodation so the pressure is there to find accommodation and because of discrimination out there in the community, we cannot find accommodation.

Andrea: And drugs and alcohol is going up so we are dealing with a lot of that at the moment in our services.

Jo: Benefits.

Cindy: And the financial pressure with our clients.

Andrea: A lot of them are unemployed.

Cindy: So it is not an easy role that we do, we just do it for the love of it.

SUPPORTING THE SUPPORTERS

The mental health support workers and the peer support worker in this group explored how they see their roles in the future and what the impediments are to this future. Here they discuss the different practices that support them in their roles. The conversation they had was to examine the virtues of group or one-on-one supervision. Supervision in mental health plays an important part in keeping staff emotionally, culturally and clinically safe. Supervision in this context is within the role development paradigm, this being distinct from line management supervision. In this conversation, the peer support worker (Andrea) advises that she has one-to-one supervision, whereas the mental health support workers advise they have group supervision. Andrea explains the value she gains from the one-to-one supervision. This enables her to focus on her issues, which the mental health support workers suggest is not possible within group supervision. In this conversation the mental health support workers verbalise that the things that happen in their day-to-day work are as

pressured as those experienced by the peer support worker; however, they are not provided with the opportunity to discuss these things in a way that suits the individual rather than the organisation.

A study undertaken by Dawson, Phillips, and Leggat (2013) investigated clinical supervision for allied health and found that there was no evidence to suggest that one-to-one supervision was better than group supervision; however, the lack of studies in the area of clinical supervision for allied health means that this is still an underdeveloped area of research. Other findings that arose from this study were the confusion over the terminology i.e. 'clinical supervision' and 'professional supervision'. A position paper by Te Pou (2013) suggests that there is no one clear definition of supervision, but that it involves reflection, feedback and guidance relating to work practice. Te Pou (2013) also found that supervision is also seen as a way to foster good relationships between employer and employee. The report identifies several types of ways that supervision can be undertaken including peer, one-to-one and group supervision. The report also identified five types of supervision: management or line supervision, direction (of work), professional supervision, clinical supervision and the dimension of cultural supervision. The report also stated that there were no substantive differences found between the outcomes between group supervision and one-to-one supervision, concluding that "support worker access to and engagement in regular supervision has a key role to play in improving the utilisation of the growing support work" (Te Pou, 2013, p. 14).

The split between what is provided for the support workers and what is provided for the peer support workers has the potential to create a rift in their relationship, as one type of supervision is perceived to be better. The mental health support workers suggest access to supervision provides an opportunity for the employer to maintain the emotional wellness of their staff. While the literature suggests there is no difference between one-on-one or group supervision, the mental health support workers' perception is that they believe they are not given access to one-on-one which is seen by some as better. In a close working relationship where person-to-person interactions are important, this division between different occupational groups based on perception rather than evidence is not productive. If employers were able to provide choices for mental health support workers and peer support

workers or to provide them with the evidence that either type of supervision is just as effective, the power of having this information may in itself be sufficient to address this issue. While this may seem like a small matter to raise it highlights some of the previous concerns of mental health support workers where they perceive themselves as the lowest workers in the health hierarchy.

Cindy also questions the nature of the work, i.e. it is a 24-hour seven days a week role. She sees a time when her weekends are able to be enjoyed by her and that there is not the blurring of own time and work time. Some of what she describes is having appropriate employment contracts in place, employers understanding the intense nature of the role and being supported. She describes being frustrated with this type of working environment.

Appropriate supervision is accessible to all mental health support workers

CAREER ASPIRATIONS

The group discussed the mystery of the role of team leader, with the mental health support workers not wanting to step into this role in part because they know what it entails but also as because it is seen as a demanding role. The development of a career pathway for mental health support workers is not evident and, unless managed within organisations, succession planning for management roles is an area that requires consideration and development. In order for mental health support workers to progress their career aspirations, they either need to step into a management role or into another occupation as there is no clearly defined pathway for them.

SUCCESSION PLANNING

During this dialogue, the group discussed the longevity of their roles and used ten years as a marker. Most of the group advised that they did not see themselves in this role in ten years' time. The demographics within this group were very different to the other

participants. Most of this group were under the age of thirty and will be needed for the workforce of the future, as many current mental health support workers are in the 'baby boomer' group and would be seeking to retire in the next five to ten years. The lack of robust workforce data for mental health services makes planning difficult. Te Pou (2014b) identified the need to have better data on supply and demand; forecasting demands has been a challenge. The issue of career and succession planning needs to be considered within workforce planning to ensure that the right people are in the right roles, and that the environment is created to develop both the future workforce and leaders of that workforce.

THEORETICAL FRAMEWORK

This group discussed and understood the recovery model; however, they viewed a future that needs to be more than just the recovery model. Their collective view was that the exisiting model of delivery is outdated and that a new way of viewing and delivering mental health services needs to be investigated and invested in. This provides a challenge to the current philosophy of delivery, but also is an opportunity for New Zealand to lead in the mental health services New Zealand could aspire too. This call to review the current philosophy model is once more the opportunity for New Zealand to lead in providing a model of citizenship for people with a mental illness and places mental health support workers as one of the professional groups that can be part of the created future.

STIGMA

The group discussed the barriers for mental health consumers and therefore some other challenges faced by the mental health support workers. Some of the challenges are not new, and relate to the stigma of being a mental health consumer when the policy is about community integration. They talked of consumers still being discriminated against when it comes to areas such as housing. This causes frustration and constrains the mental health support worker's ability to work effectively with consumers in reaching their goals. The group also raised concerns about the financial pressures that consumers are under, which is generally based on the fact that some consumers find it hard to secure employment.

CREATING THE FUTURE THROUGH KNOWING

A career framework is developed for mental health support workers

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Paul is employed as a support worker in an NGO based in Auckland. He is Pasifika and has worked in a wide range of positions within the health and social services areas. He holds a number of qualifications the highest being at degree level, but identifies as a mental health support worker. The interview for Paul took place within a group interview of mental health support workers based in different services in the Auckland region. Most of the people who attended this interview were Pasifika; however, they were from different Pasifika groups. This group also included two non-Pasifika support workers, one of whom was Asian.

> *Being honest with the management team leader and bringing up the issues regularly if they are not changing. If you had the confidence and a good enough relationship to bring it up with the clinical team, just to be honest is the best way to do it because if you don't say anything then nothing is going to change.*
>
> *Our service and what we are going through at the moment. We have always had our client's focus and recovery approach and work collaboratively with the clinical team. But there is just so much – I don't know if it is the same for other NGOs and other CSWs that are working in the field but there is so much that is happening in management and stuff like that.*
>
> *Yes so many changes, especially at the moment for us, that has a huge effect on us that is totally out of our hands, which we kind of are picking up the pieces and maintaining as a service. A lot of it is quite unprofessional, especially the communication that filters down to us. We are unaware of so many changes that occur and yet we are the main people that are affected by it. It's all through management and the changes from there which is fully out of hands which is concerning because it is making us question our role and whether we want to continue doing it when really we should be having a focus on our client's wellbeing and improving their lives. At the same time you have to keep well if you have any chance of assisting them. I don't know if that's mental health over at the DHBs or the other areas of support work, or*

> *whether specific in our area, it is a major concern and it is on-going and it has been for years and probably will be.*

SHARING THE INFORMATION

Paul voices his concerns about the struggle that mental health support workers have in keeping up with the changes. This is in part due to the fact that they do not feel involved or informed nor do they feel that they are part of what those changes will be. For him, it is the knowing. It is about being informed; by being kept informed, they will know and with that knowing comes understanding. Mental health support workers seek to be involved with the future of mental health services, no matter who or which organisation is providing those services. They bring their way of engaging with consumers and their way of knowing consumers to those conversations. As has been noted in the most recent workforce data, mental health support workers are now a workforce the size of registered nurses working in mental health. DHBs and NGOs need to engage with mental health support workers and involve them in proposed service changes at a service planning and policy level. To disregard them makes the mental health support workers question their organisational value.

Mental health support workers see some of the future needs being achieved through their employers engaging with them and having them as part of that future planning.

BRINGING ABOUT CHANGE

Paul has hesitancy in raising issues with his team leader. However, he believes that by raising issues that this will itself help to bring about change. With hesitation he suggests that it requires confidence and a good working relationship with the team leader and the clinical team to be able to bring up issues. Throughout this study, the relationship with the clinical team and management has been viewed as critical by the mental health support workers.

THE LIFE BALLAST

Paul sees one of the roles of mental health support workers is to maintain a level of services while the services themselves undergo change and to be a constant in people's lives. This

ballast enables the mental health support worker to create evenness in the lives of mental health consumers.

The ballast is also about mental health support workers keeping themselves well in order to ensure that consumers can remain well. This challenges mental health support workers as they described a sense of being disempowered by not being considered when changes that affect their role are being considered without their involvement.

In order for mental health support workers to provide ballast within the lives of consumers, they need to be able to keep themselves well while they work.

Education and training for health managers

CREATING THE FUTURE THROUGH VALUING THE WHOLE

Andrea is employed as a mental health support worker by a large, well established NGO situated in Auckland. She took part in a group interview which was comprised of one peer support worker and three mental health support workers.

> *I think mental health is such a controversial issue so horrendously in the past and psychiatrists versus actual care, the way treatment happens. Medical model, I don't when it is going to get overturned but it has to be. Slowly, but there are very defined roles and with my particular role it is very obvious to me that the roles that psychiatrists and clinical team play and that their interest in a client only goes so far. "Are you taking your medication?" "Are you getting worse or on the same level"? Awesome. "What else, are you getting a job"? So that's the rest of it. So the potential for support workers to provide a much more holistic sense of intervention I think with adequate training and resources, we could be providing that kind of level wellbeing in general with families are a huge aspect of it, just having that support, friends things like that. Most of the clients I work with have no friends, their families are often not involved with their lives and if they are this is not always positively, so it is about being able to have the adequate resource and training and be able to really help them in the real sense of recovery. We have that potential.*
>
> *We have tried to access more resources in terms of different models, not just the strength model. But because of the funding, we are so constricted*

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by funding, we just cannot and it is a bit tricky. So I think we tried to get a Māori model, Te Whare Tapu Wha[27], but it was going to cost too much to put in place so it didn't happen. That is the frustrating aspect. There are good ideas with New Zealand mental health the way they argued its place is that it is more cost effective in the community. As a whole from a Government point of view apparently it is not cost effective. But when you work in this industry and you realize that your work your job is completely defined by the funding, even though we work for an NGO, a non-government organization, it is completely down to the funding.

I have recently met someone who has worked for an NGO in Australia in a very small region and they were telling me that you can work better with clients. They had an amazing CEO [Chief Executive Officer]just came in with a real vision and just said, "to hell with funding for six months, let's give ourselves six months and let's redefine the way we work with people" and they got to the point where they were providing a service that was so economical, people were going off to achieve their life dreams, travelling the world, going back to university, getting the dream jobs, getting the best case scenario for their goals. So it is that kind of attitude shift which I again find a little bit frustrating. Because like you say there are the resources right there, but when we try and get involved, it's like "we don't have enough money".

REVIEWING THE CURRENT MODEL

Andrea's dialogue is similar to that of a number of mental health support workers; they question the current policy environment in which services must operate. Her view is that the current model is primarily driven from a financial economic model, which she suggests is not the best approach. While concerned about the economics within health, she does acknowledge that there are still opportunities. Andrea described a situation about a CEO in Australia as challenging the status quo in order to bring about change. She suggests that the time to challenge the current model is now, and what is actually needed should be considered rather than being fiscally driven.

Andrea introduces the view that people within the service that she is employed attempted to look at an alternative model, Te Whare Tapa Wha; however, this did not progress as it was considered too expensive. Andrea is suggesting that a new way of approaching service delivery needs to happen. New Zealand made a quantum shift when large psychiatric hospitals were closed, with services and consumers moved into the community and a

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[27] A model of Māori healthcare

recovery and strength-based philosophy driving service development; Andrea believes New Zealand can be at the forefront in providing that future-focused model again.

BEING THE PARADIGM SHIFT

Andrea wishes to acknowledge the advances that have been made in mental health services in New Zealand, but she does question the current model, which she sees as a medical model. She is posing a question about a model where the mental health consumer is placed in the middle. For her, a significant part of the future lies in mental health support workers being able to provide a more holistic non-medical model. This way forward would seek to de-medicalise services by uncoupling that which is medical and that which is support. Andrea sees mental health support workers as the way to achieve the required change "we have that potential". Andrea acknowledges that consumer's medication is important; she believes that discussion with the consumer about what is going on in their life is just as important. She believes that the role of the mental health support worker could be expanded if they were provided with the appropriate education and training. She recognises that support workers are part of the key to the future of mental health services.

Developing positive internal and external relationships

LEGITIMACY OF CITIZENSHIP

Dianna is a family advisor with a DHB in the greater Auckland region.

> *A lot of the clinical teams, they do not have hope in recovery ways of thinking and their language and what they write. My sister got a letter from her doctor her psychiatrist and it said "prevalent treatment". You know come on, we might live with mental illness but we have intelligence. My sister got really disheartened and was like "wow". We weren't born into this world taking medication; I certainly don't want to be leaving this world on medication. Where is the hope from the clinicians? Can't just have hope from us, the human face, there has to be hope on all levels. So do you want recovery from your clinical team, we want to hear it in the review of being supported and the language of the clinicians, there is the standard "have you eaten, have you been sleeping, blah blah blah" and*

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we understand that it's all a matter of process, but there is more to use than those questions that they ask all the time.

Dianna also questions the current model of mental health care and suggests that the future has to be more than a focus on medication. Dianna interprets the language of the clinical teams as not being the language which gives people hope. She wants the treating teams to see past the illness to the person and to ensure that person is given the rights of citizenship. Dianna suggests that the model of care has to be created and based on the aspirational future, which needs to encompass the whole team including consumers. She also describes the mental health consumers' rights to citizenship and her view is that can be in part reached by the way that mental health support workers place a different value on the lives of mental health consumers. She suggests that they value the total life of the consumer, rather than the process of questioning in order to illicit a response. Her view supported by other participants, is that in order for the consumer to seek hope and therefore recovery, there is a need to engage and understand the consumer as a legitimate citizen and not just as a form that is required to be filled in. She challenges all of those involved with treatment to speak the language of hope, not a lifetime of disappointment through being disheartened.

Vandekinderen, Roets, Roose, and Van Hove (2012) suggest that the use of economics to drive service philosophy "turns social policy into an instrument for rationing services into risk assessment rather than furnishing better care and support, due to scarce resources that are covered under the veil of autonomy, choice, and empowerment" (p. 4). The question of citizenship for mental health consumers pushes the boundaries beyond those of just strength and recovery; it seeks to provide rights that enable mental health consumers to participate as equals within our society. Again Dianna asks that clinicians look past the illness and see the person.

Aspirational services will be based on citizenship

SUPPORTED THROUGH THE CHANGES

Jordan is employed as a mental health support worker by a DHB in the greater Auckland area. Jordan begins his conversation with advising of his appreciation that he has been

given this opportunity to speak through this study about his role. Jordan has a passion for the work he does and this study provides the opportunity for others to understand the work he undertakes and he sees it as more than just a job.

> *This is something that I have really appreciated that we could do with you. Just even for management to ask us those questions. To get that insight and potentially hear our passion about the work that we do. We are not just doing it because it is a job, it is actually almost like a way of life, you have to believe in what you learnt. If you want to pass that on to someone else to get that strength to make that difference and it is about maintaining the relationships with their family and tangata whaiora [mental health consumer].*

> *We have monthly business meetings and we also have separate CSW [community support worker] meetings where we can speak with management, so there is opportunity, but sometimes it is overlooked. I have faced a lot of challenges with the clinical side through them abusing my role as a CSW. They will call on me, maybe it is my age or the CSW role, but they will just see us as taxi drivers. For example we run a weekly touch group where we will go around and pick up 20-30 clients with from other services and then our clinical team, key workers, they just come with their cup of coffee and have their fortnightly contact with about six of their clients which they haven't helped transport to the group or other area, that kind of stuff like that between CSWs and the clinical team. It should be addressed.*

> *I guess the NGO I work for at the moment you get referrals from DHBs. We also get self-referrals and GP [general practitioner] referrals but that is all about to change and it was meant to change beginning of July but it has been put off and then we are only going to get contracts from community mental health and we are only going to be supporting the top 3% of people with mental health issues. So my concern is what is going to happen to all the rest? Is there a role for support workers in PHOs [primary health organisations]? And I keep looking on their website and seeing what supports they offer, but once again they only seem to want registered health professionals and they are training up nurses and GPs to work with people with mental health issues. I don't think they are the right people for the job.*

BEING PART OF THE CHANGES

Jordan is able to articulate the relationships that he has with consumers and speaks in a positive manner about the differences he makes. He speaks about the changes he would like to see come about from within the structures in which he operates. He raises concerns about

the structural changes and that he, as a support worker, has not been involved in the changes. He also questions the increasing threshold for consumers to access services and asks what is going to happen to those who do not meet the threshold when it rises.

Jordan does not feel respected by his colleagues within the health sector; in fact, he verbalises that he feels abused. He is not able to determine if this abuse is based on his age (mid-twenties) or because he has the role of mental health support worker. He also feels that members of the clinical team use the gathering of the consumers as a way of ensuring they meet their required contacts. Jordan raises the ethics of this type of practice as it is the mental health support workers who have initiated this activity which he believes is being abused by the key workers.[28]

RIGHT PERSON FOR THE RIGHT JOB

Jordan questions the movement towards training current nurses and doctors to undertake the role that is occupied by mental health support workers. He questions why another group of health workers are being trained to undertake these roles when there is already a trained workforce in the form of mental health support workers. For them, this is a career option and needs to be undertaken by support workers, not by other health professionals. Benner (1997) discusses the 'practice environment' within nursing practice; however, what she describes can equally be applied within the practice community of the mental health support workers. Benner argues that the practice of nursing is more than mere tasks and that pivotal to the patient-nurse relationship is the level of engagement within that caring relationship (p. 50). Mental health support workers through this study have begun to define what caring means to them in terms of the relationship they have with mental health consumers and the nature of that relationship.

Recognise the differences between support work and other types of workers in mental health

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[28] The terms 'key worker' and 'case manager' are interchangeable and generally refer to the member of the clinical team responsible for the consumer's management.

CREATING THE FUTURE BUT NOT THROUGH LEGISLATION

George is employed by an NGO in a residential service as a mental health support worker.

> *It is our management that is a huge problem with us. They don't completely understand what I do and what we do, although they tell us what to do. Probably the problem that we have is the clients on a pedestal not the staff and it doesn't matter what business or industry you are in, your staff are your most important asset. In the 18 months I have been there the only time that I was ever thanked that I can remember for doing anything – "now that's a good job, well done". Even more recently they have been saying "these clients are much better and they have calmed down a lot more than they were before". They say the exact opposite. They say "we will do all the farming out from now on", so they have actually almost taken it away from us it is a bit destroying in many ways, then I think, yeah go for it. They just don't realise that the staff are the most people in the system, the only thing I stand for.*

> *So I think the clinical disciplines about having unions and forums they can go some way to address the issues, start that for support workers, otherwise it is not really going to be addressed.*

THE WORKER MANAGEMENT NEXUS

As others have discussed, a way needs to be found in which mental health support workers can be heard by management. George suggests that change cannot happen if the mental health support workers are not heard. Furthermore, those changes that are happening within the sector may not come to the attention of management, as it takes a degree of confidence on the part of the mental health support worker to raise matters with either their management or another service's management. While the focus of this study has been on the mental health support worker, it is evident that managers within many of these health services do not have the education and training required to manage. Mental health support workers have made a continual plea to be heard and involved with the services. This group of workers generally does not have the power, due to where they sit within the health hierarchy; however, the qualities and closeness with mental health consumers creates an untapped source of power.

Like a number of other mental health support workers, George is advocating for some type of professional identity similar to what other disciplines in the clinical environment have in place. It is still debated as to what is required for mental health support workers professionalisation through regulation or legislation. Tudor (2013) provides a cautionary note about what he calls statutory regulation. Instead he asks health professionals to consider: "moves towards professional recognition through statutory regulation appear largely based on a reaction to what certain other professions are doing, and as the result of an invidious domino effect whereby disciplines such as psychotherapy argue for such recognition" (p. 47). This resonates with what George is suggesting when he raises the issues of forums and unions.

A number of mental health support workers raised the issue of being seen as professional. Many of them saw the way to gain professionalism through either self-regulation or imposed regulation. They spoke about previous attempts to set up a professional body but, that these had failed.

Health workforce New Zealand fund the startup of a professional association
Service contracts require mental health support workers to be part of a professional body

SUMMARY

Mental health support workers provide a unique role within mental health services. In order for their true potential to be realised, they want and need to be involved in service planning and (just as importantly) involved and informed about service delivery. It is the view of mental health support workers that mental health services need to strive for aspirational services rather than being content with mediocrity. These aspirational services need to be based on realness and not on buzz words. In order to meet these aspirations there is the need to break down real and perceived barriers in order to view what is legitimate citizenship for consumers.

Managers of mental health services need to recognise and understand their own roles and how these can be enhanced so that they are better prepared to work alongside the mental health support workers. While the emphasis of this study has been on the mental health support worker, it has become clear that managers are critical to the success of the utilisation of this workforce.

There is a need to seek greater clarity about the role of mental health support workers by defining that role, which could be achieved through a national job description and a collective contract. In order to redefine the role of the mental health support worker it will be necessary to more clearly define the roles of others within mental health services including peer support workers, family workers, nurses, social workers and occupational therapists. This redefining of roles will enable a scope of practise to be determined for mental health support workers.

The development of a national professional body would require a code of practice and a code of ethics. Practices such as supervision for all support workers would be required. If an accepted scope of practice was developed, this may ameliorate the consideration for the direction and delegation issue associated with healthcare assistants.

The development and evolution of the mental health support worker role cannot be left to chance. Instead this role and its value to mental health service in New Zealand needs to be managed in order to make the identified gains.

The mental health support worker's role is not about just 'fixing' for mental health consumers; rather they provide a means by which the consumer is able to build resilience to cope with life changes through creating the environment of the life ballast. The possible future for mental health support work is set out in Figure 14.

Figure 14: Destiny: The possible future

- Review the current services
- Create an aspirational service framework
- Recognise the difference between support work and other workers in mental health

Creating a different future

Professional workforce

- Succession planning
- Code of ethics
- Career framework
- Education and training for manager

- Develop positive internal and external relationships
- Deconstruct professional boundaries

Relationships

CHAPTER TWELVE: DISCUSSION

The future looks bright for support workers of which I am proud to be one in what has been and still is an amazing journey (Elliot & Alderson, 2008, p. 5)

INTRODUCTION

This study has explored the profession of mental health support work, the workers who deliver these services and their contribution to the New Zealand mental health environment. The study involved interviewing mental health support workers, educators, other health professionals, mental health managers and mental health consumers in a process that gathered, listened to and interpreted meaning from stories.

The literature indicates that New Zealand was one of the first countries to formalise and provide education for the mental health support worker role, followed by England in early 2001 (Hickey et al., 2010). New Zealand's mental health services have been described as innovative and future focused. This study provides mental health support workers with opportunities to explore the future potential for their role including involvement in redesigning services; determining how those services could delivered; and being part of the continual evolution of mental health services.

The most revealing aspect of the mental health support worker's role is the relationship that they have with mental health consumers. This relationship is built up over time and displays qualities distinctive from other professionals. These qualities offer a unique form of support and care, which is highly valued by consumers.

Despite this, the attributes, traits and qualities associated with mental health support workers have largely remained in the shadows until uncovered through this study. These could be utilised in a range of ways to improve services. The identified areas are informing services development, involvement in staff recruitment, and guiding ways in which services can support and grow staff capability. These traits need to be

looked at by educators and employers when recruiting people into the field of mental health support work.

This chapter begins with an overview of the key findings that emerged across the four cycles of Appreciative Inquiry including the use of Dissonance. The aspirations for the future of mental health support work discussed in Chapter 11 emerge and are distilled along with information from the preceding chapters to create an aspirational blueprint for mental health support work.

Common ideas that have been identified throughout this study have been stylised to create a blueprint for an aspirational service framework (Figure 18). Figure 15 takes the ideas that emerged from the stories told by the participants and utilises the 4-D cycle to identify the key requirements for creating an aspirational framework for mental health services in New Zealand. The stories about mental health support workers being part of a profession and being professional were gathered together and represented in Figure 16. The industrial requirements set out in Figure 17, seeks to ensure national consistency of employment practices. The symbolism depicted is that of common ideas being distilled through a funnel to provide a blueprint for an aspirational future for mental health support workers (Figure 18).

The organisations and groups that I see as being able to implement the recommendations arising from this study are identified. I then present a case for an adaptation of the 4-D model as a means to embrace the Dissonance. The limitations of this study are examined, with areas for further research discussed. I conclude with reflections on my own learning gained through listening to participants.

OVERVIEW OF FINDINGS

Since the introduction of the mental health support worker role and the increase in the numbers now employed in this role, very little attention has been paid to the work that they do.

Stories from participants revealed that the most striking contribution that mental health support workers make is the nature of that relationship that they have with mental health consumers. This is a unique relationship, built up over time and displaying qualities that are different from other professionals in the mental health sector. It seems that being on-the-ground alongside the people they work with, being flexible, and offering their own unique personal characteristics to the relationship (i.e. they become real people known by more than their name) offers a different type of healthcare and support.

The mental health support worker comes to know the client in their own home, and social context, they discern the consumer's aspirational hopes and they listen to their fears. The relationship with consumers is time intensive, and provides care and support. It affords a non-judgmental and non-clinical way of working. Because the mental health support worker is free from formal assessment and treatment responsibilities, they are able to engage at a level that engenders trust and openness with consumers. Paradoxically it seems that the very characteristics that professionalise a role with regulated health professionals may be the barrier preventing the 'knowing of others' within the relationship. I suggest that it is the authentic relationship that fosters possibilities for recovery. In order to have potency within that relationship, the study has revealed that it is important that the right mental health consumer is matched to the right support worker, the chemistry of the relationship matters. Elliot and Alderson (2008) suggest that the "key to support work is knowledge of self and the community and that knowledge fuels our passion" (Elliot & Alderson, 2008, p. 4).

Having argued that the role of the mental health support worker is both unique and of value, this chapter offers a blueprint for an aspirational future to preserve, strengthen and grow mental health support workers and their practice. The discussion that follows takes each of the three threads (Aspirational Services, Professionalism and Employment Practices) and demonstrates in a diagrammatic way, showing how the threads that emerged through the Discovery, Dream and Design phase of the study are brought together. A discussion of these key threads is then offered.

The four phases of the AI cycle were used throughout this study. The Discovery phase created an environment that encouraged participants to tell stories of their peak experiences. In the Dream phase, mental health support workers and others spoke about 'discovered potentials' and what it is that mental health support workers do that brings a different perspective to that role.

Common ideas from the Discovery and Dream phases were further developed through the provocative statements captured in the Design phase into the Destiny goals. The stories and ideas provide a blueprint for a plan to create the aspirational future expressed throughout this study. The blueprint provides the basis on which to design a realistic means for reviewing the current model of service development and delivery, including the role and employment practices around mental health support work. This diagram creates a template to action the findings and recommendations from this study.

This study found that there is a need for greater scrutiny of the requirements of the workforce when undertaking service planning and reconfiguration. Mental health services are people orientated and therefore highly dependent on having a well-trained and educated workforce in order to be able to deliver responsive, future focused services.

ASPIRATIONAL SERVICE FRAMEWORK

Through their stories, participants articulated that there was a need for change to the current service framework. They put forward a view that mental health support workers are in a position to be able to make a positive contribution to a review of the current service model and to be actively involved in a new service design and the implementation of that design based on their experiences.

Figure 15: Creating the aspirational service framework
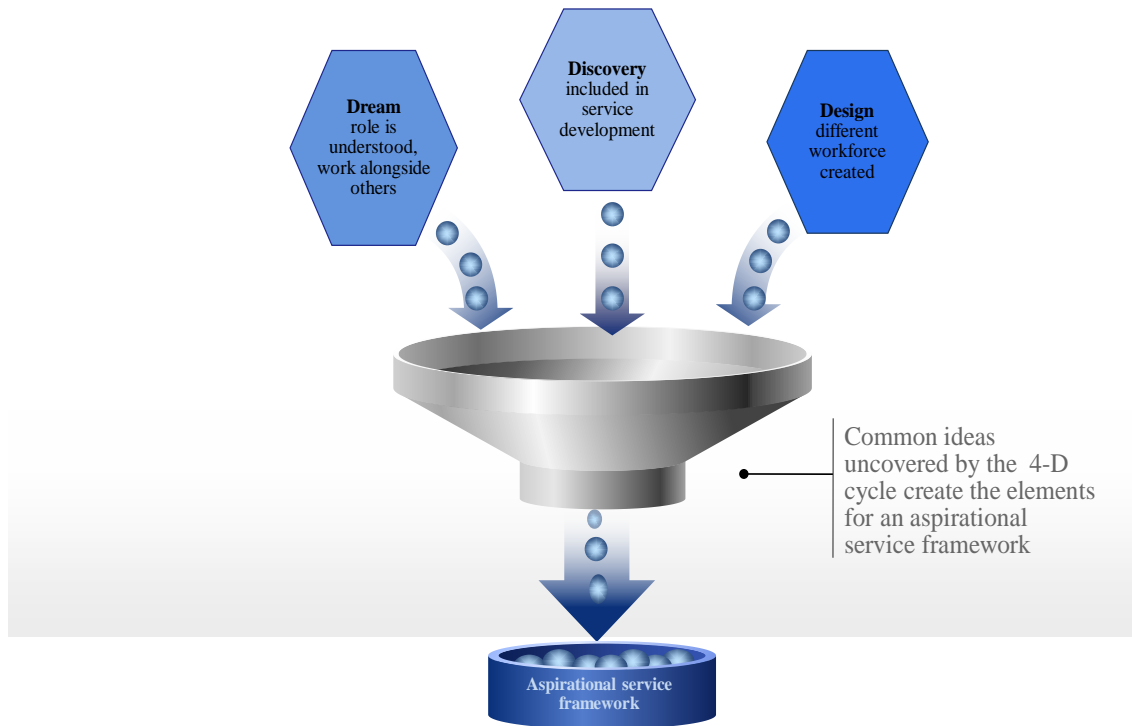
Mental health support workers participating in this study posed challenges to the current policy and service development paradigm, suggesting that the philosophy that underpins service delivery needs addressing to make it more responsive to the needs of mental health consumers. They suggest that the current model is outdated and that insufficient attention has been paid to mental health services for the past 10 to 15 years. Mental health support workers have developed a body of knowledge that can be used to inform service design and create service change, enabling New Zealand to once again position itself as an international leader for mental health services.

The view of metal health support workers is that they are critical to any service changes. As many aspects about their role are not understood, how they could undertake a greater role within a service reconfiguration has not been considered. It is their view that their relationship with mental health consumers is different from

that of other health professionals and it is this difference that needs consideration for service design.

Mental health support workers spoke not only about the different areas that they were employed in (such as community services, acute inpatients, rehabilitation and forensics) but also about the different areas of support, including family support, cultural support and peer support. The evaluations of the National Certificate in Mental Health (Mental Health Support Work) undertaken by Rangiaho (2003) and Annadale and Instone (2004) added to knowledge about support work and assisted with gaining a better understanding from a cultural perceptive about the work that mental health support workers do. While earlier policies emphasised the need for culturally appropriate services, there is no recent research available; however, this study also provides new information about the cultural context of mental health support workers. There continues to be a need for an increased focus on services provided for Māori and Pasifika by mental health support workers; this is supported by the numbers of these groups accessing mental health services. Māori health workers spoke about Kāupapa Māori services and how the emphasis is on whānau ora[29]; this is a model of care and support that could be applied to services other than Māori services and provides the framework for a new delivery model. The emphasis on whānau ora may be one of the keys that unlocks the current delivery model and encourages New Zealand uniqueness of mental health service delivery.

MENTAL HEALTH SUPPORT WORKERS' CONTRIBUTION TO SERVICE DEVELOPMENT

Mental health support workers have sought, through this study, to be more involved with service planning and service development at both a local level and national level. They believe that their role is different from that of other health professionals. This difference provides an important perspective that needs to be considered and included when service or policy changes are being undertaken, as by the very nature of their role they bring another dimension to service provision.

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[29] Māori term for wider family

There remains a lack of clarity across the mental health sector about the role of mental health support workers, including a lack of a clear understanding of the parameters of the role. Mental health services' policies continue to advocate for services to operate with a multi-disciplinary team model. The mental health support workers suggest that this does not happen; they and their contributions are often omitted, or overlooked and their impact is thus invisible. The role of a mental health support worker is there to complement the roles of other health professionals, not to compete with them. Health team members need to understand and appreciate other roles in the team, especially the roles and functions of the mental health support worker.

The current environment has the need for fiscal constraints; however, there is still the need to deliver services that are responsive to mental health consumers. The constraint on health resources could in part be addressed through greater acceptance and involvement of the mental health support worker in the consumer's recovery. as this would free up time for other health workers to undertake roles that mental health support workers are not trained or educated to undertake. The mental health support worker has to be considered when treatment and care decisions are being made; to not do so could be to the determent of the consumer's recovery. Mental health support workers are better positioned to understand what is going on with consumers than other professionals who meet the consumer on an ad hoc basis.

When opportunities are created, mental health support workers have the ability to generate greater aspirational futures for mental health consumers. This ability relates to the way they practice and the expansive nature of their current role. This is due to the role having fewer restrictions and constraints, due to its limited regulations. The professional boundaries that exist within health provide a 'safe' way of working, but do not fully appreciate the nature of the human-to-human relationship that gives the consumer a sense of belonging being respected and being valued. Being part of 'something' through the mental health support worker, whether it is a family or a constructed whānau can provide the life ballast for the mental health consumer.

As previously discussed in this study, mental health support workers were established as a result of the deinstitutionalisation of mental health services that occurred in New Zealand at the start of the 1970s and escalated in the 1990s. The introduction of the National Certificate and Diploma for mental health support workers provided formal education, part of the fabric required to develop this group as a profession. The development of the mental health support worker role was a response to the need to have a different type of health worker, and to ensure that the worker was equipped with skills for the new environment. Their qualification prepares them to work in a recovery, strength-based way with consumers.

The nationally recognised qualification that can be gained in mental health support work provides workers with an accepted pathway for entry into the field of mental health support work. Many mental health support workers spoke about the National Certificate being the minimum criterion for employment as a mental health support worker. This provides an aspect of what is required to be considered a professional and to be able to self-regulate.

If what has been described was to be adopted as part of policy and employment, the question of professionalism of the mental health support worker would be addressed. Mental health support workers would be able to take their place alongside other professionals in the health sector with a body of knowledge that relates to their profession. They would gain the mana they spoke about needing in order to have their input considered along with other health professionals involved in the support and care of mental health consumers. This would enable mental health support workers to be added to the total workforce of mental health services, rather than sometimes being considered. The qualities inherent to mental health support workers, together with their educational preparation, enable them to work in a recovery, strength-based way that is sought and valued by consumers.

Working alongside colleagues

Interprofessional collaborative practice within the health and social service sector is described by Nancarrow and Borthwick (2005) as both interdisciplinary and intradisciplinary, suggesting the need for expansion of the role of the discipline being examined but also expanding the roles of other disciplines. This requires an environment where interprofessional practice or 'working alongside colleagues' is a natural evolution of the role of the mental health support worker. A study by Kinnair, Anderson, and Thorpe (2012) demonstrated the value of introducing interprofessional education into the curriculum for mental health nursing students and ultimately how this improves the outcome for mental health consumers. This transfer of knowledge across disciplines could be introduced into the curriculum of all health professionals, as the ultimate outcome is to improve services to consumers.

Mental health support workers spoke of their variable relationships with the clinical team. They suggested this variability was due primarily to the other health professionals not understanding their role. If not addressed, this lack of understanding will continue to put up unnecessary barriers in an area of health that is under serviced and under resourced.

Mental health support workers suggest that their knowledge of the consumer in settings other than clinical settings would help to inform the clinical team. Exclusion of the mental health support worker from the multi-disciplinary team does not provide the clinical team with the holistic information about mental health consumers required for ensuring appropriate treatments and interventions are prescribed and decisions are made.

Mental health support workers have the time to spend with the consumer; the interactions that occur during that time are important as they bring another dimension to the total health care and support being provided. This aspect of their role enables mental health support workers to be the 'eyes' and 'ears' for the clinical team. To maximise this benefit, mental health support workers need to be seen as integral to the services provided to mental health consumers not separate and ignored.

Mental health support workers create 'space' through the use of time. They bring support mechanism to the relationship with consumers, which enable them to manage the provision of unconditional care. This type of close relationship places a high emotional demand on the worker, particularly as it frequently operates in the consumer's environment. This type of relationship is favoured by mental health consumers and is not only founded on the traits that consumers value but also relates to the longevity of the relationship; which can endure over years not months. Mental health support workers spoke about the opportunities they create for consumers so that their hopes for the future could be realised. They spoke of the importance to have support from their managers and other service providers, and of the need for their employers to provide them with supervision in order to assist them with the emotional burden they carry.

PROFESSIONALISM

As discussed in Chapter Three, legislation is in place in New Zealand that determines the scopes of practice that are regulated under the Health Practitioners Competence Assurance (HPCA) Act (2003). For those areas of health that are not under this Act, there is the ability for groups of practitioners to self-regulate. An example provided was that of the Addictions sector. This group of practitioners self-regulates by way of their professional association, the Addiction Practitioners' Association, Aotearoa-New Zealand (Dapaanz). Another means of ensuring current and on-going competency is through the use of certification or credentialing as discussed in Chapter Four. Professionalism and being professional has been noted throughout this study as something that is important to mental health support workers and to the public of New Zealand. In order to achieve professionalism, there are a number of aspects that need to be considered. These are discussed below.

REVISITING REGULATION AND LEGISLATION

Mental health support workers are often referred to as an unregulated workforce; however, as previously discussed there does exist legislation to provide public

protection. However, the mental health support worker's practice is highly dependent upon their role being regulated through employment policies and procedures; these are different to professional regulations. Many of the participants throughout this study, including mental health support workers, spoke of the need to be either regulated or self-regulating.

Prior to commencing this study my view was that mental health support work required more than just self-regulation; due to the nature of their role, they should be required to have their practise legislated. However, my view changed as I listened to and heard what it was that mental health support workers, do. That shift was based on the restrictions that the (HPCA) Act (2003) could have on the role of mental health support workers. It is my opinion that if mental health support workers were to be regulated under an act such as the HPCA Act (2003), much of the work that mental health support workers do would be lost as a result of the restrictions within that regulatory framework. I would argue that this loss would be greater than any gains that might be made through legislating their practice; this type of regulation would restrict their role, rather than enhancing it. After careful consideration, I recommend this group of health worker should, with support, be a self-regulating professional group. Psychotherapists sought to have their scope of practice included under the HPCA Act (2003). In doing so, they found it not to be the holy grail they believed it to be as described by Tudor (2013). The legislative regulation could have the potential of restricting the practice of mental health support workers; however, through self-regulation, the public of New Zealand, service users and other health professionals can have confidence in the professionalism of mental health support workers.

PROFESSIONALISATION OF THE MENTAL HEALTH SUPPORT WORKER

Within the context of the Shadow, this study examined the issue of self-regulation or imposed legislation. The legitimacy of the support workers' professionalism was questioned through the lack of professional regulation/legislation environment in which they operate. Participants in this study agreed that there was the need to both professionalise and regulate this health worker role. With the spread of mental health

workers across vast geographical regions the development of a national organisation for mental health support workers has been difficult to achieve despite a number of attempts.

It is my view that there is a role for Health Workforce New Zealand (HWNZ) to take leadership in this area and support the development of a national body for mental health support workers similar to that of other self-regulating professionals in the health sector. Mental health support workers have a history around the struggle of attempting to establish such a professional body; they have not been successful with these efforts. Self-regulation and education are the mechanisms that will place support workers on the pathway to professionalisation. Self-regulation has all the components to address areas where practice falls short of the required standard such as a code of practice, code of ethics, and continuing competence requirements. If mental health support workers seek self-regulation, this in itself will assist to address the issues in relation to being accepted by other health professionals.

HWNZ has the ability to fund innovative projects; the development of a professional body for mental health workers should be considered for such funding. Successful projects accessing this funding have been used to develop the professional requirements of other health professionals. For example, HWNZ funded a pilot scheme that developed a competence framework for nurses working in primary health care who had either no or minimal mental health and addiction education in their undergraduate programme or who believed they required updating in this field. The project led to the evaluative report *Mental Health and Addiction Credential in Primary Care* (Te Ao Māramatanga New Zealand College of Mental Health Nurses, 2014).

CAREER FRAMEWORK AND CAREER PROGRESSION

Many occupational groups in the health environment have both the prospect of career progression within their own discipline as well as the ability to progress into health management. For some, the pathway is clear and well defined, whereas for others

(including mental health support workers), there is an absence of an overt career or promotional pathway.

Mental health support workers in this study spoke about wanting career progression. In 2015 this progression only exists within some organisations and there is no clear pathway; therefore a framework for progression needs to be developed in order to make mental health support work a desirable career.

Mental health support workers spoke about the role of team leaders, which for some is a potential career pathway; however, many support workers did not fully understand the role of a team leader. Other support workers spoke of the people they had worked with who went from being a support worker to being a manager. From the conversations, it appeared that these changes happened organically, not through any known or understood career pathway. Mental health support workers saw that opportunities for them to advance in their profession required a career pathway similar to other professions; this would take them another step closer to being a profession.

Mental health support workers agreed that there needed to be an entry level into the field; however, they also aspired to have opportunities created that saw the development of roles such as senior support worker. This would create a pathway that was different from going into management and would allow those who preferred to work directly with consumers to continue to do. With the identified workforce opportunities, it was also acknowledged that training and education needed to be in place to ensure mental health support workers were supported and therefore successful in these expanded roles.

Career, educational and employment pathways need developing; this requires education and health to work together to agree on what a career pathway would entail and put in place the programmes and mechanisms to enable mental health support workers to have career aspirations similar to those enjoyed by other disciplines in the health workforce.

A PROFESSIONAL TITLE

Many of the mental health support workers sought to have a new but consistent title for the work they undertake. They believe that titles are important, they give mana to a role. While there was no one title used by participants in this study, many sought to have a new title that is more reflective of the work they do. Titles tell others about whom we are and what we do, for the mental health support worker this is not clear. Alan, Jane and Anaru spoke throughout this study about having a title that not only reflected the role but also gave it mana. Anaru suggests that a better title would be that of 'kaitiaki'[30].

MAKING THIS A CAREER WHICH IS AN ATTRACTIVE OPTION FOR YOUNG PEOPLE

Concerns were raised in this study about the ageing workforce, not only in terms of replacement but also in terms of succession planning. The report, *Health of the Health Workforce 2013 to 2014* (Ministry of Health, 2014a) identified that "61% of kaiāwhia[31] were aged 45 or older" (p. 13). This compares with 46% of registered nurses over the age of 50 and 38.3% of medical staff over the age of 50 (Ministry of Health, 2014a). No specific information is available on the demographics of mental health support workers; however, there is nothing to suggest that of this subset of the non-regulated workers would be different from other non-regulated health and support workers. It is important that a strategy is developed within a workforce planning framework to make this occupational group attractive, not only to a range of ages but to younger people seeking a career in mental health. There is a need to create an environment within mental health services whereby mental health support work is seen as a long-term career possibility and not just a stepping stone to other careers. Having a strategy in place is important for growing a young workforce and as part of an overall succession planning to sustain this discipline for the future. Figure 16 takes the stories told in this study to create an environment that leads to being a professional and professionalism.

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[30] Māori term for guardianship of knowledge
[31] Non-regulated workers (Ministry of Health, 2014a)

Figure 16: Creating professionalisation of mental health support workers
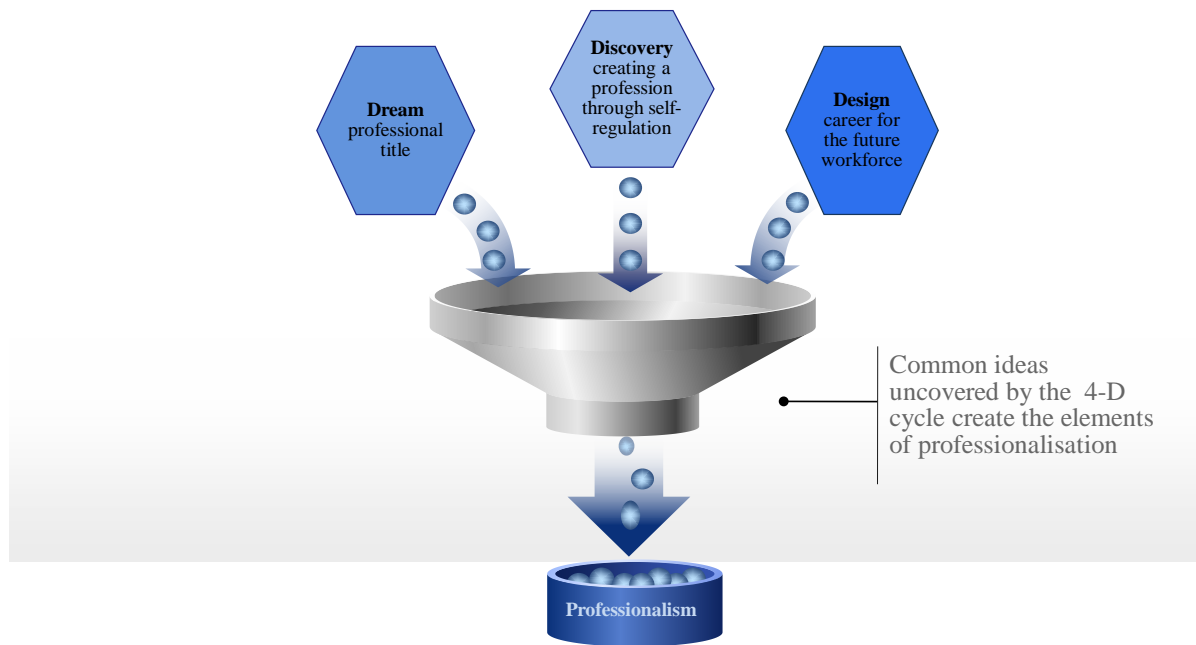
EMPLOYMENT PRACTICES

Many of the mental health support workers in this study spoke of feeling undervalued by not only their employers but also by staff in other services. This view was generally spoken about more within the Non-government organisations (NGO) sector. The sense of being devalued was primarily based on the salary differential between the NGO and the District health Boards (DHB) mental health support workers. Mental health support workers employed by DHBs reported that they received a higher salary than those employed by NGOs. While there was a difference in the salary and overall employment conditions primarily due to employment contracts, the work being undertaken by the mental health support workers was very similar across organisations.

ADEQUATE REMUNERATION

The salary and conditions of employment potentially create a barrier for the development of the work force in the NGO sector, with limited positions within the DHBs. The lack of a national employment agreement and position descriptions is a serious impediment for the development of this critical part of the mental health workforce. Pay disparity creates tension within the mental health sector and creates barriers for mental health support workers entering the field and being employed by NGOs. In order to attract, support and maintain this workforce, there is an urgent need for a national approach to addressing these barriers. If the employment contracts and salary disparities are not addressed, the future of the NGO mental health support worker workforce will be seriously compromised.

ATTENDING TO THE WORKING ENVIRONMENT

Within this study, those mental health support workers employed by DHBs were generally more satisfied with their working environment than those employed by NGOs, with the DHB support workers commenting less on their employment environment than the NGO staff. Many of the mental health support workers expressed concern about their physical environment, which they did not believe to be conducive for their own wellbeing. This has identified another barrier to the continued need to develop the NGO workforce; without this workforce, services such as home-based support and NGO-based residential services will face a critical staffing shortage.

FEELING VALUED

Some mental health support workers spoke about being valued and supported by their organisation; however, this was not universally evident throughout the sector mental health support workers did not generally feel valued by other health professionals. There was a difference expressed between the mental health support workers employed by DHBs and NGOs, although a number of the mental health support workers working in DHBs also expressed that they did not feel valued by their co-workers. Some support workers in NGOs felt supported by their organisation, but this was not translated to remuneration. This creates a Shadow

within the world of mental health support workers. While there was a mixed response from those employed by DHBs, overall they expressed feeling some sense of being valued by other health professionals within their organisation. Staff within the NGO sector also had a mixed response to feeling valued by their organisations; however, like their DHB colleagues, they did not feel valued by other health professionals. When staff within the DHBs gained a better understanding of the role of mental health support workers, this was said to improve the working relationship.

Figure 17 has captured the common ideas told throughout the study about the need for a view on national employment practices for mental health support workers and what the required components are in order to achieve this.

Figure 17: Creating a career for mental health support workers
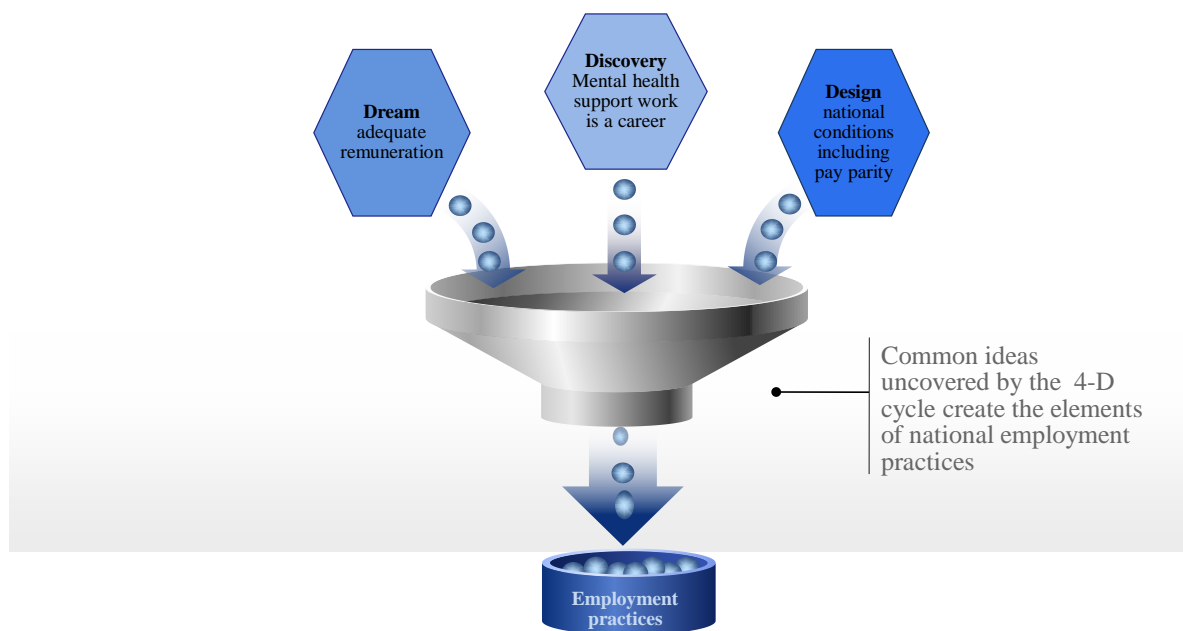
SECTION SUMMARY

Mental health support workers are ready to be part of a new service design. They now have 17 years of experience in delivering support work from which to draw their knowledge to inform a service framework review.

Figure 18: Blueprint to meet the aspirational future

Aspirational services	Professionalism	Employment practices
Mental health support workers actively involved in service planning and delivery	Code of ethics and a developed competency framework	National position description which also considers the personal qualites for mental health support work
Succession planning for mental health support workers - career pathway	Identifying the characteristics for positive support work and support workers	National employment collective agreement
Recognise the differences between support work and other types of work in mental health	Developing postive internal and external relationships	Service contracts require mental health support workers to be a member of a professional body
Inter- and intra-professional education and training for mental health managers and colleagues about the mental health support workers role		A career framework is developed for mental health support workers
		Condusive working enviroment

Their knowledge and understanding about what mental support work is needs to be captured so that an aspirational future for mental health services can be realised. The

way they work with mental health consumers is different from other workers in mental health services. The relationships they build supports recovery in a manner that the medical model approach is unlikely to achieve.

This thesis argues that if the value of the nature of mental health support work is understood by the health service, this will then enable the strategies outlined in Figure 18 to be enacted so that mental health support workers' contribution to the support of mental health consumers is understood, recognised and valued.

TO WHOM RECOMMENDATIONS ARE DIRECTED

FOR POLICY MAKERS

Ministry of Health

The Ministry of Health in New Zealand sets the policy framework for mental health services. Sitting within the Ministry is HWNZ which has responsibility for developing the health workforce. Jointly these two organisations hold the ability to review the current contractual arrangements related to support workers, ensure all services employ qualified support workers and collaborate with the health sector to develop a professional organisation for mental health support workers.

The Ministry of Health also has the ability to assist in facilitation of the development of a professional body for mental health support workers, through HWNZ. The Ministry of Health needs to seek more innovative ways for measuring care than through the current ways of using statistical data. Participants in this study suggest that such information does not reveal the impact of their work nor the nature of the recovery being made by their clients.

For New Zealand to again be seen as a global leader in mental health service provision mental health support workers see themselves as actively contributing to any such review.

New Zealand Qualifications Authority

The New Zealand Qualifications Authority (NZQA), is the government organisation responsible for developing, accrediting and approving national qualifications. Therefore, NZQA is the lead organisation with responsibility for the development of qualifications required by the health sector for mental health support workers.

Those qualifications are being reviewed in 2014-2015 through the national mandatory review of qualification, being led by NZQA. This creates an opportunity for mental health support workers to be part of the qualification redesign.

FOR MENTAL HEALTH SERVICES

Services need to consider reviewing the way that they potentially constrain service delivery and how they can deconstruct the artificial silos that exist between services. Staff should be able to move seamlessly between services with the optimal goal of providing integrated care and support for mental health consumers.

District Health Boards

DHBs continue to be the largest provider of mental health services. While it is understood that many of these services are clinical by nature and are expensive to deliver, the economies of scale enjoyed by DHBs and the compliance requirements for areas such as training create opportunities for DHBs to offer supervision, training and education to mental health support workers.

Mental health support workers also become another group that can be employed in order to meet the requirements for a multi-disciplinary approach to service delivery.

Non-government organisations

Managers of NGOs need to actively engage with DHBs to ensure ease of access to training and education offered through the DHBs. NGO managers need to meet regularly with DHB managers in order to develop the relationships needed for seamless service delivery. By working collectively, NGOs and the DHBs could develop and agree on a national position description for mental health support workers, that identifies the unique characteristics of this role. DHBs and NGOs need to create new ways of working so that the services are consumer centric and staff and consumers move seamlessly between services.

FOR MENTAL HEALTH SUPPORT WORKERS

This study has revealed the characteristics that are unique to the role of mental health support work. The importance of this role has at times been marginalised by this group not being viewed as professional. There are certain characteristics identified that provide the hallmarks for professionalism; these include:

- A professional body

- Code of practice

- Code of ethics

- Mechanism to monitor practice

- Continuing professional education

- Professional supervision (Nancarrow & Borthwick, 2005; O'Brien, 2005; Rogers, 2004).

Mental health support workers need to invest in developing the above if they wish to take their rightful place within the health sector and be seen as credible health professionals. Funding to support the establishment of a professional body needs to be sought from HWNZ's innovation fund. This would enable the requirements for self-regulation and the professionalisation of the mental health support worker workforce to be put in place.

AN APPRECIATIVE INQUIRY APPROACH WILL ASSIST SERVICES TO GROW

For me, the use of AI for this study entailed a journey into the unknown. It meant learning a new way of looking at research a way which does not focus on the problem. This meant continually seeking to find the high points within the conversations, rather than being drawn into seeking out the problems. As the study progressed, so did my sense of the rightness of this approach for this topic. The voyage of discovery and the alignment of AI with what is the current philosophy within the mental health sector created an opportunity to view support work within the context of mental health services. AI is understood as a way of bringing about positive organisational change that allows participants to celebrate and acknowledge what is working well and to articulate future possibilities.

The foundation of AI sits within research that evolved into a way of viewing organisational change. Hennessy and Hughes (2014) suggest the use of AI for research and evaluation for mental health services "is innovative and could provide an approach that is both modern and transformational" (p. 36). The introduction of AI into mental health services as a vehicle for service improvement and development

could create a new way of viewing mental health services and reducing the defensiveness that provides barriers to transformation. If adopted as a way of viewing mental health services and the role of the staff within those services, applying the appreciative prism would allow the richness within services to be better understood.

An AI approach for this study created an environment whereby the participants were provided with the opportunity to celebrate what is working well within mental health support work. AI created the space for participants to see beyond the problems and instead enabled them to focus on a vision for the future. The understanding of the potential of AI for mental health has only been touched on in terms of this study; the future horizons would only be limited by the limitations of our thoughts. The evaluative aspects of AI could be used to strengthen the current philosophies of recovery and strength-based services approaches.

ADAPTATION OF THE 4-D CYCLE

This study has used an adapted AI model to gather and interpret the data. This has created an environment where the stories about mental health support work could be shared and the roles they have developed given the ability to be built on to create a positive future. However throughout the study, the Shadow appeared at each stage of the data analysis. In keeping with Fitzgerald and Oliver's (2012) belief that the Shadow can be generative and transformational and in support of the views of Verma (2012) that the Shadow is the glittering diamond in the coalmine, I have acknowledged and named the Shadow as a 'Dissonance'. The process of identifying and embracing the Dissonance has the ability to transform the perceived barriers into real opportunities. It is my view that addressing the Dissonance allows for the acknowledgment of what is not working well and removes the criticism that AI is sometimes Pollyanna-ish (Liebling, Price, & Elliot, 1999; Smythe, Payne, Wilson, & Wynyard, 2009). This criticism suggests that AI is flawed in its methodology because it only focuses on the positive. As a foil to this challenge, I suggest that as AI has evolved so has the need to give recognition to the existence of the Shadow. Taking the energy from within the Dissonance and using this to act as a catalyst

acknowledges allowing movement into and out of the 4 D-cycle. The Dissonance cradles the Discovery, Dream, Destiny and Design and acknowledges this as a force for transformation. Rather than discount or deny the Dissonance, it needs to be embraced as an agent for change.

CREATING A 5-D CYCLE

I have developed a model which moves the Shadow into a notion of 'Dissonance'. As such, I have adapted the model of Cooperrider (1986) and wrapped a cloak of Dissonance around the four Ds: Discovery, Dream, Design and Destiny. The transformational and energy-giving model depicted in Figure 19 which I conceptualised and was transformed into existence by Teriu Lemon, Head of School for Creative Industries at Wellington Institute of Technology. The vibrancy within this model shows an inner 4-D cycle surrounded by and held at each stage through a transformational Dissonance. This pictorial interpretation of the Dissonance within the 4 D-cycle depicts the potential energy that this model can create. The renaming of the Shadow moves the nature of inquiry into a space where the critiquing of inquiry can take place in every step of the process, the things that have remained unnamed and unclaimed within AI can now be carried into the light and used to transform that which may have remained hidden in the shadows. This naming of the discord is in itself transformational as it creates a place of safety so that appreciative discourse can be undertaken. It also acknowledges the Dissonance, it hears the stories and, by virtue of the hearing and telling, they in themselves became a transformational force.

Figure 19: 5-D cycle: a transformational model
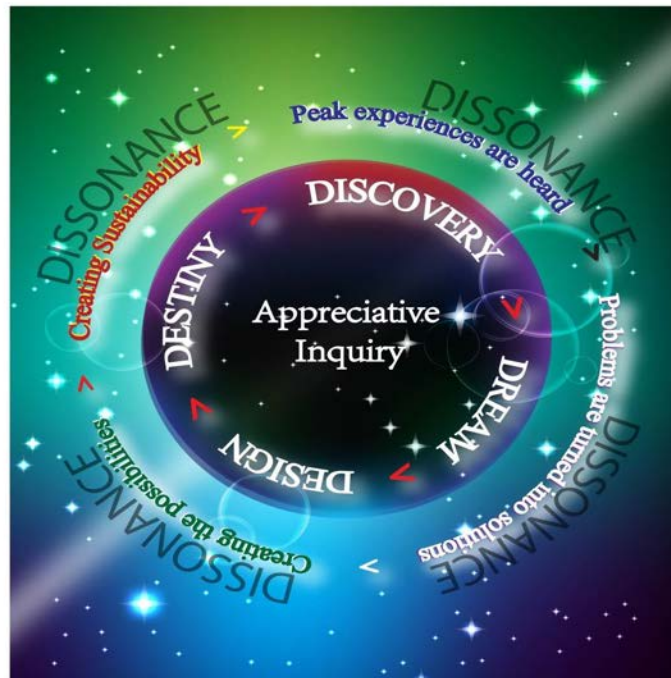
LIMITATIONS OF THIS STUDY

ON-LINE PLATFORM

The on-line platform that was established through the PB Works website did not generate the discussion I had hoped for. While all of the participants were invited to take part in a secure on-line discourse, only one participant went through the process. Although he reported through the on-line site that he had found the research approach invaluable this did not generate any further uptake. I closed the site several months after the completion of all the interviews.

INVOLVING THE PARTICIPANTS IN DESIGNING THE FUTURE

Within an orthodox AI approach, the Design and Destiny phases are worked through with the participants. However, given this study was taking an AI approach that was sector rather than organisational wide, I have taken on the role of interpreter of the stories told by the participants and used those to create and Design the Destiny. Had I decided to take the approach to work in partnership with one organisation, participants may have been able to work with me in achieving change. Drawing participants from multiple health providers across New Zealand means this study can offer recommendations for change, not create those changes. This has the advantage of drawing in a range of experiences and providing a framework that has the potential to have national impact. This study has created the cracks for the aspirational light to filter through and provide generative change.

GROUP PARTICIPANTS

AI takes an approach whereby whatever creates the environment where stories can be told is the environment that is right for those particular participants. While focus groups have the ability to generate lively discussion, this needs to be tempered with the recognition that input from quieter members of the group is at times limited. This domination of the group by the more vocal members at times created an environment where those who may have thought differently were silenced. On the other hand, the strength of focus groups in an appreciative approach is that one positive story generates others amongst the group, transforming the mood to hope and possibility. This spirit of excited dialogue often emerged.

EDUCATION PROVIDERS

Only one education provider took part in this study. There are significant changes within the education sector taking place, in 2015, through the Targeted Review of Qualifications. This study has the opportunity to influence the outcomes of these reviews. The review process involves education providers as well as service providers. The one educator interviewed had significant experience in the education sector and has been involved with the delivery of an education programme for mental

health support workers for most of that time. Many of the observations made by this participant were echoed by others in the sector.

FURTHER STUDY

As in any study, revealing insights has opened more questions. This study looked at the role of mental health support workers primarily through the eyes of support workers or other health professionals. Future studies could examine the relationship of mental health support work and the staff who undertake those roles from a consumer perspective. This could be extended to include input from family/whānau about how they perceive the input of the mental health support worker. This study also revealed the similarities between the characteristics of a mental health support worker and peer support worker. A future study could identify what makes mental health support work different from peer support work apart from having a service user experience.

The cultural aspects of mental health support work are shown throughout this study to be an integral part of the relationship between consumers and support workers; therefore, consideration and further examination of this aspect of the relationship need to be performed. I believe that there are rich insights to be gained from within the culturally specific ways of service delivery.

The earlier studies about mental health support work have focused on the national qualification. Since the inception of the qualification in 1998 there has been a significant increase in the Asian population in New Zealand particularly in Auckland, with mental health services being developed for this group. What has not been examined is the development of support services for this population and what those differences would be in terms of services provided by mental health support workers.

Another area for further research is a comparative study of clients that have a mental health support worker and those that have not have a mental health support worker.

CONCLUSION

Health service provides both nationally and internationally are struggling to find ways in which to make health services more accessible and affordable. New Zealand's health services are primarily funded through taxes with no co-payment for mental health services. As the population in this country ages, there will be a struggle to find a way to meet the health demands. New Zealand is in an advantageous position in that it has a developed workforce to provide a range of different types of services for mental health consumers. There needs to be acknowledgement that what is provided by mental health support workers is a different but complementary type of service and has the potential to change the way in which services are delivered. Making space for mental health support workers to fully enact their skills would free other professionals to practice to the top of their scope. In order to do this, other health professionals need to understand the role of mental health support workers. Mental health support workers need to be embraced as part of the treating team and their knowledge of individual consumers sought and valued. To achieve this future-focused service requires an interagency approach including (but not limited to) education and DHBs.

If mental health services understand the breadth and depth of the role of mental health support workers and an environment is created whereby their input into service planning and policy is sought, a significant shift in how mental health services work together could be achieved. Key to this is the understanding of the role of mental health support work, remunerating the staff appropriately, having a career pathway in place and welcoming the mental health support workers' input.

The relationship between mental health support workers and mental health consumers is unique. Careful consideration needs to be undertaken as to how the public is offered protection when having services delivered by mental health support workers. Service users are increasingly demanding a better level of health care as they become more knowledgeable about their rights. With the devolution of the service planning function to the DHBs, the potential for regional variations becomes greater. If the role were to be regulated under legislation similar to the HPCA Act

(2003), there is a danger that this would inhibit and restrict the role and therefore the uniqueness would be lost. The need to place more parameters around the safety of practice is understandable. Drawing on other successful models such as those used by Dapaanz is a way that would assist with the professionalisation of the role and ensure safety for the public.

Throughout this study, stories about what the mental health support worker does in their everyday role has demonstrated that they make a significant contribution to mental health services in New Zealand and have, through necessity, brought about service change. They need to be a part of that ongoing change so that their knowledge and experiences are harvested to create a future for mental health consumers that is based on a dynamic understanding of the practice environment.

Mental health support workers provide a simplicity of support by virtue of the work they do. They are not another clinical person in a consumer's life, nor should they be. They are Andrew and Ashleigh and other known people. Mental health support workers need to continue to reveal the uniqueness of their role as this is where their strengths lie, rather than emulate the roles of others.

When I commenced this study, I thought I knew a little bit about what mental health support workers did. This study has shown how narrow my initial thinking was. The mental health support workers in this study work to meet the needs of the mental health consumers. They work to create aspirational futures for mental health consumers and try whatever it takes to support those consumers during their recovery.

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APPENDICES

APPENDIX A: ETHICS APPROVAL MULTI-REGION ETHICS COMMITTEE

Health and Disability Ethics Committees

27 January 2011

Ms Julia Hennessy
4 Fyvie Ave
Tawa
Wellington 5028

Dear Ms Julia Hennessy

Ethics ref:	**MEC/11/01/001** (please quote in all correspondence)
Study title:	The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?
Investigators:	Ms Julia Hennessy

The Multi-region Ethics Committee considered your study on 18 January 2011 and approved it subject to the following conditions.

General	1) Facebook is an unsecured website and using this medium means participant confidentiality cannot be ensured. Please explain what precautions you will take to ensure the confidentiality of participants' information. Please consider having a secure website forum.
National Application Form	1) Section F: Please seek Maori Consultation for all locations; there are many consumer driven groups.
Participant Information Sheet and Consent Form	1) Please remove the reference made to the Ethics Committee being the contact for participant's who have clinical concerns.

You may **not** proceed with your study until ethical approval has been given. In order to obtain ethical approval from the Committee, please forward evidence that the above conditions have been met, with one copy of amended documentation, including:

— amended pages of the National Application Form
— a full copy of the amended information sheet/consent form/questionnaire etc with updated version number and date.

Provided the conditions above have been met, final approval for your study will be given by the Chairperson of the Committee. You will receive a letter advising you that final approval has been given, and may then proceed with your study.

Please don't hesitate to contact me for further information.

Yours sincerely,

Claire Lindsay
Administrator
Multi-region Ethics Committee
Email: multiregion_ethicscommittee@moh.govt.nz

APPENDIX B: AMENDED ETHICS APPROVAL MULTI-REGION ETHICS

This approval is valid until **21ˢᵗ April 2016**, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

— the researcher responsible for the conduct of the study at a study site
— the addition of an extra study site
— the design or duration of the study
— the method of recruitment
— information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by **21ˢᵗ April 2012**. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Statement of compliance
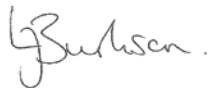
The committee is constituted in accordance with its Terms of Reference. It complies with the *Operational Standard for Ethics Committees* and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Please do not hesitate to contact me should you have any queries.

Yours sincerely

Laura Jayne Burlison
Administrator
Multi-Region Ethics Committee
Email: Multiregion_ethicscommittee@MOH.govt.nz

APPENDIX C: REVISED ETHICS APPROVAL MULTI-REGION ETHICS COMMITTEE

Health and Disability Ethics Committees

Multi-region Ethics Committee
Ministry of Health
No. 1 The Terrace
PO Box 5013
Wellington 6145
Phone (04) 816 2403
(04) 816 2646
Fax (04) 496 2343
Email: multiregion_ethicscommittee@moh.govt.nz

30 September 2011

Ms Julia Hennessy
4 Fyvie Ave
Tawa
Wellington 5028
New Zealand

Dear Ms Hennessy -

Re: Ethics ref: **MEC/11/01/001**   (please quote in all correspondence)
       Study title: The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?
       Investigators: Ms Julia Hennessy

This study was given ethical approval by the Multi-region Ethics Committee on **21st April 2011**.

Approved Documents

- NAF
- Signed Part 4 declaration for Julia Hennessy
- Page 2 of Signed Locality Assessment for Wellington Institute of technology
- Page 2 of Signed Locality Assessment for Waikato Institute of Technology
- Appendix One - Social network Site, dated 15 Nov 2010
- Appendix Two - Confidentiality Agreement, dated 15 Nov 2010
- Appendix three (A) - Consent Form to participate in a one to one interview, dated 19 March 2011
- Appendix three (B) Consent form to participate in a paired interview or focus group (no version or date)
- Appendix four – Participant Information Sheet, version dated 1 Feb 2011
- Appendix five - Expression of Interest
- Website pages
- Evidence of Maori Consultation - Letter of support - signed and dated 3 March 2011 by Deborah Rowe (National Maori Advisory Committee for the Ministry of Health
- Evidence of Maori Consultation - Email dated 20 Sep 2011 from Chris Cunningham (Massey university - Wellington, Palmerston North and Auckland)
- Appendix three (B) - Consent Form for participation in a paired interview or focus group - signed by Rongo Larkin Clinical Leader Maori Mental health Services Capital and Coast DHB
- Appendix three (A) - Consent Form for participation in a one to one interview - signed by Rongo Larkin Clinical Leader Maori Mental health Services Capital and Coast DHB
- Evidence of Maori Consultation - Letter of support signed and dated 17 February 2011 by Tohi Tohiariki - He Waka Tapu (Christchurch)
- Evidence of Maori Consultation - Letter of support signed and dated 15 March 2011 by Huperio Tepania - Kaumatua at Maraeroa Mare, Waitanguira, Porirua

APPENDIX D: ETHICS APPROVAL AUCKLAND UNIVERSITY OF TECHNOLOGY

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To:	Liz Smythe
From:	**Dr Rosemary Godbold and Madeline Banda** Executive Secretary, AUTEC
Date:	10 June 2011
Subject:	Ethics Application Number 11/138 **The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?**

Dear Liz

We are pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 23 May 2011, subject to the following conditions:

1. Provision of the letter of support from AUT Counselling;

2. Clarification of the use of an interpreter, as indicated in the last bullet point of the Consent Form, and provision of a Confidentiality Agreement if one will be used;

3. Clarification of how long the interviews will take, given the inconsistent responses in the application, and inclusion of this in the Information Sheet.

We request that you provide the Ethics Coordinator with a written response to the points raised in these conditions at your earliest convenience, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires written evidence of any altered documents, such as Information Sheets, surveys etc. Once this response and its supporting written evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

When approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee. Data collection may not commence until full approval has been confirmed. Should these conditions not be satisfactorily met within six months, your application may be closed and you will need to submit a new application should you wish to continue with this research project.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

Yours sincerely

Dr Rosemary Godbold and Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Julia Hennessy hennessyw@xtra.co.nz

APPENDIX E: AMENDED ETHICS APPROVAL AUCKLAND UNIVERSITY OF TECHNOLOGY

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To:	Liz Smythe
From:	**Dr Rosemary Godbold and Madeline Banda** Executive Secretary, AUTEC
Date:	22 June 2011
Subject:	Ethics Application Number 11/138 **The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?**

Dear Liz

Thank you for providing written evidence as requested. We are pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 23 May 2011 and we have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 11 July 2011.

Your ethics application is approved for a period of three years until 20 June 2014.

We advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 20 June 2014;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either

when the approval expires on 20 June 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of AUTEC and ourselves, we wish you success with your research and look forward to reading about it in your reports.

Yours sincerely
Dr Rosemary Godbold and Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Julia Hennessy hennessyw@xtra.co.nz

APPENDIX F: REVISED ETHICS APPROVAL AUCKLAND UNIVERSITY OF TECHNOLOGY

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To:	Liz Smythe
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	17 May 2012
Subject:	Ethics Application Number 11/138 **The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?**

Dear Liz

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved the amendment to your ethics application seeking an extension of the catchment area for recruitment at their meeting of 30 April 2012.

I remind you that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 20 June 2014;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 20 June 2014 or on completion of the project, whichever comes sooner;

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It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Julia Hennessy hennessyw@xtra.co.nz

Expressions of Interest

My name is Julia Hennessy, I am an experienced mental health nurse and educator and a part-time PhD student at the Auckland University of Technology. I am undertaking research about the contribution of mental health support workers in New Zealand.

I am seeking to interview the following:

- mental health support workers
- mental health consumers
- health professionals who have worked alongside support workers
- service providers that employ mental health support workers and
- educators delivering the National Certificate in Mental Health (mental health support work)

Selected participants would be required to be interviewed either individually, in pairs or in a focus group. It is anticipated that the interviews will take up to two hours.

If you are interested in being part of this research or you require more information please contact me through my email address, which is
Julia.Hennessy@weltec.ac.nz

Thank you

Participant

Information Sheet

Date Information Sheet Produced: 1 February 2011

Project Title

Contribution of the mental health support work to the mental health environment in New Zealand – an appreciative inquiry approach.

An Invitation

My name is Julia Hennessy. I am a registered nurse currently enrolled in a Doctor of Philosophy at Auckland University of Technology.

You have been invited to take part in this research study of what is working well with mental health support work in New Zealand. This study will interview, mental health support workers, health professionals working in mental health, mental health consumers, and employers of mental health support workers. I am intending to interview at least forty people from the identified groups. The interviews will commence in 2011. The interviews will last approximately 60 to 90 minutes. The interviews will take place at a time and place that is mutually convenient.

What is the purpose of this research?

This research seeks to find what is working well in New Zealand for mental health support work.

This study uses and appreciative inquiry (AI) approach. The reason for adopting this approach is that AI has a high level of congruency with the current philosophies within mental health services ie Strength based approach, Tidal model and Recovery approach.

This research is being undertaken for a Doctor of Philosophy at Auckland University of Technology. The information gathered through the research process will be used for a doctoral thesis.

It is anticipated that several publications will result from this study. Additionally, the findings from this study may be used to further inform about the role of mental health support workers,

the relationship they have with other health professionals, how their contribution is viewed by mental health consumers and their educational prepares them for the roles they undertake.

How was I chosen for this invitation?

An Expression of Interest (EOI) was sent out through a number of key stakeholders. As a result of the EOI you have indicated that you are interested in being part of this study. You also identified that you have knowledge about mental health support work in New Zealand.

What will happen in this research?

Participants will be required to take part in an interview of approximately 60 to 90 minutes duration. These interviews will take place in Wellington, Auckland, Christchurch or Hamilton. The preferences for the type of interview you wish to be part of are set out in the Consent Form. You are able to select whether you would like to be interviewed on a one-on-one basis, in a pair or in a focus group. The participants in this study will be either:

- ➢ Mental health support workers
- ➢ Mental health consumers
- ➢ Mental health professionals who have worked with mental health support workers
- ➢ Employers of mental health support workers

The interviews will be audio-taped, using a digital dictaphone, with the recordings being transcribed. Data from the tapes will be stored by the principle investigator and held in a locked cabinet for the duration of the study. The raw data will then be held for six years in a secure cabinet by AUT. The transcriptions will be accessible only to the transcribers, myself and my supervisors. At the end of the six year period the transcriptions will be shredded. Members of the paired groups and focus groups will be required to agree to maintain the confidentiality of other members of the group.

The person undertaking the transcribing will be required to sign a confidentiality agreement in order to ensure your privacy.

Your involvement in this process will remain anonymous unless you indicate on the consent form that you wish to be acknowledged.

The information gained through the interview process will be coded into themes. These themes will be further analysed and used for my PhD thesis. Additionally short articles relating to the research may also be published in relevant journals or presented at conferences and seminars.

What are the discomforts and risks?

While all practical steps have been taken to minimise discomfort and risk during the interviews you may wish to withdraw, as is your right, from the process. If you do find you need to withdraw from the process this will be done without any adverse outcomes.

How will these discomforts and risks be alleviated?

Participants can withdraw from the study at any time without any adverse outcomes. The contact details for the independent health and disability advocate: Free phone: 0800 555 050, Free fax: 0800 2787 7678, Email: advocacy@hdc.org.nz. Access to SEED, a telephone counselling service 0508664981 or Auckland residents can access the counselling service provided by AUT, details of how to access this service can be obtained from the study supervisor or through the on-line details on the AUT website.

Participants can also raise with the researcher or supervisor any concerns they have. At the commencement of the interviews it will be reiterated that all the information will remain confidential and anonymous.

What are the benefits?

Your participation in this research will assist with providing knowledge about mental health support work in New Zealand. It is estimated that there are up to 5,000 mental health support workers in New Zealand. This study seeks to potentially provide recognition for the contribution of mental health support workers, highlight what is working well, what could be done differently and the adequacy of their training and education for the task they undertake. The information gained from this research will also be beneficial and informative for the various stakeholders.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

All participants will be required to complete a consent form. This sets out the parameters of the requirements related to confidentiality. All identifying material will be removed to ensure your details remain anonymous. If you wish to be acknowledged in the document please indicate this on the consent form.

What are the costs of participating in this research?

Participants will be provided with light refreshments and reimbursement of travel costs of $0.62 per kilometre up to a maximum of $30.00 per participant.

What opportunity do I have to consider this invitation?

Two weeks after the invitation is received I will make contact with you to answer any queries you may have and to ascertain whether you wish to take part in the research.

How do I agree to participate in this research?

All potential participants will be contacted directly by me. If you agree to participate in this research you will be provided with a consent form and a pre-addressed, stamped envelope.

Will I receive feedback on the results of this research?

All participants will be provided with a summary of the research finding. Once the Academic Board of AUT approves the awarding of the degree access to the full thesis is available through **ScholarlyCommons@AUT** http://aut.researchgateway.ac.nz/.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:
Associate Professor Liz Smythe
Auckland University of Technology
Phone: 64 9 921 9999, extn 7196
Email: liz.smythe@liz.smythe@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the
Executive Secretary, AUTEC,
Madeline Banda, madeline.banda@aut.ac.nz
Phone 921 9999 ext 8044.

Whom do I contact for further information about this research?
Researcher's Contact Details:

Julia Hennessy
Wellington Institute of Technology
Phone: (04) 9202 472 or 0272309379
Email: Julia.Hennessy@weltec.ac.nz

Project Supervisor Contact Details:

Associate Professor Liz Smythe
Division of Health Care Practice
Health Studies
Auckland University of Technology
Phone: 64 9 921 9999, extn 7196
Email: liz.smythe@aut.ac.nz

Dr Frances Hughes
Adjunct Professor
Auckland University of Technology
Phone: 0212764977
Email: frances.hughes@clear.net.nz

Professor Max Abbott
Dean of Faculty of Health and Environmental Sciences

Pro Vice-Chancellor, North Shore and Community
Auckland University of Technology
Email: max.abbott@aut.ac.nz

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

APPENDIX I: CONSENT FORM 1:1

Consent Form

Please complete this form if you agree to participate in a one to one interview

Project title: *Contribution of Mental Health Support Worker to the mental   health environment in New Zealand – an appreciative inquiry   approach*

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I wish to be interviewed on my own.
- ○ I understand that notes will be taken during the interview and the interview will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of the data collection, without being disadvantaged in any way.
- ○ If I do withdraw, I understand that all relevant information including tapes and transcripts of my interview, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the findings from the research (please tick one): Yes ○ No ○
- ○ I wish to have an interpreter (please tick one):   Yes ○ No ○

Participant's signature:.................................……………………………………………………….

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Participant should retain a copy of this form.

APPENDIX J: CONSENT FORM GROUP

Consent Form

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Please complete this form if you agree to take part in a paired interview or focus group

Project title: *Contribution of Mental Health Support Work to the mental health environment in New Zealand – an appreciative inquiry approach*

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

○ I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I do withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

○ I agree to take part in this research.

○ I wish to receive a copy of the summary of findings from the research (please tick one): Yes ○ No ○

○ I wish to have an interpreter (please tick one):Yes ○ No ○

Participant's signature:...……………………………………………………

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138.
Note: The Participant should retain a copy of this form.

APPENDIX K: CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

Transcribing Audiotapes

Project title: *Contribution of Mental Health Support Work to the mental health environment in New Zealand – an appreciative inquiry approach*

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

○   I understand that all the material I will be asked to transcribe is confidential.

○   I understand that the contents of the tapes or recordings can be discussed only with the researchers.

○   I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....………………………………………………………

Transcriber's name:

Date:

Project Supervisor's Contact Details (if appropriate):

Associate Professor Liz Smythe

Phone: 64 9 921 9999, extn 7196

Email: liz.smythe@aut.ac.nz

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Transcriber should retain a copy of this form.

APPENDIX L: INTERVIEW SCHEDULE (FOR THOSE THAT WORK WITH MENTAL HEALTH SUPPORT WORKERS)

For those who work with:

- What are the things that you value about working with mental health support workers?

- Tell me a story about a mental health support worker that has made a difference

- Are there any things that you would like to see done differently in regards to the role of mental health support workers that would make them even better?

APPENDIX M: INTERVIEW SCHEDULE (FOPR THOSE THAT HAVE SERVICES PROVIDED BY MENTAL HEALTH SUPPORT WORKERS)

For those that have services provided by mental health support workers:

- What difference has a mental health support worker made to your life?

- What is it that you value about the services you have delivered by a mental health support worker?

- What has worked well with your relationship with mental health support workers?

- In your experience could anything be done differently to improve the service you received?

APPENDIX N: INTERVIEW SCHEDULE (FOR MENTAL HEALTH SUPPORT WORKERS)

For mental health support workers

- Tell me a story about how you as a mental health support worker have made a difference.

- Reflecting on your experience as a mental health support workers what inspires you most about you work?

- What challenges you to most in your role?

- What relationships have you developed with other mental health professionals?

- What do you most value in your role as mental health support worker?

- Are there things that you would like to see done differently?

- What would make you able to do things even better?

APPENDIX O: INTERVIEW SCHEDULE (FOR OTHER KEY STAKEHOLDERS)

For other key stakeholders:

- What are the things you value about mental health support workers?

- Tell me about what your experiences of mental health support workers?

- Reflecting on your experience with mental health support workers, what aspects do you think should be focused on for the future?

APPENDIX P: INTERVIEW SCHEDULE (FOR THOSE THAT EMPLOY MENTAL HEALTH SUPPORT WORKERS)

For those who employ:

- What are the things that you most value about employing mental health support workers?

- How has mental health support workers made a difference?

- Are there any things that that you would like to see done differently, in regards to mental health support workers that would make what they do even better?

APPENDIX Q: CONSENT FORM 1:1 INTERVIEWS

Consent Form

Please complete this form if you agree to participate in a one to one interview

Project title: *Contribution of Mental Health Support Worker to the mental   health environment in New Zealand – an appreciative inquiry   approach*

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

○   I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.

○   I have had an opportunity to ask questions and to have them answered.

○   I wish to be interviewed on my own.

○   I understand that notes will be taken during the interview and the interview will also be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this   project at any time prior to completion of the data collection, without being   disadvantaged in any way.

○   If I do withdraw, I understand that all relevant information including tapes and transcripts of my interview, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a summary of the findings from the research (please tick one):   Yes ○ No ○

○   I wish to have an interpreter (please tick one):   Yes ○ No ○

Participant's signature:...................…………………………………………………………

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Participant should retain a copy of this form.

APPENDIX R: CONSENT FORM GROUPS AND PAIRED

Consent Form

Please complete this form if you agree to take part in a paired interview or focus group

Project title: Contribution of Mental Health Support Work to the mental health   environment in New Zealand – an   appreciative inquiry approach

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

○ I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I do withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

○ I agree to take part in this research.

○ I wish to receive a copy of the summary of findings from the research (please tick one):

   Yes ○ No ○

○ I wish to have an interpreter (please tick one):

   Yes ○ No ○

Participant's signature:...……………………………………………………

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Participant should retain a copy of this form.

APPENDIX S: TRANSCRIBER CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

Transcribing Audiotapes

Project title: *Contribution of Mental Health Support Work to the mental health environment*
in New   *Zealand – an appreciative inquiry approach*
Project Supervisor: **Associate Professor Liz Smythe**
Researcher: **Julia Hennessy**

○   I understand that all the material I will be asked to transcribe is confidential.

○   I understand that the contents of the tapes or recordings can be discussed only with the researchers.

○   I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....……………………………………………………………

Transcriber's name:

Date:

Project Supervisor's Contact Details (if appropriate):

Associate Professor Liz Smythe

Phone: 64 9 921 9999, extn 7196

Email: liz.smythe@aut.ac.nz

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Transcriber should retain a copy of this form.

APPENDIX T: TRANSLATOR CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

For an interpreter

Project title: *Contribution of Mental Health Support Work to the mental health*

environment in New Zealand – an appreciative inquiry

approach

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Julia Hennessy**

○   I understand that the interviews meetings or material I will be asked to translate is

confidential.

○   I understand that the content of the interviews meetings or material can only be discussed

with the researchers.

○   I will not keep any copies of the translations nor allow third parties access to them.

Translator's signature: ....

Translator's name: ....

Translator's Contact Details (if appropriate):

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

Date: 1 July 2011

Project Supervisor's Contact Details (if appropriate):

Associate Professor Liz Smythe

Phone: 64 9 921 9999, ext. 7196

Email: liz.smythe@aut.ac.nz

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of

Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Translator should retain a copy of this form.

APPENDIX U: INTERVIEW QUESTIONS

Questions to focus the interviews

For those that have services provided by mental health support workers:

- What difference has a mental health support worker made to your life?
- What is it that you value about the services you have delivered by a mental health support worker?
- What has worked well with your relationship with mental health support workers?
- In your experience could anything be done differently to improve the service you received?

For mental health support workers

- Tell me a story about how you as a mental health support worker have made a difference
- Reflecting on your experience as a mental health support workers what inspires you most about you work?
- What challenges you to most in your role?
- What relationships have you developed with other mental health professionals?
- What do you most value in your role as mental health support worker?
- Are there things that you would like to see done differently?
- What would make you able to do things even better?

For those who employ:

- What are the things that you most value about employing mental health support workers?
- How has mental health support workers made a difference?
- Are there any things that that you would like to see done differently, in regards to mental health support workers that would make what they do even better?

For those who work with:

- What are the things that you value about working with mental health support workers?
- Tell me a story about a mental health support worker that has made a difference
- Are there any things that you would like to see done differently in regards to the role of mental health support workers that would make them even better?

For other key stakeholders:

- What are the things you value about mental health support workers?
- Tell me about what your experiences of mental health support workers?
- Reflecting on your experience with mental health support workers, what aspects do you think should be focused on for the future?

APPENDIX V: SOUTHERN DISTRICT HEALTH BOARD APPROVAL (UNIVERSITY OF OTAGO)

Health Research Office
Dunedin School of Medicine and Southern District Health Board

21/03/2012

Project ID 00745

Prof Paul Glue
Dept Psych Med

Dear Paul

REF: **Contribution of the mental health support work to the mental health environment in NZ: an appreciative inquiry approach**

I am writing on behalf of the combined Southern District Health Board and Dunedin School of Medicine, Research Advisory Group (RAG) to confirm that the project mentioned above has been granted approval to proceed.

According to our records:
This project is due to commence on: 21/03/2012
It is due to be completed by: 31/12/2015

If you have any questions with regards to this process, please contact me quoting the project ID shown above.

Yours sincerely

Ruth Sharpe
CLINICAL RESEARCH ADVISOR

cc.:   ELAINE CHISNALL, SOUTHERN DHB
        JULIA HENNESSY, 4 FYVIE AVENUE, TAWA, WELLINGTON 5028

APPENDIX W: NGAI TAHU APPROVAL

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KAI TAHU

24/01/2012 - 42
Tuesday, 24 January 2012

Professor Glue
Psychological Medicine
Dunedin

Tēnā koe Professor Glue

Title: The contribution of the mental health support worker to mental health services in New Zealand an appreciative inquiry approach. What is working well with mental health support work in New Zealand?

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 24 January 2012 to discuss your research proposition.

By way of introduction, this response from the Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum, it states "Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology; they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGechan:

> *"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."*

The Committee considers the research to be of importance to Māori health.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project. That is the questions on self-identified ethnicity and descent, these questions are contained in the 2006 census.

The Ministry of Health website http://www.health.govt.nz/publications contains a list of Māori health publications. The Committee recommends you review the Māori health publications on this website, eg. Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and

Participant

Information Sheet

Date Information Sheet Produced: 1 February 2011

Project Title

Contribution of the mental health support work to the mental health environment in New Zealand – an appreciative inquiry approach.

An Invitation

My name is Julia Hennessy. I am a registered nurse currently enrolled in a Doctor of Philosophy at Auckland University of Technology.

You have been invited to take part in this research study of what is working well with mental health support work in New Zealand. This study will interview, mental health support workers, health professionals working in mental health, mental health consumers, and employers of mental health support workers. I am intending to interview at least forty people from the identified groups. The interviews will commence in 2011. The interviews will last approximately 60 to 90 minutes. The interviews will take place at a time and place that is mutually convenient.

What is the purpose of this research?

This research seeks to find what is working well in New Zealand for mental health support work.

This study uses and appreciative inquiry (AI) approach. The reason for adopting this approach is that AI has a high level of congruency with the current philosophies within mental health services ie Strength based approach, Tidal model and Recovery approach.

This research is being undertaken for a Doctor of Philosophy at Auckland University of Technology. The information gathered through the research process will be used for a doctoral thesis.

It is anticipated that several publications will result from this study. Additionally, the findings from this study may be used to further inform about the role of mental health support workers, the relationship they have with other health professionals, how their contribution is viewed by mental health consumers and their educational prepares them for the roles they undertake.

How was I chosen for this invitation?

An Expression of Interest (EOI) was sent out through a number of key stakeholders. As a result of the EOI you have indicated that you are interested in being part of this study. You also identified that you have knowledge about mental health support work in New Zealand.

What will happen in this research?

Participants will be required to take part in an interview of approximately 60 to 90 minutes duration. These interviews will take place in Wellington, Auckland, Christchurch or Hamilton. The preferences for the type of interview you wish to be part of are set out in the Consent Form. You are able to select whether you would like to be interviewed on a one-on-one basis, in a pair or in a focus group. The participants in this study will be either:

➢ Mental health support workers

➢ Mental health consumers

➢ Mental health professionals who have worked with mental health support workers

➢ Employers of mental health support workers

The interviews will be audio-taped, using a digital dictaphone, with the recordings being transcribed. Data from the tapes will be stored by the principle investigator and held in a locked cabinet for the duration of the study. The raw data will then be held for six years in a secure cabinet by AUT. The transcriptions will be accessible only to the transcribers, myself and my supervisors. At the end of the six year period the transcriptions will be shredded. Members of the paired groups and focus groups will be required to agree to maintain the confidentiality of other members of the group.

The person undertaking the transcribing will be required to sign a confidentiality agreement in order to ensure your privacy.

Your involvement in this process will remain anonymous unless you indicate on the consent form that you wish to be acknowledged.

The information gained through the interview process will be coded into themes. These themes will be further analysed and used for my PhD thesis. Additionally short articles relating to the research may also be published in relevant journals or presented at conferences and seminars.

What are the discomforts and risks?

While all practical steps have been taken to minimise discomfort and risk during the interviews you may wish to withdraw, as is your right, from the process. If you do find you need to withdraw from the process this will be done without any adverse outcomes.

How will these discomforts and risks be alleviated?

Participants can withdraw from the study at any time without any adverse outcomes. The contact details for the independent health and disability advocate: Free phone: 0800 555 050, Free fax: 0800 2787 7678, Email: advocacy@hdc.org.nz. Access to SEED, a telephone counselling service 0508664981 or Auckland residents can access the counselling service provided by AUT, details of how to access this service can be obtained from the study supervisor or through the on-line details on the AUT website.

Participants can also raise with the researcher or supervisor any concerns they have. At the commencement of the interviews it will be reiterated that all the information will remain confidential and anonymous.

What are the benefits?

Your participation in this research will assist with providing knowledge about mental health support work in New Zealand. It is estimated that there are up to 5,000 mental health support workers in New Zealand. This study seeks to potentially provide recognition for the contribution of mental health support workers, highlight what is working well, what could be done differently and the adequacy of their training and education for the task they undertake. The information gained from this research will also be beneficial and informative for the various stakeholders.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

All participants will be required to complete a consent form. This sets out the parameters of the requirements related to confidentiality. All identifying material will be removed to

ensure your details remain anonymous. If you wish to be acknowledged in the document please indicate this on the consent form.

What are the costs of participating in this research?

Participants will be provided with light refreshments and reimbursement of travel costs of $0.62 per kilometre up to a maximum of $30.00 per participant.

What opportunity do I have to consider this invitation?

Two weeks after the invitation is received I will make contact with you to answer any queries you may have and to ascertain whether you wish to take part in the research.

How do I agree to participate in this research?

All potential participants will be contacted directly by me. If you agree to participate in this research you will be provided with a consent form and a pre-addressed, stamped envelope.

Will I receive feedback on the results of this research?

All participants will be provided with a summary of the research finding. Once the Academic Board of AUT approves the awarding of the degree access to the full thesis is available through **ScholarlyCommons@AUT** http://aut.researchgateway.ac.nz/ .

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Associate Professor Liz Smythe
Auckland University of Technology
Phone: 64 9 921 9999, ext. 7196
Email: liz.smythe@liz.smythe@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the
Executive Secretary, AUTEC,
Madeline Banda, madeline.banda@aut.ac.nz
Phone 921 9999 ext. 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Julia Hennessy
Wellington Institute of Technology
Phone: 920 2472 or 0272309379
Email: Julia.Hennessy@weltec.ac.nz

Project Supervisor Contact Details:

Associate Professor Liz Smythe
Division of Health Care Practice
Health Studies
Auckland University of Technology
Phone: 64 9 921 9999, ext. 7196
Email: liz.smythe@aut.ac.nz

Dr Frances Hughes
Adjunct Professor
Auckland University of Technology
Phone: 0212764977
Email: frances.hughes@clear.net.nz

Professor Max Abbott
Dean of Faculty of Health and Environmental Sciences
Pro Vice-Chancellor, North Shore and Community
Auckland University of Technology
Email: max.abbott@aut.ac.nz

APPENDIX Y: CONSENT FORM 1:1 INTERVIEWS SDHB

Southern District
Health Board

Consent Form

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Please complete this form if you agree to participate in a one to one interview

Project title: *Contribution of Mental Health Support Worker to the mental health environment in New Zealand – an appreciative inquiry approach*

Project Supervisor: **Associate Professor Liz Smythe**
Researcher: **Julia Hennessy**

○   I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.

○   I have had an opportunity to ask questions and to have them answered.

○   I wish to be interviewed on my own.

○   I understand that notes will be taken during the interview and the interview will also be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of the data collection, without being disadvantaged in any way.

○   If I do withdraw, I understand that all relevant information including tapes and transcripts of my interview, or parts thereof, will be destroyed.I agree to take part in this research.

○   I wish to receive a summary of the findings from the research (please tick one):
                                                                         Yes ○ No ○
○   I wish to have an interpreter (please tick one):   Yes ○ No ○

Participant's signature:........................…………………………………………………………

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Participant should retain a copy of this form.

APPENDIX Z: CONSENT FORM GROUPS AND PAIRED SDHB

CONSENT FORM

Please complete this form if you agree to take part in a paired interview or focus group

Project title: *Contribution of Mental Health Support Work to the mental health environment in New Zealand – an appreciative inquiry approach*

Project Supervisor: ***Associate Professor Liz Smythe***

Researcher: ***Julia Hennessy***

○ I have read and understood the information provided about this research project in the Information Sheet dated 1 February 2011.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I do withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

○ I agree to take part in this research.

○ I wish to receive a copy of the summary of findings from the research (please tick one):

                                                                     Yes ○ No ○

○ I wish to have an interpreter (please tick one):   Yes ○ No ○

Participant's

signature:..…………………………………………………

Participant's name:

Participant's Contact Details (if appropriate):

Date:

When you have completed this form please return it to Julia Hennessy, Private Bag 39803, Lower Hutt 5045 or in the attached addressed and stamped envelope.

Approved by the Multi-region Ethics Committee 21/4/2011, MEC/11/01/001 and Auckland University of Technology Ethics Committee on 22/6/2011, AUTEC Reference number Ethics Application Number 11/138

Note: The Participant should retain a copy of this form.

APPENDIX AA: PSYCHOLOGICAL SUPPORT FOR RESEARCH PARTICIPANTS

AUT STUDENT SERVICES

MEMORANDUM

TO	Julia Hennessy
FROM	Kevin Baker
SUBJECT	Psychological support for research participants
DATE	14th June 2011

Dear Julia

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

"The contribution of the mental health worker to mental health services in New Zealand - an appreciative inquiry approach. What is working well with mental health support work in New Zealand?"

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:
- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website: **http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing**
-

Yours sincerely

Kevin Baker

Head of Counselling

Health, Counselling and Wellbeing