

What it's Like: How Consumer Staff Members Experience Working in Mental Health

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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 or material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: _____
Christine Rigby

Dated: _____

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ABSTRACT

This qualitative descriptive study is about consumer staff members' experience working in mental health. Three participants with lived experience of mental illness and using services who have worked as staff in direct service delivery roles in mental health in New Zealand provided their personal accounts in semi structured interviews. The research aims to inform understanding of the part consumer staff enact in the workplace, benefits and rewards of their role, challenges faced, and meanings derived from their work.

This enquiry was prompted by the increasing recognition of consumer staff within the mental health recovery paradigm. Relevant literature was reviewed that provides the philosophical context and examines this employment practice from a range of perspectives. Thematic analysis was carried out to interpret the interview data which is presented in the findings as the four main themes that emerged: 'being paid to be myself'; 'the mixed blessing of being a consumer'; 'actually making a difference'; and 'benefits gained from the job'. The findings align with and extend existing knowledge.

This study revealed that while working in mental health poses some challenges, consumer staff predominantly experience their work role as rewarding, satisfying and worthwhile. They benefit from working in mental health whilst making a valuable contribution to clients and the system. Of note is the special nature of the relationships consumer staff establish with clients based on shared experience. This finding lends support to current endeavours to develop the consumer staff workforce.

In order to promote and ensure a viable consumer staff workforce, further research is recommended to identify what needs to occur to enable successful employment experiences. Although tentative, the findings support individualised employment arrangements which address individual consumer staff member's needs. It is proposed that mental health organisations model strategies on recovery approaches to cater flexibly to the uniqueness of each staff member and their changing circumstances. It is suggested that what proves useful in retaining consumer staff has the potential to improve the job satisfaction and success of the whole workforce.

Chapter One: Introduction

This qualitative descriptive study explored the experiences of three individuals with mental illness who work in a mental health service. Data were collected through semi structured interviews and thematically analysed. It is important to hear about the relatively new practice of employing consumers as staff from those staff whose reality is different from the majority of the mental health workforce.

The study was conducted in the context of a consumer driven recovery approach, in which consumers are being employed as workers within organizations providing mental health services. Identification as a consumer or service user means the person has lived experience of mental illness and using mental health services. That experience may be past or ongoing. A staff member is a worker employed on full regular terms and conditions in a mental health organization. A generic role can be filled by any qualified person, in contrast to a role designated for consumers only, such as consumer advisors (Mental Health Commission, 2005). Generic frontline workers provide services directly with clients. Various titles have been given to people working in paid mental health positions, who also acknowledge and disclose their mental illness. Terms include consumer employee, consumer provider, prosumers, consumer staff, consumer case manager aides and service user workforce (Besio & Mahler, 1993; Bledsoe, 2001; Doherty, Craig, Attafua, Boodock, & Jamieson-Craig, 2004; Fisk, Rowe, Brooks, & Gildersleeve, 2000; Frese & Davis, 1997; Manning & Suire, 1996; Mental Health Commission, 2005). In keeping with Fisk et al (2000) and the local practice context I have chosen to use the descriptor consumer staff to identify the participants in this study. Other people are also referred to in the study. The term client refers to a person currently receiving direct services from an organization related to their mental illness. Tangata Whaiora is a Maori term, which translates as a person seeking wellness, and is used interchangeably in New Zealand to refer to consumers and clients. Mental health organizations are those providing specialist treatment, rehabilitation, and support for clients.

Background to the Study

The most significant philosophical influence on this research is the mental health recovery paradigm. Recovery approaches have gained wide acceptance over the past two decades, as

deinstitutionalisation has taken place and community services have become the norm in New Zealand. Community based service delivery has involved diversification of services, with clinical treatment services remaining with government run health authorities and support services being provided by contracted non-government organizations. During this period, recovery has become a significant concept in mental health literature and practice internationally (Anthony, 1993; Lunt, 2002; Ralph, 2000). Patricia Deegan (1992) and Esso Lette (1992), well-known writers and consumer advocates, express that meaningful employment is believed by consumers to be essential to the recovery process. Research describes the negative effects of unemployment on both physical health and psychological wellbeing (Schneider, 1998) and studies have identified that two thirds of people with severe mental illness express a desire to be employed (Drake, Becker, Biesanz, Torrey, McHugo & Wyzik, 1994; Farkas, 1996).

The theme people with severe mental health have in common is the experience of recovering a new sense of self, beyond the limits of the disability (Strong, 1998). Deegan (1992) explores this notion further, stating that the process of participation in meaningful occupation appears to interrupt the cycle of disempowerment and despair. Therefore while stressors associated with working have been identified as potentially detrimental for consumers' mental health, the benefits are deemed to outweigh this risk. This was clearly the case for one participant in this study who spoke of keeping steady work on set days each week, at least on a part-time basis during periods of unwellness, as being important in providing structure and stability in their life. This was coupled with the need to keep an income, as the stress and worry associated with living costs was also a barrier to staying well. This participant's commitment to work echoes the recovery vision being promoted in New Zealand (Mental Health Commission, 1997). The 'Like Minds, Like Mine' is a public de-stigma campaign that has been implemented in New Zealand over the last decade to counter discrimination and pave the way for consumers to integrate into society (Mental Health Commission, 2004). Consumer rights have been raised as a priority issue (Chamberlain, 1990) and highlighted in areas such as employment and housing (Frese & Davis, 1997). I agree it is a consumer's right to seek fair rewarding employment across all sectors including mental health. It is in this context that consumers are entering open employment and the mental health workforce.

Some of the consumers who have been instrumental in creating an understanding about recovery are employed in the mental health field (Chamberlain, 1990; Curtis, 1997; Deegan, 2001; Leibrich, 1999). Placed in a dual role, these people are in a unique position to tell about working in mental health and may provide insights that might not otherwise be accessible.

While my experience supports the assertion that there is a relationship between being employed and higher levels of functioning, I concur with Kirsh (2000) that we do not know enough about the meaning of work and the important elements of workplaces as perceived by consumers. It is these experiential aspects of their work role I am seeking to shed light on by collecting consumer staffs' perspectives of working in mental health.

What is occurring now in New Zealand has been evolving for over two decades overseas, with an increasing recognition of the valuable contributions consumer staff can make. Consumers are reported as having skills, knowledge and motivation that are of benefit to clients, including understanding, advocacy, role modelling, accessing resources, and overcoming obstacles (Besio & Mahler, 1993). The consumer movement strongly supports the need for consumer staff, for the special contributions that can be made by those who have developed special expertise through their own experiences with mental illness (Frese & Davis, 1997).

Initially, employing people with a known history of mental illness mostly involved recruitment into designated consumer advisor or consultant roles to provide input to organisational planning, with some client advocacy functions included. Current practice includes consumer staff holding a range of positions, including direct care roles. Deliberate strategies are evident with consumer run services and the introduction of a peer support workforce. Where the philosophy has been embraced, there are instances of preferential recruitment. One participant in this study attributed their entry into working in mental health to this trend, as they were approached and offered work by virtue of having consumer status as well as relevant work experience and personal qualities. As the uptake and acceptance of this employment practice has spread existing staff with lived experience have 'come out' as consumers. Another participant described 'coming out' as part of their work story, with the inherent uncertainties and risks this entailed.

Employing consumers as mental health workers is not happening across the whole sector and it is hard to know how much this is occurring. This study does not aim to quantify how widespread the practice of employing consumers has become. My intention is to contribute to a better understanding before this employment practice becomes commonplace and during the current period of articulating this as a deliberate strategy.

Implications around employing consumer staff in mental health settings have been identified for consumer staff, clients, and organisations (Besio & Mahler, 1993; Manning & Suire, 1996). In gaining more knowledge about the benefits and problems, organizations are now beginning to develop policies and strategies to support consumer staff (Challenge Trust, 2005). This study will contribute to identifying and developing components of the workplace that facilitate successful work integration, job satisfaction, and tenure of consumer staff, by articulating the participants' underlying motivations for holding their positions and their expectations of the workplace.

Outline of the Study

This study was carried out part-time over 12 months in 2006 and early 2007. Qualitative descriptive methodology, which falls within an interpretivist theoretical perspective (Crotty, 1998), was used to hear, understand, and report the motivation, rewards, benefits and meanings participants' experiences hold for them. Accounts of participant experiences were collected at audio taped semi-structured individual interviews, using an informal conversational style which started with an open-ended trigger question, followed by further open-ended questions and prompts as required to assist the participant in keeping their flow going and sharing their stories. The focus was on enabling participants to give their account about working as a mental health worker, and eliciting their perceptions of key elements in their work role, such as their satisfaction and success.

Guided by constructionism, participants' subjective meanings and realities, as interpreted out of interacting with their work settings, were described and analysed (Denzin, 1994). Issues and narrative themes were identified about each participant's experience of their work role and identity, and meanings they interpret from choosing to work in mental health.

Thematic analysis was completed of the accounts collectively, explicating participants' motivation for undertaking this employment, the rewards and benefits they derive from their jobs and the meanings they interpret from their roles. The benefits and challenges cited in their work experiences provide insights that can contribute to better understandings to inform strategies to improve the work experience of consumer staff.

Arriving at the Research Question

The area of inquiry has arisen from my interactions with colleagues and employees working in mental health, particularly with consumer staff. In practitioner, managerial, and staff development roles held during the past 20 years of working in mental health, I have personally experienced the transition from institutional care to community services. I have participated in policy and service development, and had supervisory, training and mentoring relationships with staff and students from a range of backgrounds. From my background as an occupational therapist I have retained a strong humanistic belief in every person's right and ability to reach their full potential. This is supported by the post graduate education I have completed in mental health rehabilitation, which has given me the expertise and techniques to work with people and systems to enact this value. Through the variety of roles and relationships I have been in, with people from professional and other groups, I have gained an appreciation that valuable attitudes, knowledge and skills are developed from theoretical, praxis, and experiential learning. I consider that all staff development methodologies are relevant and valid, that professional knowledge is not implicitly superior, and that a combination produces the best results. I concur with Anthony, Cohen, Farkas, and Gagne (2002) that the personal qualities of staff are far more important than professional training, to be effective in mental health rehabilitation endeavors. Numerous benefits of employing consumer staff have been identified and accepted in the field (Carlson, Rapp, & McDiarmid, 2001). Studies comparing consumer staff and non-consumer staff found no significant differences between the two groups in service delivery, concluding consumer staff can deliver effective, quality services for clients (Felton et al., 1996; Lyons, Cook, Ruth, Karver, & Slagg, 1996; Mowbray et al., 1996; Solomon & Draine, 1996). It is from these perspectives that consumer staff in the workforce is a given, and I mandate consumer experience as valuable and informative.

To examine my existing views on the topic being investigated, I undertook a presupposition interview prior to commencing this study. With many years working in mental health I was already warmed up to this topic. This assisted me to uncover my interest and motivation in explicating a better understanding of consumer staff experiences. I articulated my opinion that the experiences of consumer staff will be representative of the whole mental health workforce. I derived this view from my own observations and my concurrence with the recovery literature which describes that what consumers want in life is the same as what other people aspire to, such as relationships, jobs, and homes. My broader area of interest is the workforce in general and what makes enabling workplaces. My hope was that by undertaking a study to generate more understanding of how it is for these participants, who may be particularly sensitive to workplace cultures, I would elucidate elements and dynamics of workplaces that enable or hinder staff functioning. I believe that a more satisfied and successful workforce will better serve clients, which leads directly to my main reason for studying this topic; my desire for mental health organizations to be better for everyone.

Summary

This was a small research study involving three participants. The question the research addressed was “How do consumer staff members experience working in mental health?” Its purpose was to reveal their reasons for holding their positions, rewards and benefits they derived, challenges they encountered, meanings they interpreted, and any other insights that are not readily available. To provide context for the study the prevailing recovery paradigm has been outlined, particularly its translation into the contemporary New Zealand mental health sector. This sets the scene for how consumer staff have self-identified, been recruited, selected, employed, and maintained in the mental health workforce. Related issues this study does not explicate are noted. Why this inquiry is relevant and important is discussed from the basis of evolving practice and existing literature. This is supported by an explanation of my own experience and beliefs, with a statement as to my reasons and motivation for undertaking this study.

Chapter two places this study in the context of the practice of employing consumer staff in mental health. Information is provided from the literature about consumer staff work

experiences, in particular workplace challenges and benefits. Chapter three outlines the research methodology and method, describing how the participants' perceptions about their experiences were accessed. A description is given of how ethical considerations and rigor was attended to in the design and conduct of the study. The findings are presented in chapter four, generated from a thematic analysis of the participants' interview transcripts. Chapter five completes this dissertation with a discussion of the research findings and limitations. Finally recommendations and further research possibilities are proposed.

Chapter Two: Literature Review

In this chapter existing literature regarding consumers being employed as staff in mental health services is reviewed to provide an understanding of how this works in practice and the related issues. To set the scene, literature addressing the recovery paradigm, consumer rights, and the value placed on employment are briefly summarised. Current mental health workforce issues and developments are outlined, followed by an overview of the emerging trend of employing consumer staff. Rationale is given for employing consumer staff to help further contextualise the topic. In particular efficacy of these staff in working with clients, the aim of bringing about systemic changes in mental health services and notions of consumer empowerment are discussed. The benefits claimed and challenges faced, including pros and cons perceived for clients, of employing consumer staff are presented. Strategies that have been identified to address the challenges are summarised. Throughout the discussion, it is primarily consumer staff perspectives that are presented, with the addition of mental health professionals' and providers' viewpoints as relevant.

Recovery and Employment

Recovery, with its associated emphasis on consumer rights, is the predominant paradigm influencing contemporary mental health service philosophy and practice. Recovery is described as a process not an end point (Anthony, 1993; Curtis, 1997; Vermont, 1996) or an end result (Deegan, 1988). These authors also point out that the process is not linear, with no set order or series of stages a person goes through. Recovery is the self-determined, subjective experience of each consumer. It has been described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (Anthony, 1993, 2002; Curtis, 1997; Mancini, Hardiman, & Lawson, 2005; Ralph, 2000; Vermont, 1996; Walsh, 1996). These notions of recovery as an individualised, subjectively experienced and developmental process are widely and frequently cited, and have stood the test of time with a good deal of agreement about recovery evident across mental health professional and consumer stakeholders. Locally and abroad, consumers have informed this conclusion through telling their stories in which they

describe the recovery process (Clay, 1999; Deegan, 1996; Lapsley, Nikora, & Black, 2002; Leibrich, 1999). Furthermore, a substantial and growing body of research has shown that people can and do recover (Deegan, 2001).

There is agreement in the recovery literature that recovering from mental illness is more than managing symptoms, and includes overcoming many other factors such as stigma, poverty, homelessness and unemployment (Anthony, 1993; Chaplow, 2004; Mancini et al., 2005; Spaniol, Koehler & Hutchinson, 1994). From a recovery standpoint, employment is considered a right and an important component in mental health (Mancini et al., 2005; Manning & Suire, 1996; Rogers, Anthony, Cohen & Davis, 1995). Two factors are often cited in support of the testimony of mental health survivors. Firstly, being employed is accepted as a contributor to wellbeing for the general population (Kirsh, 2000), and secondly, vocation has played a part in mental health treatment and rehabilitation for over a hundred years (Meyer, 1977). Recovery and current mental health rehabilitation approaches uphold having a job in the regular workforce as an aspiration and a reality for consumers (Anthony et al., 2002; Baron & Salzer, 2000). Moreover, the consumer movement strongly supports employing consumer staff in service delivery and other roles in mental health (Frese & Davis, 1997). It is in this ideological context that consumers are entering the wider employment sector and the mental health workforce.

As the practice of employing consumers into staff positions becomes more commonplace, it is increasingly discussed in the literature. One concentrated focus within the literature has been the views of other professionals towards employing consumer staff (Dixon, Kraus & Lehman, 1994; Doherty, Craig, Attafua, Boodock, & Jamieson-Craig, 2004). The caution expressed and experiences shared by employers and colleagues have raised awareness of the complexity of this process for mental health organisations and systems, and contributed to a better understanding of the benefits and issues while addressing how to respond to these (Besio & Mahler, 1993; Salzer, 2002). Complimenting those perspectives, service provider commentary has raised concerns about the potential for unhelpful categorisation of consumer staff and myths about who is a consumer and who is a provider which perpetuate division around the employment of consumer staff (Stephens & Belisle, 1993). Stephens and Belisle point out that an individual's experience of mental illness does not predict their

recovery outcome and nor is it a predictor of future work performance. Two early medium size quasi-experimental comparative studies in separate states in America examined client outcomes to establish the efficacy of consumer staff working with clients. The studies concluded that these staff members achieved positive results with clients (Felton et al., 1995; Lyons et al., 1996).

The other point of view covered in the literature is that of consumer staff. Gaining their perspective on their experiences in the work role is important to provide a rounded knowledge of the issues outlined above. Considering their experiences, it is also necessary to increase understanding of how being employed as a consumer staff member impacts these workers (Mowbray et al., 1996). Consumer staff have made their perspectives available in the form of personal accounts providing first hand insights about their work experiences and personal beliefs about their place in mental health service delivery (Bledsoe, 2001; Fisk, Rowe, Brooks, & Gildersleeve, 2000; Mack, 2001). Exploring and understanding the benefits and challenges of consumer staff roles and work experiences has also been accessed via research which has consumer staff as key informants (Carlson et al., 2001; Doherty et al., 1996; Middleton, Stanton & Renouf, 2004; Mowbray et al., 1996; Silver, 2004; Solomon & Draine, 1996; Yuen & Fossey, 2003).

Mental Health Workforce Issues and Developments

Workforce issues are topical in this sector, with much attention focussed on the shortage of trained staff and the professional skill sets required across the workforce (Health Funding Authority, 2000; Ministry of Health, 2005). Staff competencies have been comprehensively identified, with personal attributes emphasised. Within those competencies, the personal qualities being sought concern sensitivity, respect, and placing a high value on clients as people (Anthony et al., 2002; Aubrey, Flynn, Gerber & Dostaler, 2005; Everett et al., 2003; Mental Health Commission, 1997; Ministry of Health, 2001; Lapsley et al., 2002; Onken, Dumont, Ridgway, Dornan & Ralph, 2002; Solomon & Draine, 1996).

It has been suggested consumers are an available resource to bolster the mental health workforce due to their high unemployment rates, and that as a group they remain untapped in the mental health workforce (Besio & Mahler, 1993; Mental Health Commission, 2005).

Consumers have been considered in a better position than others to make valuable contributions as potential staff members through their lived experience of having had a mental illness and having received services (Dixon et al., 1994; Felton et al., 1995; Fisk & Frey, 2002; Frese & Davis, 1997; Mental Health Commission, 2005). It has been proposed that in certain roles consumer experience can be an advantage (Felton et al., 1995; Fisk & Frey, 2002; Lyons et al., 1996).

Solomon and Draine (1996) however, have pointed out that individual staff characteristics and personalities are equally important in relationships with clients as whether staff have lived experience. This perspective challenges the notion of implicit suitability for the work by virtue of consumer status. Rather, it has been argued that consumers do not automatically hold the necessary expertise to work effectively in service delivery to clients and they need training to increase their skills and employability and perform their jobs (McDiarmid, Rapp, & Ratzlaff, 2005; Silver, 1998). This critique has contributed to the development of strategies to support and ensure the success of consumer staff, including efforts to train and prepare consumers for work roles in mental health services (McDiarmid et al., 2005).

In line with international initiatives, there has been an increasing acknowledgement in New Zealand over the past decade of the need to develop consumers in the mental health workforce (Mental Health Commission, 2005). This is reflected in the national plan for the next 9 years published by the Ministry of Health (2006) in which developing a consumer workforce is a stated action as part of creating and ensuring better mental health services.

Consumers in the Mental Health Workforce

The emergence of reported experiences and studies concerning employing consumers in mental health services suggests this practice has become increasingly widespread and accepted. For example, in a national survey of supported housing agencies, Besio and Mahler (1993) ascertained that out of 378 respondent organisations throughout the United States, 38% had consumers as paid staff. This decade-old survey gives an indication of how long ago this practice was occurring and to what extent. Indeed, Barrett, Pratt, Gill and Basto (2000) claimed that there is a long history of consumers providing services in the

mental health field. Though not universal, this practice has spread from initial predominance in recovery-oriented psychosocial rehabilitation programmes focussed on self-help, vocation and social support, to more traditional clinical settings, with consumer staff holding positions as case managers and members of treatment teams (Fisk et al., 2000). The employment of consumer staff however has not been quantified in any definitive or authoritative way, which means it is not possible to offer a clear current picture nationally or internationally.

Despite the lack of clarity surrounding timeframes and current statistics, it seems that the roles consumer staff are fulfilling can be clustered into two groupings. The first are roles designated for consumers only, which include advisors, representatives, governance on boards, auditors, peer support workers and employees in consumer run organisations. The second group are generic roles that can be filled by any qualified person such as frontline workers, administrators, managers, policy analysts and researchers (Barrett et al., 2000; Mental Health Commission, 2005).

Further complicating the picture is the fact that for over a decade it has been recognized that a significant number of mental health professionals, administrators and clinicians have had experiences of a major change in mental status (Doherty et al., 2004; Salzer, 2002; Stephens & Belisle, 1993). This realization reflects the statistic that one person in five in New Zealand is likely to experience a mental illness at some period in their lifetime. As Basto et al. (2000) stated: “of course, consumers have always been employed in this system, although usually without disclosing their consumer status” (p. 106). This statement directs attention towards issues associated with how people identify themselves, the definition of a consumer, and that the nature of mental illness creates changes as some people recover and others become unwell, which means the location of consumer staff is not static. Nonetheless, there are an increasing number of mental health workers who are becoming more open about their identity as consumers and their lived experience of mental illness (Basto et al., 2000).

Concurrently mental health services are employing consumers as staff, with instances of lived experience being acceptable and even sought during recruitment. To this end various descriptions have been applied as to the experience an individual needs to have to qualify

as a consumer. Commonly the definition requires personal past or current experience of diagnosable mental health problems and psychiatric treatment (Doherty et al., 2004; Salzer, 2002). In a small study involving consumers as case managers, findings revealed that in a service delivery team in Oregon, the criteria to be employed as a consumer staff member specified the amount and nature of treatment undertaken (Solomon & Draine, 1996). To qualify, in addition to having a diagnosed major mental illness, consumer staff needed to have had a psychiatric hospitalisation at some prior time; psychiatric inpatient care for at least 14 days or at least five service contacts in the past year; and be undertaking regular outpatient treatment (Solomon & Draine, 1996). Other definitions specify experience of having used mental health services and remain silent about diagnosis or the experience of mental illness symptoms (Mental Health Commission, 2005).

Additionally there are instances of making explicit that previous or current mental health services cannot have been received from the agency where the consumer staff member is employed (Solomon & Draine, 1996). This is stated in an attempt to overcome the difficulties associated with dual relationships and boundary challenges (Carlson et al., 2001; Fisk et al., 2000). Another approach taken is to define eligibility for consumer staff positions by an individual's acknowledgement and disclosure of her or his experience of mental illness (Bledsoe, 2001). This is considered absolutely critical by some authors and in their view the absence of open identification and sharing of personal experience invalidates the definition of consumer delivered services and eliminates staff who, in spite of consumer experience, do not identify as such (Salzer, 2002). For instance, in a homeless outreach project employment as consumer staff required experience of homelessness and a mental or substance abuse disorder (Fisk et al., 2000), while in another service for homeless persons with mental illness the requirement was either/or both mental illness and homelessness (Dixon et al., 1994). While this last example holds merit in tailoring the definition to match consumer staff experience with a specific client group, Stephens and Belisle (1993) disagreed with consumers needing to meet an ex-patient or system victim test. They suggest a litmus test for who is a real consumer is akin to a debate about whether a person is sufficiently marginalised or disabled (Stephens & Belisle, 1993).

Rationale for Employing Consumer Staff

The trend of employing consumers in mental health services follows on this traditionally common practice in other fields including substance abuse, human immunodeficiency virus (HIV), hearing impaired, and spinal cord injuries (Carlson et al., 2001; Dixon et al., 1994; Fisk et al., 2000). This practice is built on the assumption that people can provide sustaining support to others with similar disorders (Fisk et al., 2000) and that reliance on professionals is not essential to become well (Dixon et al., 1994). Self help and the consumer movement are among the factors that have contributed to consumer participation and the establishment of consumer staff. The emergence of self help in mental health services mirrors other fields, as outlined above. Of greater significance in mental health has been the consumer movement, a diverse international phenomenon which has grown from consumer demands to have rights upheld, have a voice in policy and politics, and lobbying to bring about change (Frese & Davis, 1997; Middleton et al., 2004; Mowbray et al., 1996). In response to these broad imperatives, multiple reasons are cited for consumer staff employment, with the expression of affirmative action resonating most closely with the agenda of the consumer rights movement (Mowbray et al., 1996).

The various rationales given for employing consumer staff fall into two broad categories which are embodied in the objective of improving service sensitivity and responsiveness to clients needs (Mental Health Commission, 2005; Middleton et al., 2004). The first category, as identified above, is founded on the belief that consumers possess unique insights and personal qualities that are desirable in direct service delivery to clients (Bledsoe, 2001; Dixon, et al., 1994; Doherty et al., 2004; Fisk et al., 2000; Frese & Davis, 1997; Mack, 2001; Manning & Suire, 1996). This belief has been supported by qualitative and quantitative studies with an international spread spanning more than a decade that have consistently concluded consumer staff make a valuable contribution, and demonstrated that this staff group are at least as effective at achieving client outcomes as other staff (Besio & Mahler, 1993; Felton et al., 1995; Fisk & Frey, 2002; Lyons et al., 1996; Mowbray et al., 1996). The second rationale is focussed on impacting the system as a whole, bringing about reform of organisational cultures towards the recovery paradigm by reducing discrimination, educating staff and ensuring the consumer voice is represented in policy and planning (Carlson et al., 2001; Doherty et al., 2004; Mental Health Commission, 2005; Middleton et al., 2004).

Another less commonly articulated rationale concerns the philosophical alignment between recovery and consumers having work made accessible and available, with the recognised benefits to individuals of being employed (Doherty et al., 2004; Mowbray et al., 1996). Furthermore the potential for consumer staff empowerment is associated with work that is meaningful and purposeful, personally enriching, a sense of contributing to the system, having their contributions valued, and helping other consumers (Honey, 1999; Yuen & Fossey, 2003).

Benefits, Challenges and Issues Associated with Consumer Staff Employment

Benefits

The benefits and challenges of employing consumer staff in mental health services have drawn significant attention in the literature. The benefits have been identified as existing on multiple levels with beneficiaries identified as including the consumer staff themselves, clients, and mental health services and the system as a whole (Carlson et al., 2001). A global benefit for the mental health system is that employing consumers into staff roles underscores the sector's commitment to consumerism (Mowbray et al., 1996).

Empowering consumer staff.

In several early qualitative studies, evaluating the experience of consumer staff employed in a range of service settings, benefits for consumer staff have been identified as including personal growth, skill development, increased confidence, and improved self esteem (Besio & Mahler, 1993; Manning & Suire, 1996; Mowbray et al., 1996). Those findings are supported by a later personal account in which Mack (2001) recounted the benefit of being able to be open about her own mental illness without fearing repercussions, an experience also described by participants in two qualitative evaluations in which consumer staff considered it an advantage not having to hide their own mental health problems and claimed the chance to be open about their own disability contributed to their empowerment (Doherty et al., 2004; Manning & Suire, 1996). The opportunity to work has been identified as having benefits of earning an income, purposeful activity, social connectedness, sense of belonging to a team, and gaining a first position as a stepping stone back into employment, which was not linked specifically to working in mental health services (Besio & Mahler, 1993; Doherty et al., 2004; Yuen & Fossey, 2003). More directly linked to the nature of working with clients in mental health is consumer staffs' belief they are helpful to clients

with rewards and satisfaction derived from helping others (Yuen & Fossey, 2003). In addition to feeling good as a result of the positive feedback they received from clients and professionals, consumer staff who participated in a focus group expressed pride in clients' achievements (Mowbray et al., 1996). This leads to a cyclical process of consumer staffs' growth and learning through their job helping to cope with their own mental illness, and in turn feeling this increased their ability to help clients (Manning & Suire, 1996; Mowbray et al., 1996).

Role modelling to clients.

An examination of benefits for clients includes studies that have concluded consumer staff are equally as effective in service delivery as non-consumer staff and make valuable contributions, and that inclusion of consumer staff can enhance client outcomes (Felton et al., 1995; Lyons et al., 1996). Based on evaluations of situations where consumer staff work with clients, there is a growing consensus within the literature as to the specific benefits consumer staff offer clients as a result of their unique expertise and perspectives they bring to the job (Doherty et al., 2004; Manning & Suire, 1996). Reflecting on their work experience with clients, consumer staff have identified they make a special contribution to clients (Yuen & Fossey, 2003). That role modelling is of benefit for clients is an often repeated claim in studies reporting the advantages of employing consumer staff to work alongside clients (Besio & Mahler, 1993; Dixon et al., 1994; Fisk et al., 2000; Frese & Davis, 1997; Middleton et al., 2004; Mowbray et al., 1996). Consumer staff represent a positive, hope inspiring role model, by demonstrating that they are in employment and making a contribution to society (Doherty et al., 2004). Having "a positive role model who has a personal understanding of the issues pertaining to having a major mental illness" (Doherty et al., 2004, p. 80) has been considered the greatest advantage for clients. Bledsoe (2001) in particular has linked this concept to recovery, with clients witnessing consumer staff doing positive things with their lives and coined the term "believable hope" (p. 35).

An associated factor in regards to role modelling is the nature of the relationship between consumer staff and clients, based on clients identifying that they have something in common with consumer staff, as people they can relate to and who understand their issues

(Doherty et al., 2004; Mowbray et al., 1996). Consumer staff are described as relating to clients with empathy and understanding, and as being safe to talk to, leading to a higher level of trust (Besio & Mahler, 1993; Bledsoe, 2001; Doherty et al., 2004; Frese & Davis, 1997). Client engagement in the relationship with the consumer staff member is deemed a client benefit, both in its own right and for the other outcomes this engagement enables (Bledsoe; Dixon et al., 1994; Doherty et al.). Bledsoe and Dixon et al identified as significant the 'street smarts', survival skills and mental health system knowledge consumer staff have accumulated through their own experience. This insight and knowledge are widely deemed to be beneficial in helping and advocating for clients to overcome obstacles and obtain resources from mental health services and the wider community (Besio & Mahler; Dixon, et al.; Fisk et al., 2000; Middleton et al., 2004). Similarly consumer staff are thought to have developed a repertoire of coping strategies and practical advice which are beneficial for clients (Dixon et al.; Fisk et al.; Frese & Davis).

Mental health services and systems.

Benefits to mental health services and the system as a whole have been considered with flow on effects identified for the wider community. In terms of organisations employing consumer staff, Frese and Davis (1997) who support this practice from a consumer perspective, presented the view that consumer staff bring greater motivation to their work. This viewpoint is supported by the findings of a large national survey of supported housing programmes in the United States in which consumer staff were typically reported to be good employees (Besio & Mahler, 1993). In this same review, Besio and Mahler reported consumer staff as being extremely dependable, willing to do more than routinely expected and more flexible in hours and tasks, based on consumer staffs' strongly felt responsibility to help others, having been through the system themselves.

A key benefit for mental health services and the system is the positive effect consumer staff can have on non-consumer staff and others, which parallels the role modelling benefit for clients. In a small scale study of a community mental health team, staff benefited from examining their own attitudes and practices prompted by working alongside consumer staff (Doherty et al., 2004). Likewise consumer consultants who were the participants in a small qualitative Australian study felt their presence had positively influenced staff attitudes

(Middleton et al., 2004). More specific claims of benefits include educating other staff about recovery from a consumer staff perspective increases the sensitivity of staff, in turn sensitising and influencing the mental health services approach to consumers, making services more attractive and relevant to clients (Besio & Mahler, 1993; Dixon et al., 1994; Doherty et al.; Fisk et al., 2000). The message sent and the learning gained from the example set by employing consumers and consumer staff as spokespersons has also decreased negative stereotypes, reduced stigma across the mental health system and extended to the wider community (Besio & Mahler; Dixon et al.; Fisk et al.). Based on this rationale, Besio and Mahler proposed consumer staff are well placed to act as advocates for system changes.

Challenges and Issues

The challenges outlined in the literature are oriented around the difficulties and confusion faced by consumer staff themselves, which become the issues mental health services are compelled to address in light of the acceptance of the benefits of employing consumers as covered above. Several of these challenges relate to factors that are endemic in the mental health system such as stigma, while other issues identified are common to all staff such as feeling valued, conditions of employment including remuneration and role clarity, and being well equipped to do the work. Other issues described may not be unique to consumer staff, but for this group present particular challenges pertaining to boundaries and roles related to being both a consumer and a staff member, and concerns associated with their own mental health problems.

Stigmatising behaviour.

As early as 1993, Besio and Mahler uncovered stigma and distrust of consumer staff by non-consumer staff, especially in the early stages of employment. This phenomenon was also reported by Middleton et al (2004) with consumer consultants experiencing hostility, suspicion and disrespectful attitudes toward themselves and consumers in general from clinical staff. Evidence includes descriptions of the experiences of two consumer staff in a community service, which were shared in small discussion meetings and subsequently published in a co-authored paper that reported either experiencing or witnessing other consumer staff being discriminated against in the workplace (Fisk et al., 2000). Early in

their employment discriminatory attitudes manifested in being asked to perform menial tasks (Fisk et al.) such as making coffee, cleaning offices and doing paperwork. However it was noted that distrust and being asked to perform work activities perceived as less important was similarly experienced by other paraprofessionals and people with different credentials who were perceived to be lower in the hierarchy, and therefore, it is not conclusive that these acts of discrimination were specific to consumer staff (Besio & Mahler; Fisk et al.). While not couched in terms of discrimination, the three research participants working in a consumer staff team who were interviewed in a small study by Yuen and Fossey (2003) identified feeling frustrated by team processes, including the tedium of basic tasks.

Perhaps more revealing are examples of being excluded socially and noticeable differences in the way staff interacted with consumer staff compared to non-consumer staff (Fisk et al., 2000). Similarly, findings of a qualitative evaluation in which 16 consumer staff were interviewed about factors they felt had affected their employment reported that all participants identified stigmatising behaviour by non-consumer co-workers (Manning & Suire, 1996). As well as exclusion from socialising and legitimate work activities, consumer staff have told of how they lacked decision making autonomy, their opinions regarding clients were not accepted, and their input into decision making processes was ignored (Doherty et al., 2004; Manning & Suire, 1996; Mowbray et al., 1996). Consumer staff considered the reason co-workers remain distant from them was their mental illness (Manning & Suire).

The stigma surrounding mental illness is described as subtle and pervasive. Joking about people with mental illness, black humour, inappropriate terms used to describe clients, careless remarks and the way consumers are related to including paternalistic attitudes exists within mental health services and in the community (Doherty et al., 2004; Manning & Suire, 1996; Middleton et al., 2004). The participants in Manning and Suire's (1996) evaluation viewed their label of mental illness as overshadowing other factors such as their job performance and how co-workers perceived them, and proposed that the discrimination was linked to their mental illness. This was reiterated by Fisk et al's (2000) study, in which the consumer staff considered discrimination was more likely after they disclosed their mental health history. Discriminatory behaviour is not confined to co-workers. Whether or

not to disclose their own mental health history to clients poses a further dilemma for consumer staff, as while the benefits of role modelling and educating clients from a consumer perspective hinge on disclosing their own experience, clients do not always accept consumers as role models or as legitimate staff able to help them (Doherty et al.; Fisk et al.; Manning & Suire).

Another form of stigma experienced by consumer staff is the ‘pathologising’ of their presentation in the workplace, where their ways of acting and opinions are interpreted as illness related rather than an appropriate and valid response to the situation. Consumer staff have felt frustrated at their behaviour being misinterpreted as a manifestation of their mental illness and experienced supervision as being monitored for signs of ill health (Manning & Suire, 1996; Middleton et al., 2004).

Disclosure and maintenance of wellbeing.

The issue of disclosure has been identified as a challenge, with an implicit expectation consumer staff will disclose either overtly or by virtue of having consumer status reflected in their job title. Based on a reflective review of a year long project informed by consumer staff and professional colleagues employed in a team to deliver outreach services, Fisk et al (2000) argued that disclosure needs to be handled carefully for the sake of the consumer staff member and to maximise the intended benefits. They also give the proviso that they consider disclosure is not absolutely necessary and benefits of having a unique consumer perspective as part of service delivery transcends their visibility (Fisk et al.). In light of the discrimination that exists, routine self-disclosure carries with it risk to the individual consumer staff concerned and threat to the practice of employing consumers as staff. Frese and Davis (1997) highlighted the vulnerability for consumers associated with disclosure. This is keenly felt in the context of feeling inadequate to do the job or feeling lesser than other staff, especially during the transition from client to staff member (Bledsoe, 2001; Fisk et al.). According to Frese and Davis, consumer staff have concern that disclosure will lessen their credibility, and Fisk et al suggested disclosure may be best held off until after consumer staff members have demonstrated their ability to do their jobs. This carries with it the pressure to prove themselves because they have had a mental illness, as was the experience of one of the respondents in the first hand accounts informing the study by

Doherty et al (2004). Similarly Bledsoe recounts overextending herself and avoiding making waves.

Associated with holding their own in spite of their illness, whether this is visible or undisclosed, is the effort consumer staff have to put into remaining mentally well. While other staff may be aware of consumer staffs' extra support needs, they do not necessarily understand the specific issues consumer staff face in relation to their mental health needs and appreciate how difficult it is to maintain themselves in work (Doherty et al., 2004). All three consumer staff participants interviewed by Yuen and Fossey (2003) raised issues about working and maintaining wellbeing, which included coping with work related stressors, monitoring workloads and demands, and relapse prevention. The consumer staff informants in the study by Middleton et al (2004) were mindful that work related stressors had the potential to trigger their own distress. Bledsoe (2001) shared that mental illness symptoms and staying well are a focus among her consumer staff peers, but despite best efforts relapse does occur and carries with it the additional challenge of returning to work afterwards while saving face. Paradoxically the very things that might assist in avoiding work related issues compromising consumer staff members mental health and compounding the risk of relapse can engender concerns in the consumer staff. Consumer staff carry fear that a back lash may accompany a request for reasonable accommodations, whereby modifications are made to the work role or activities, to overcome disabilities and enable successful performance (Dixon et al., 1994; Frese & Davis, 1997).

Employment concerns and conditions.

Besio and Mahler (1993) recognised the call for consumer staff to address their own needs and problems, to avoid an increase in disability-related behaviours which may affect job performance or attendance. Despite this recognition, Dixon et al's (1994) perspective as the leaders of a community team employing consumer staff was that the greater attrition among the consumer staff in their team compared to other staff may be illness related. A decade later, the non-consumer staff in the team studied by Doherty et al (2004) raised concern about the amount of sick leave taken by consumer staff, and the consequential inconsistency in client care. However it is important to note this team only had two consumer staff members and the authors made the point that this was not the experience of

other teams operating with consumer staff members in the area and this has not been a reported concern in other studies (Doherty et al.).

Employment conditions which have been raised as areas of concern for consumer staff include low pay and status, job insecurity, availability of part-time work only, limited discretionary use of time and authority to act autonomously, lack of decision making power, lack of time to do the job being asked, and poor role clarity (Fisk et al., 2000; Manning & Suire, 1996; Middleton et al., 2004; Mowbray et al., 1996). While these concerns may be shared by the wider workforce, consumer staff experience disparity with non-consumer staff, and these factors become indicative of not feeling valued or respected as equals (Doherty et al., 2004; Manning & Suire; Mowbray et al.). Fisk et al labelled this “institutional discrimination” (p. 249) and indicated low wages and part-time positions for consumer staff may reflect a cautious approach to employing them and a lack of appreciation of the unique perspectives these staff bring to the work. Conversely, consumer staff are reported to consider receiving a wage as satisfying recognition that their services are valued (Yuen & Fossey, 2003).

Poorly defined roles with lack of clarity regarding expectations, inadequate job descriptions, and feeling unsure what they should be doing, is a common experience raised in several pieces of literature (Carlson et al., 2001; Dixon et al., 1994; Manning & Suire, 1996; Middleton et al., 2004; Mowbray et al., 1996). In a review of the literature Carlson et al identified this role confusion as ambiguity in the work and duties, with close association with role conflict. Role conflict occurs between consumer and non-consumer staff, with discomfort on the part of both groups and an ensuing power struggle as non-consumer staff have difficulty accepting consumer staff as equals (Carlson et al.).

Boundary issues.

Boundary issues prevail between consumer and non-consumer staff, especially as the transition is made from client to staff member. Dual relationships further complicate boundaries among the staff team if the consumer staff member is employed in the same agency as they have previously or are currently receiving services as a client (Bledsoe,

2001; Carlson et al., 2001; Dixon et al., 1994; Doherty et al., 2004; Fisk et al., 2000; Mack, 2001; Manning & Suire, 1996; Mowbray et al., 1996).

Another phenomenon experienced by consumers in their role as staff is their boundaries with clients, most acutely felt when establishing themselves in their positions. Mowbray et al (1996) described role strain occurring between consumer staff and clients as resentment creeps into the relationship as the consumer staff member makes the transition from client to staff, repositioning the power and dynamics that existed previously with their peers. Some clients feel betrayed by the consumer staff 'crossing over' to the other side, creating complications in the boundary between the consumer staff's new professional role and friendships between consumer peers (Fisk et al., 2000). Whether to maintain or form friendships, dual relationships and boundaries between work and personal relationships, 'taking sides' with clients versus the treatment team, torn loyalty, and feeling like a traitor to other consumers are among the challenges that have been identified, impacting all parties concerned (Bledsoe, 2001; Carlson et al., 2001; Dixon, et al., 1994; Manning & Suire, 1996; Mowbray et al.). Bledsoe, in her personal account as a consumer staff member, described experiencing a conflict of interest and torn loyalty between consumers and other staff. Consumer staffs' alignment with other staff has been reported to result in loss of friendships and loneliness for consumer staff, as they are no longer implicitly accepted among their consumer peer group and not yet included as belonging to a staff team identity (Fisk et al.). Taking on a new identity and sense of belonging to a staff team can be fraught for consumer staff who, in addition to not feeling fully accepted, do not necessarily agree with the ethos among the staff, such as experiencing difficulty witnessing the mental health service not treating clients well (Mowbray et al.).

Professional issues.

In the context of multiple role relationships and complex boundaries, confidentiality presents as a particular challenge. While Carlson et al (2001) acknowledged confidentiality is an issue for all staff, consumer staff hold particular tensions about issues such as sharing with the client's treatment team information about the client which they have acquired through personal contact, regardless of whether the intention is in the client's best interests (Besio & Mahler, 1993; Bledsoe, 2001; Carlson et al.).

Another challenge that has arisen for consumer staff in working with clients is in encouraging client participation in programmes, working with clients who are unmotivated, or factors such as substance use undermining client progress (Mowbray et al., 1996; Yuen & Fossey, 2003). While these clinical challenges are shared by all staff, consumer staff have a special sympathy toward their peers which may be eroded when clients are not making the requisite progress to reward the consumer staff's efforts (Mowbray et al.).

A further significant issue identified in many settings is the indication for and lack of consumer staff training to impart information, enhance skills, prepare for their roles, and enable them to carry out their jobs (Doherty et al., 2004; McDiarmid et al., 2005; Mowbray et al., 1996; Silver, 1998; Solomon & Draine, 1996). The unmet need for training encompasses formal education as well as on the job development, including reported inadequate support, supervision and guidance (Middleton et al., 2004). Clinical staff receive training that may not be available to consumer staff, who on entering the mental health workforce can be said to be on a steep learning curve in getting to know about the complexities of the mental health system among other needed subject areas (McDiarmid et al.; Middleton et al.). Orientation, with ongoing forms of support, is cited by Manning and Suire (1996) as key to making the transition into employment for consumer staff who had undergone training. Many of the 16 members of this consumer staff cohort who were interviewed had experienced being "thrown in" and told to "figure out what to do" in the absence of a clear job description (Manning & Suire, p. 47). Similarly, both the consumer staff members in the small mixed methods study by Doherty et al said they had insufficient training for their job and the training they did receive did not provide the skills they required. The three consumer staff interviewed by Yuen and Fossey (2003) also suggested that skill development would be helpful.

As this overview of the literature reveals, understanding the challenges inherent in the practice of employing consumer staff is being generated alongside a widespread acceptance of the advantages. Consequently attention is being paid and commitment made to incorporating consumers in the mental health workforce in positive ways that minimise the toll on these workers and maximise the benefits for clients and the system itself. Strategies to counteract the challenges, address issues, and remove barriers are being developed and tried out with an emerging body of knowledge being shared. As outlined above, the

challenges and issues extend well beyond the sphere of control or influence of consumer staff themselves. Responses are required from professionals, service leaders and others in positions of power to impact systemic and organisational phenomenon that throw up difficulties for the consumer staff themselves, threatening their wellbeing, job tenure and role effectiveness.

Strategies to Support Consumer Staff Employment

The increasing trend of employing consumer staff indicates a consensus that working in mental health is viable for consumers, and holds potential benefits for consumer staff and clients. In order to overcome the challenges and realize the benefits, the practice of employing consumer staff who hold lived experience of mental illness as their primary qualification and job credential needs to be well understood, planned for, and carefully managed (Besio & Mahler, 1993; Dixon et al., 1994; Doherty et al., 2004; Fisk et al., 2000; Manning & Suire, 1996; Stephens & Belisle, 1993). In New Zealand, the Mental Health Commission (MHC) (2005) has the stated aim of recruiting more consumers into staff roles, with improved employment practices to retain them. The Commission specifies adopting affirmative action policies, reasonable accommodations, training, support, better defined jobs, improved work conditions and creating professional associations for consumer staff (MHC, 2005). In contrast, McDiarmid et al (2005) cautioned that despite increased attention to consumer staff, there remains a lack of models that prepare, support and sustain consumers in staff roles in mental health.

Efforts to provide effective support have been varied. Mack (2001), in her personal account as a consumer staff member, recounted new policies being put in place by the organization she worked in following discussions between herself and her employers about the issues and stress she encountered in her job. There is some evidence that policy initiatives may be effective. The consumers interviewed by Manning and Suire (1996) identified a range of agency policies including job sharing, flexible hours and a team approach with a back up system if someone is temporarily unable to perform to usual capacity, as supportive in reducing stress and promoting job security. These responses typify what is occurring in the field with attention being paid to organizational and systems policies, and practice guidelines being developed to address the challenges that have been identified.

In an attempt to identify best practices, Salzer (2002) pulled together information from a review of literature about the employment of consumer staff and the perspectives of leaders from a large mental health agency in Pennsylvania, to provide a set of practice guidelines specific to consumer staff. He makes the proviso that these guidelines do not reiterate all ready well documented best practice for mental health programmes, and that employing consumers does not necessarily alter the general philosophies and approaches underlying services. Solutions and strategies are provided regarding training, supervision, dual relationships, role conflicts and confusion, confidentiality, and creating a positive environment for consumer staff (Salzer). Other authors add reasonable accommodations to Salzer's list in their descriptions of solutions, supports, and coping strategies (Fisk et al., 2000; Silver, 2004), as well as conditions of employment including the need to attend to remuneration discrepancies (Yuen & Fossey, 2003). From a consumer staff perspective, Bledsoe (2001) identified the value she has found in forward planning by using recovery tools to anticipate, recognize, and monitor symptoms of her mental illness.

The various strategies presented below are not tagged to address specific challenges and issues, or directed at any singled out group such as consumer staff, other staff or organisations. The phenomena that occur affect all parties concerned and as such require collaboration and participation by all stakeholders to address them. Issues are complex, multilayered, and often situation and person specific, though the experiences and learning of others can be helpful and informative to those seeking solutions. Challenges tend not to occur in isolation, sole solutions do not provide the full answer, and the following strategies need to be combined and tailored to meet the need.

Training

Training has received a large amount of attention in the literature with agreement among consumers, providers and policy makers that it is necessary to prepare consumer staff with knowledge and skills to work in mental health services (Barrett et al., 2000; Basto et al., 2000; McDiarmid et al., 2005; MHC, 2005; Mowbray et al., 1996; Salzer, 2002; Silver, 1998; Solomon & Draine, 1996; Stephens & Belisle, 1993; Yuen & Fossey, 2003). Consumer staff have reported feeling better equipped to perform their role with the appropriate training (Silver, 1998), defined broadly as all forms of development including

formal education, in-service and on-the-job (MHC, 2005). Training has also been attributed with increasing employability and enabling consumer staff to obtain and maintain employment in the mental health field (McDiarmid et al., 2005).

Supervision

The importance and value of supervision is repeatedly endorsed in the literature, with commentary on the availability as well as suitability in terms of the nature of the supervisor and the approach taken (Carlson et al., 2001; Fisk et al., 2000; Mowbray et al., 1996; Salzer, 2002; Silver, 2004; Yuen & Fossey, 2003). For consumer staff, as for all staff working with people, supervision is important to fulfill accountability functions as well as resolving interpersonal issues that may affect an individual's performance. Supervision is also a strategy to proactively address challenges associated with dual relationships, boundaries, role conflicts and confidentiality (Salzer). Fisk et al explained how they found in the setting they explored that the usual supervision approach taken with staff was modified to better meet the needs of the consumer staff by including opportunities for discussion of feelings, which were often related to role adjustment and other workplace challenges such as discrimination. Supervision can help explore and normalize emotions and reactions to situations, without the consumer staff member's behaviour being pathologised or seen as symptomatic of their mental illness (Carlson et al.). The accessibility of supervision is important, with consumer staff feeling the supervisor is approachable and available. Mowbray et al also raised the value of mentoring so consumer staff have a more experienced peer they can turn to for support and assistance in mastering the demands of the workplace.

Accommodations and Support

Reasonable accommodations are mandated by the 1990 Americans with Disabilities Act and involve adjusting work schedules and activities to enable individuals with disabilities' work performance (Bledsoe, 2001; Fisk et al., 2000; Silver, 2004). As Fisk et al. pointed out, not every situation calls for accommodations, which are not to be confused with modifying work responsibilities or expecting co-workers to compensate for poor performance. Lack of competence should be addressed by other strategies such as training. Specific evidence about the efficacy of workplace accommodations is limited. In a

qualitative study 12 consumer staff informants advised they found flexible use of time and work schedules helpful (Silver). However caution is advised so as not to create discrimination, a factor that has been identified as making it hard for consumer staff to ask for reasonable accommodations in their desire to hold their own as equals in the staff team despite their belief accommodations would have been helpful to them at times (Bledsoe; Fisk et al.).

Job supports have been described as being similar to accommodations and the other strategies being outlined here. However social support has been identified as an essential coping mechanism in its own right, taking the form of interpersonal support from understanding and encouraging co-workers, supervisors and personal contacts including family (Silver, 2004). Solomon and Draine (1996) identified the importance of support among consumer staff colleagues in a small randomized trial involving seven consumer staff with the sample split between working in consumer staff only team and the remainder in a predominantly non-consumer team. Hiring more than one consumer staff member in a setting to enable peer support and providing other opportunities for consumer staff to get-together and provide support to one another has been recommended (Salzer, 2002; Solomon & Draine, 1996).

Mental Health Services Culture and Systems

Employing consumers needs to go further than affirmative action as employment needs to take into account the effects on the consumer staff members themselves. Embedding a recovery philosophy which helps create a positive environment in which consumer staff are valued and enabled to function well, requires the acceptance of this practice by all involved (MHC, 2005; Mowbray et al., 1996). Training and support for non-consumer staff have also been recommended, to increase their understanding and acceptance of consumer staff as equals. Additional strategies identified to build acceptance and create an environment where consumer staff feel comfortable discussing their difficulties include making relationships and resolving conflict between consumer and non-consumer staff groups the focus of team processes and meetings; direct communication of performance expectations to all staff; and a nil tolerance approach towards discrimination (Carlson et al., 2001; Fisk et al., 2000; Mowbray et al., 1996; Salzer, 2002; Silver, 2004).

Organisational policies and practice guidelines that translate philosophy into day-to-day workplaces have been reported as helpful (Besio & Mahler, 1993). In reading various policies and practice guidelines that have been tried and proposed the underlying theme is to create strategies that are relevant to a given setting and situation. For example, to address the issues of dual relationships some agencies do not hire consumers who are clients of the service; however in areas where no other service provider is available this would not be an option (Carlson et al., 2001). Reported strategies span having processes in place ranging from advocacy and grievance processes that can be called into use for a range of situations including addressing concerns not yet anticipated, to more prescriptive protocols governing staff in areas such as confidentiality and friendships with clients. While policies should be as unambiguous as possible, many times a judgment call is involved which needs to be accompanied by open discussion (Carlson et al., 2001). Along with clear policies, organisational documents such as job descriptions should delineate roles and responsibilities and make explicit behavioural expectations to enable job performance and avoid role confusion (Carlson et al.).

Working conditions and job security such as adequate remuneration, availability of enough hours to do the job and earn a living, an understanding of how the organisation will support staff through a period of need, and sick and other leave allowances send a message of how much consumer staff are valued (Fisk et al, 2000; Yuen & Fossey, 2003). Applying organizational resources to appropriately employ and remunerate consumer staff is a tangible way to move the practice of employing consumers from philosophical rhetoric to just reality.

Strategies and responses need to be system wide, such as career advancement pathways in the mental health and education sectors (Barrett et al., 2000; MHC, 2005). Such strategies need to be broadly framed, as some consumers view working in mental health as a starting point or stepping stone rather than seeking a career in mental health per se and have taken the skills gained in training and work experience to progress on to other employment (Doherty et al., 2004; Weingarten, Chinman, Tworkowski, Staynor & Davidson, 2000). For others the aspiration to move beyond paraprofessional roles, shedding stigmatizing consumer designated positions and adopting professional status should be an option. Opportunities for advancement, including formal education, need to be available for

consumer staff who want to pursue a career “ladder” in the mental health field (Barrett et al., 2000; Mowbray et al., 1996).

Finally in considering the culture and ethos of the mental health system as a whole, the labeling of consumer staff warrants consideration. Rigid definitions of who is a client, consumer, or staff member may promote division and escalate power differentials, the tensions of which can be mitigated if people are released from the exclusive roles of client or employee (Doherty et al., 2004; Stephens & Belisle, 1993).

Workforce Implications

A comparative study conducted in New Jersey across a large mental health workforce sample drawn from 35 agencies found consumer staff felt more supported by their employers than their non-consumer colleagues (Basto et al., 2000). This seemed to be based on consumer staff receiving a variety of organizational supports generally not available to other staff, including training, education, support, and supervision. For instance in this statewide survey using multiple measures consumer staff reported greater levels of commitment to their employing organization and higher career commitment (Basto et al.). In discussing these results the authors ask: if consumer staff who perceive they are supported by their organization reciprocate with commitment, why not create these same conditions for all staff? Similarly, Carlson et al. (2001) proposed the host of solutions to attenuate the difficulties of employing consumer staff would also create a more desirable work environment for all.

Conclusion

The existing literature provides a background towards addressing the research question of how consumer staff members experience working in mental health. This review illustrates how employing consumers as staff has emerged in the context of the mental health recovery paradigm, with attention paid to how this philosophical ideal translates into practice. A growing body of international studies and narrative commentaries is generating a broad and in-depth understanding of this practice from a range of perspectives. What started out as largely anecdotal support has been critically examined through formal inquiry. That benefits exist for consumer staff, clients and organisations, has been established with

associated challenges and issues identified. Alongside a frank exposure of these challenges and issues, strategies and solutions are being trialed and evaluated to support the successful employment of consumer staff.

A preponderance of small scale qualitative studies and personal accounts in the literature to date offer an understanding of the advantages and implications of employing consumer staff which is informative in developing a mental health consumer workforce. Whilst deliberate efforts to employ consumer staff are not happening across the whole sector, there has been no conclusive stock take completed to indicate how much and where this is occurring. Limitations in the body of knowledge make it difficult to gauge whether the trend towards employing consumer staff is accelerating or declining, and whether initiatives to reduce workplace stigma and provide support are being adopted or prove effective. A general climate of concern for the welfare of consumer staff is conveyed, but a greater volume of their voices telling how it is for them in a variety of employment roles and settings is still needed to develop this employment practice in a sound way.

New Zealand is following general trends occurring abroad, but little local evidence is available regarding the extent to which international findings relate. Thus there is a need for research to establish the nature of and issues surrounding consumer staff employment in this country. Prior research strongly points towards the value of research approaches that involve recruitment of consumer staff as key informants and methodologies that capture their work role experience.

Chapter Three: Methodology and Methods

Current trends of employing consumer staff in mental health provider roles indicate a need to better understand the employment experience of these workers. The purpose of this current study is to hear, understand and tell of the work-related experiences of people working as consumer staff. Furthermore, the study aims to provide insights not readily available, to understand and improve the experience of employing consumer staff for both the workers and organisations that employ them.

The question the research addressed was “How do consumer staff members experience working in mental health?” To answer the research question, the subjective perceptions of the participants was sought. Analysis identified common themes in the data, which reveal the participants’ motivation, rewards and benefits gained, and the meanings they interpret from their role as mental health workers.

This chapter outlines the methodology and research design. The philosophical assumptions underpinning the research are presented, and the qualitative approach taken discussed. The fit between qualitative methodologies and mental health research is explained to justify the approach taken to address the research question and meet the aims of the study. The remainder of the chapter is dedicated to the specifics of the research design including methods employed for data gathering and analysis, tests of rigour applied to ensure trustworthiness, gaining ethical approval, and ethical conduct. The description of methods addresses accessing participants, nature of the interviews and data collection, and treatment of the raw data. The final part on methods covers the thematic content analysis that was completed using a general inductive approach. The chapter concludes with naming the themes that make up the findings.

Methodology

This qualitative descriptive study is situated in the interpretivist paradigm. A paradigm is the worldview that describes the “nature of the world”, individual’s place in it, and the range of possible relationships to that world and its parts (Guba & Lincoln, 1994, p. 107). Interpretivism is a theoretical perspective developed to understand and explain human and social reality (Crotty, 1998). This philosophical stance has been selected as the basis from

which to hear, understand and tell the participants' work-related stories, enabling their experience and subjective perspectives to inform the study and enlighten readers.

There are three elements which comprise any paradigm: epistemology, ontology, and methodology. Epistemology is concerned with the questions "How do we know the world?" and "What is the relationship between the inquirer and the known?" Ontology "raises basic questions about the nature of reality" (Denzin, 1994, p. 99) and methodology is focussed on how we gain knowledge about the world. The epistemology of constructionism guided my attitude to knowledge, believing that there are multiple realities which are constructed contextually. The inquiry is more specifically informed by social constructionism, which assumes the world is understood through social interaction. The world is made meaningful and reality is constructed according to the social, cultural and historical context (Crotty, 1998). In addition to the interconnection between self and social structures, there is an interrelationship between self and language in social constructionism (Crossley, 2000), giving significance to the participants own words as spoken in the context of the current era.

In contrast to the positivist worldview prevalent in quantitative research approaches, I am not looking for a sole truth that is waiting to be discovered. Likewise totally subjective knowledge and meanings which are conjured up by the participants and imposed on their situations is not desired. Rather I sought a blend of the participants' objective and subjective meanings, which are interpreted out of interacting with their settings.

One of the differences between qualitative and quantitative approaches is that qualitative research asserts that there is a relationship between the researcher and what is known. The relationship between the inquirer and what can be known is transactional as well as subjectivist. That is, the inquirer does not suppress her or his values or primary subjective experience, but accepts that the acquired knowledge is then reflected from a personal perspective (Reason, 1994). As outlined in chapter one, with over 20 years working in mental health, including working alongside and managing consumer staff, I already had experiences that influenced my understanding of the subject under study. I hold a primarily positive and optimistic perspective on the practice and value employing consumer staff in mental health. I took steps to make my own perspectives explicit and ensure I did not

colour the participants' accounts in the data gathering or analysis processes. A tenet of naturalistic inquiry is that the researcher's prior knowledge influences the understanding that is reached of the phenomenon or experience being studied by being present and part of the research. How I guarded against exerting undue influence to support the trustworthiness of the findings is outlined later in this chapter.

Personal accounts cannot be scientifically judged as empirical evidence, but can offer insights to contribute to our understanding of human experiences (Mattingly & Lawlor, 2000). Part of their strength is in revealing the differences amongst people's perspectives. For example, Deegan (2001) rejects Frank's restitution narrative, which she considers is preferred by medical professions but does not hold true for many consumers. Consistent with how mental health recovery has been described by consumers' stories, the participants in this study are valued as key informants. Particular attention has been paid to retaining the participants' intended meanings, emphasis and words so as not to lose the essence of their experiences by reducing their stories to data (Frank, 2000; Leibrich, 1999). While each participant's story is unique and valid, their accounts have been contextualised and analysed to give deeper understanding (Finlay, 2004). Social constructionism is the lens through which the participants' accounts were read and analysed to understand how they made and gained meaning from their roles as a mental health workers. Some of the unique contextual factors for each participant are presented in general terms only to conceal their identities.

With interpretivism as the ontology, the natural world may exist in the absence of our consciousness, but a meaningful world comes about through social constructionism. Qualitative descriptive methodology with thematic content analysis has been used to interpret the participants' construction of meaning of their work experiences, identities, relationships and workplaces. Those meanings were gathered in the form of personal accounts which, according to Martin-McDonald (1999), are variously referred to as stories or narratives. Narrative can be a methodology and also a method used in many other research approaches. In this study a narrative approach informed the method, with semi-structured interviews capturing the participants' experiential stories about working in mental health. Some researchers differentiate between how they use the variety of terms pertaining to narrative (Frid & Ohlen, 2000), whereas others use them interchangeably

(Frank, 2000; Martin-McDonald, 1999; Molineux & Rickard, 2003). I elected to use the terms personal accounts, narrative and story interchangeably and adopted the definition “storied data which are elicited by another person” offered by Molineux and Rickard (p. 56). Narrative inquiry seeks an account of living an experience in context. Meaning is made and conveyed in the telling of stories, as events, time, emotions and consciousness of experiences are organised (Kirkman, 1999; Martin-McDonald; Thomas-McLean, 2004).

The ontology of interpretivism, social constructionism and narrative are contextual (Mischler, 1986). As addressed in chapter two, recovery, with its roots in consumer rights, is a significant guiding principle in mental health services and provides the contemporary context. The philosophical orientation of this inquiry places each of the participants’ individual experiences in this communal era and context (Fitzpatrick, 1999; Mattingly & Lawlor, 2000). Predominantly common themes and sub-themes were identified from the participants’ accounts, with some additional stand-alone messages from sole participants included as relevant. These themes, supported by quoted examples in the participants’ own words, contribute to the findings as the basis for informing practice.

Research Design

To emphasize socially constructed realities in an interpretive paradigm, an emergent design was used to refine the research process as the data was collected and analyzed (Denzin, 1994). Both thematic content analysis and narrative approaches shaped the process.

While the philosophical stance guides the focus of a study, methods and processes form the actual structure of the research design. Narrative is considered a useful research method and fits with the definition used earlier of eliciting storied data (Molineux & Rickard, 2003). A narrative method assembles the data into a descriptive picture or account, as much as possible leaving the participants’ accounts to “speak for themselves” (Neuman, 2003, p. 448). Personal accounts relate to the lived experience of the narrator, create a bridge over time and contain a direction that makes its wholeness into something greater than its parts. This study holds true to the principle of narrative method in retaining richness and authenticity from the original source, and the participants’ terminology has been used in reporting the findings. However other core narrative principles as described by A. Frank (personal communication, July 13, 2005) were not followed, such as recounting complete

stories in chronological order, supplying two or more events in temporal or causal sequence replete with a plot containing the elements of a beginning, middle and end. Rather the data was analysed and organised according to patterns that emerged as the participants' accounts were searched for recurrent behaviours, knowledge and insights to interpret meaning (Neuman, 2003). Therefore a thematic content analysis method was employed in a process of recovering themes embodied in lived experience to see the meanings (van Manen, 1997).

Methods

Qualitative descriptive research using thematic analysis uses interview questions to facilitate people talking, allowing them to set the research agenda and explore the concepts or themes germane to the topic (Tolich & Davidson, 1999). Mattingly and Lawlor (2000) stated that narratives concern action, particularly social action. The action or activities the participants experienced in their workplace provided the core ideas or themes (Tolich & Davidson). The interviewing and collecting of narratives is an activity in itself and the methods describe how this activity of collecting and analysing the data was carried out.

Participants

The participants were three consumer staff with experience as generic frontline workers in community mental health services in the Auckland area. As defined in chapter one this means they have fulfilled a role providing clinical or support services directly with clients. No demographic data was specifically collected from the sample group, however they were all adults between the ages of 25 and 60, and comprised of male and female members who identified as Pakeha (New Zealand European ethnicity) or Tau Iwi (non Maori).

Sample Criteria

The coherence of any account is dependent on the story teller's narrative abilities, therefore one criterion was that the participants were articulate, with the ability to reflect and tell about their identity and experience as a mental health worker. Fluency speaking English was important, as this is the only language I understand and an interpreter would have been beyond the resources available for the scope of a dissertation. Beyond their willingness to participate and ability to tell their story, the key criteria for inclusion was that the participants identified as consumers and had worked as generic frontline mental health

workers. Age, gender and ethnicity were taken into consideration, but as a spread across these demographic features was desirable but not essential, these were not specified as criteria. The participants represented a cross section of age and gender.

Exclusion criteria included people who were currently experiencing an acute episode of mental illness, as this would have presented as a priority in their life and could have distracted from their focus on their experience and identity as a worker in this field. Another exclusion criterion meant anyone who I had worked directly with, especially as their line manager or tutor, was not included due to real or perceived conflicts of interest.

Sampling Strategy

Purposive sampling was used to recruit and select participants (Schneider, Elliot, LoBiondo-Wood, & Haber, 2003). Initially I talked to people among my networks in the mental health sector about the study, outlining the employment status and experience I required participants to have. At the time of inception of the study word of mouth created approaches from several people who came forward requesting participation. One person sought to participate on the basis “no-one knows what it has really been like for me [working in mental health] and someone has to hear my story”. This person was eliminated due to potential role conflict as we had previously worked closely together. However the strategy of spreading the word and selecting people to approach from among my professional networks was successful. I followed up on some of the people who had expressed interest early on and readily identified potential participants. The ease with which participants were recruited and several people’s desire to participate lends strength to the relevance and importance of the study topic and focus.

I approached three people directly, providing them with an ‘information sheet’ (refer to Appendix A) about the study and possible implications of participating. Steps to protect their anonymity were spelt out to potential participants, and it was stressed to them as an additional safeguard to think carefully who they told about their participation, to limit the ways in which their identity could be linked to the findings in the final report. The effectiveness of using purposive sampling by networking within the local mental health sector supports the assertion that the mental health field in New Zealand can be likened to a

small town (Tolich & Davidson, 1999). This reinforced the need for tight measures to ensure participants' anonymity and confidentiality. All three people I approached keenly accepted the invitation to participate, and provided unsolicited feedback during and after the process about how pleased they were to have taken part.

Ethical Approval

Full ethical consent was gained on the 9th May 2006 from the Auckland University of Technology Ethics Committee (AUTEK) prior to commencing the study (refer to Appendix B). As the participants were involved in their capacity as staff members, rather than as clients of a health or disability service, ethical consent from a health authority ethics committee was not deemed necessary.

Ethical Conduct

Ethics are the outward expression of values. According to Tolich and Davidson (1999) there are many ethical codes for social science research, which they have reduced to a core of five principles. These are confidentiality or anonymity; do no harm; voluntary participation; informed consent; and avoid deceit. These create artificial separations, and each of the strategies I employed satisfied more than one of these principles. Bearing in mind this overlap the explanation in this section of my ethical conduct is organized according to these principles.

I am a registered occupational therapist and hold a current annual practicing certificate, so my actions needed to comply with the requirements of the Health Practitioners Competence Assurance Act (Ministry of Health, 2003). The field of study is closely related to practice and I used professional skills such as interviewing in the research methods, therefore I was also governed by the Code of Ethics for Occupational Therapists (Occupational Therapy Board of New Zealand, 2004). The use of a Participant Information Sheet (refer to Appendix A) and an Informed Consent Form (refer to Appendix C) supported other processes I implemented to address the five ethical principles listed above (Tolich & Davidson, 1999).

To ensure safety, voluntarism and justice prior to and during the research the option to withdraw at any time was made available to each of the participants, right up until the stage

of the final transcription of their interview. This included deletion of any data they wanted removed. All three participants elected to leave in all the contents of their interview in the final transcript and gave me full permission to use and treat the data in any way I saw fit. One participant double checked that their anonymity would be protected. They have all requested and will receive a copy of the final report.

Confidentiality and Anonymity

Anonymity is difficult to guarantee in the mental health arena where there is a high degree of interconnectedness and people have multiple role relationships. Therefore additional measures were taken to protect the participants' identities. People's experiences as relayed in stories are embedded in a context, so for the findings to be understood and useful the participants and settings needed to be explained. The minimum amount of information possible to contextualize the data has been revealed in this final report, to provide protection for any individuals and their work settings. The Auckland regional mental health sector where the study was situated has many like organizations, so any descriptions are similar which can be applied across a range of work settings, providing an additional protective factor.

The risks of being recognized were made explicit to participants at the outset; alongside telling them the ways their anonymity and confidentiality would be assured (refer to Appendix A). Pseudonyms were not used to prevent parts of stories being brought together by the reader to deduce specific participant's identity. Potentially identifying features, such as length of tenure in any given employment situation, have also been omitted. Likewise, participants' gender was hidden in the final report, with gender neutral terms used to refer to the participants individually and collectively. Not identifying the participants as male or female meant finding alternative wording in the final report. This was dealt with in several ways. When possible pronouns were dropped altogether, rephrasing was done replacing him or her with 'that person' or 'an individual', or the pronoun was replaced with an article such as 'the workplace' instead of her workplace (American Psychological Association, 2001) (APA). Plural nouns and pronouns have been used as third person singular, such as they and their, to refer to participant's data. While this is potentially contentious and grammatically incorrect, there are examples of it in everyday speech giving a precedent for considering this an acceptable option (University of North Carolina at Chapel Hill, 2006).

Maintaining each participant's anonymity was the overriding consideration in adopting this approach. Combination forms such as 'she or he' and 'she/he' were not used as these can be awkward and distracting for the reader (APA).

Maintaining the participants' anonymity was inclusive of their employer, colleagues and clients, acknowledging the significance the workplace played as the context for their data. Therefore, as well as participants' anonymity, names of places including hospitals, geographical areas and employing organisations, and other people, such as colleagues and managers, were protected. To mitigate risk to individuals, participants were asked not to name specific people or places. It was spelt out and reiterated at the start of the interviews that this included clients, clients' families and others associated with clients such as landlords. Participants were also asked not to provide information about any illegal activities of clients. To further reduce the risk of individuals being identifiable, as the interviewer I did not probe regarding clients or others identities or activities. Where specifics were referred to in the data, these people or places were disguised or not named in the final report.

In addition participants were interviewed at the university rather than at their home or workplace, to avoid the risk of them being seen in my company and having others guess about their involvement in the research. The interviews were conducted outside business hours when the campus was not occupied, which further reduced the chance of participants being seen and arousing curiosity as to what they were doing with me. To date, and ongoing, I have maintained confidentiality by not making public connections between participants and their information.

Privacy rights were upheld during and after the research process, with all information and data stored securely. During the study the data was only accessed by the researcher and research supervisor. The taped interviews were transcribed by a typist who had signed a confidentiality agreement (refer to Appendix D). The tapes were destroyed after the transcriptions had been checked for accuracy. One copy of the transcripts remains in secure storage in a locked cupboard in the postgraduate office at the university (Auckland University of Technology, AUT), where it will be held for a minimum of six years. The completed participant consent forms are securely stored in a separate location in a locked

cupboard in the postgraduate office, Faculty of Health and Environmental Sciences, AUT, where these will remain for a minimum of six years.

Do No Harm

Also known as nonmaleficence, the principle of doing no harm was applied to the participants in the study throughout the research process, which encompassed telling their story in the interview and reading their transcript. Participant safety, comfort and support have been, and continue to be, paramount. Participants did not know in advance the effect telling and reading their story would have on them and the issues this may raise, for instance, the interview process may have enticed participants to reveal more than they would normally. As the researcher I am also mindful to guard against the final report or subsequent outcomes of the research resulting in harm to the participants, for example the final report may raise issues or leave participants feeling exposed. To prevent participants feeling vulnerable about anything they disclosed on tape which would appear in final print, the opportunity to withdraw all or some of their data was made available to them as part of reviewing their written transcript. None of the participants removed any of their data and gave consent for everything they had shared to be used. I am available beyond the final report to assist the participants to process and make sense of their feelings upon reading the final report and to seek extra support if indicated. In much the same way I was able to talk through with the participants the impact of reading their transcripts. The participants were given safety assurances that every possible care would be taken to avoid any negative consequences. There were no anticipated or actual physical risks. The steps outlined above that were taken to ensure their confidentiality, anonymity and privacy held importance as part of harm prevention.

Information was provided in advance to the participants about the potential for the process to raise discomfort for them, which assisted in individualised planning to avoid this occurring. For instance, to reduce the risk of feeling disloyal to their workplace, interview questions did not probe about their employer. This planning was further activated with one participant who was experiencing an exacerbation in mental health symptoms when the scheduled interview date was drawing close, so through careful negotiation the interview was postponed. Consistent with recovery philosophy people have the right to be self

determining, so the participant's choice was central to this decision. Based on many years in practice, my clinical assessment and reasoning expertise were valuable in exercising the judgment to support the participant in deferring the interview.

Similarly my sensitivity and mental health professional skills played a crucial role in planning for and responding to participants' needs during the interviews. They were made aware that together we would use our judgement and stop the interview at any point they would like to, and that nothing would proceed without their complete agreeance. Correspondingly I spoke with each of them regarding safety nets to minimize any unwanted or unanticipated side effects from participating. This involved ensuring they had available support people, or assisting them to locate resources to get in touch with, if required after the interview. All the interviews proceeded to completion without participants experiencing psychological distress or requesting follow-up beyond the opportunities for reflection I provided as the researcher. As it eventuated, all the participants thanked me for their involvement and said they had enjoyed the experience. This was replicated upon reviewing and approving their transcripts for use as data.

Beyond not being harmful, there was intent that the research would be beneficial. The notion of beneficence in this study applies to the participants, and to the wider intended audience. This study sets out to benefit the mental health sector by furthering the understanding of, and informing best practice in, employing consumer staff. Hutchinson, Wilson and Wilson (1994) provide a perspective that the benefits of participation go beyond the potential for generating knowledge, and they reported a range of participant benefits from telling their story. Validation, gaining new perspectives and making meaning of their experiences result from being interviewed, along with participants caring about the outcomes of a study in which their information may be shared to help others (Hutchinson et al.). It was preferable for the participants in this study to gain some benefit through the experience of giving their accounts and believing in the value of their contribution.

It is also realistic to expect participation may be empowering, as indicated by literature supporting the value of narrative methods in therapeutic work (Finlay, 2004; Mattingly & Lawlor, 2000). Telling one's story and being heard can be empowering for people who, by virtue of their illness or experiences, are often unheard or misinterpreted (Clay, 1999;

Deegan, 1988; Frank, 2000). With this in mind, I set out to do everything possible to make this research process a good experience for the participants, such as purposively selecting people who I anticipated would maximise their gains and by attending to them throughout. The viewpoint that participating can be beneficial for participants was borne out in this study, as confirmed by unprompted communication at a later date from each of the participants telling me they had found it a good and useful experience. None of them expressed regret, and they have maintained their interest in the finished product being an informative and positive influence in the field. In spite of the desirability of the research process benefiting these participants, this is still considered a secondary benefit of the study, as this does not feature in the stated aims of the study and is not captured in the findings. That these secondary benefits materialized is not considered a flaw in method or a limitation of the study, in that these were not entirely unanticipated or unwanted.

I believe my experience in mental health equipped me well to anticipate and deal with complexity and issues as these arose. As part of attending to the participants, and to my own psychological needs, I proactively engaged in regular supervision. Other professional skills and strategies I have developed as a mental health practitioner also came into play, including risk management, clinical reasoning and reflective practice.

Voluntary Participation and Informed Consent

The sampling strategy has been described earlier, in which potential participants were given verbal and written information to enable them to decide whether to take part in the study. This included the purpose, process and intended use of their stories, including the likely audience for the study. An undertaking was given that any deviation from the negotiated processes or outcomes would necessitate regaining participants' consent, and this same guarantee will hold if any attempts are made to misappropriate the study findings informed by their data.

Hutchinson, Wilson and Wilson (1994) purport people have self-protective behaviours which mean that people who do not want to talk about a topic will not consent to the interview. People were approached respectfully and treated equally in this procedure. As outlined earlier, the initial three people who were invited to participate all willingly

accepted and each signed a 'consent form' (refer to Appendix C). No coercion was employed to gain their consent, and enticements or rewards were not offered, though a small amount was given as a petrol voucher to assist with travel expenses to attend the interview.

Based on careful examination of the range of roles and relationships I have across the mental health sector, anywhere power differences or conflict of interest existed with me as the researcher was avoided. As mentioned earlier this meant excluding anyone I had worked closely with in the past or at the time of the study. The principle of voluntarism was applied prior to and during the data collection, with the proviso participants could withdraw anytime up until the commencement of analysing their interview transcript.

Participants' consent was assessed during the interviews, rather than relying just on prior agreement as given on the consent form. This included awareness of any mental health issues that might have impacted their ability to give informed consent.

Avoid Deceit

This principle included consideration of both justice for the participants and fidelity of the research. I have taken every step to value and treat the participants and their contributions respectfully. Participants were given full information in advance and set plans were followed, unless otherwise negotiated. Information and stored data has only been used for the purposes of this dissertation as agreed prior to collection. An open process which included the participants checking and approving their transcribed interviews, and an audit trail created of the process from raw data through to analysed findings contributed to ensuring the rigour, fidelity and integrity of the study. This was supported by adhering to recognized qualitative research protocols as approved when ethical consent was granted, guidance from my research supervisor throughout, and regular reporting to the faculty.

Opportunities were made available for participants to ask questions and discuss the research, while the support and counseling offered an additional debriefing function. As well as providing a psychological intervention to process any issues that may have emerged, this debriefing would have allowed any concerns to surface about being deceived

or misled. None of the participants sought external counseling or raised any fidelity concerns, other than assurances that they would remain anonymous in the final report. The parallel for me as a researcher was fulfilled through supervision. Rechecking of the study purpose, plan and processes after each interview facilitated reflection on the integrity of my actions.

While I believed there were potential benefits for individuals from participating, and for the mental health sector from the findings, it would have been misleading to overstate these. Therefore the likely personal benefits and drawbacks were an explicit topic during recruitment. I also engaged the participants in a discussion about the expected readership and uptake of the results, without being overly optimistic. As consumer staff they were familiar with the politics and dynamics of the mental health sector and well able to judge for themselves the potential impact.

Te Tiriti O Waitangi

Te Tiriti O Waitangi is a treaty agreed to in 1840 between Maori as the indigenous first nation people of Aotearoa (New Zealand), and the British Crown as the primary immigrant population and subsequently the colonising government. In signing this document Maori understood their self-determination, beliefs, lifestyles, rights and liberties would be assured, while being afforded full citizenship in the newly forming nation. The fullness of the document and developments over the past 166 years has led to many reasons why special consideration needs to be given to the mental health of Maori. This treaty is structured around articles, with each article addressing core constructs and commitments to be upheld. This is demonstrated in article three, which cites equity among all people of New Zealand. Applied here, this indicates Maori will enjoy the same health and achieve the same level of mental wellbeing as other New Zealanders.

In keeping with the Te Tiriti O Waitangi, Maori were considered in research decision-making, ethics, design and participation, and as potential beneficiaries of the findings from this study. Smith (1999) and Thomas (2000) provide guidance about research involving Maori, including consideration of whether the research is by, for, or with Maori. As the researcher I am not Maori and the context is mainstream organizations. Maori are over

represented as recipients of mental health services (Ministry of Health, 1997), therefore I considered this study's location in and interest to the New Zealand mental health sector meant the outcomes needed to be relevant to Maori. Maori expertise was gained in relation to the purpose and design of the study to ensure the principles of participation, partnership and protection were met (Thomas, 2000). The research proposal was reviewed favourably by a Maori colleague who has mental health practice and research knowledge.

Participants were not specifically sought nor excluded on a cultural or ethnic basis. Even though it eventuated that none of the participants were Maori, resources were available to enable Maori participants and ensure cultural safety had they chosen to participate. Maori worldview is enacted through language, customs, and self-determination and organized around whanau (family groups), hapu (extended family groupings) and communities. The methods would have allowed flexible processes, for example interview location and having support people present.

Data Collection

Data was collected using semi-structured face-to-face in-depth interviews which were audio taped and transcribed. An informal conversation style was used to enable participants to tell their story about working as a mental health worker. Each interview began with an open-ended trigger question: "Tell me a story about your experience of being a mental health worker". The story being sought was about each participant's experience and identity as a mental health worker. Their identity as a consumer was considered as a particular experience and perspective they hold. Whilst it was explicit that their consumer experience was an inclusion criterion, their experience of mental illness and receiving mental health services was not specifically asked about or prompted. It depended on each participant whether they made this aspect relevant and available, however all participants shared stories regarding their consumer status and experience.

Pre-prepared open-ended prompt questions were used to assist participants in keeping the flow of their story going. The prompt questions facilitated participants to move beyond their initial starting point as elicited by the trigger question, to gather a broad range of disclosures about their work experiences (refer to Appendix E). Data collection drew on mental health rehabilitation (Anthony et al., 2002) in which satisfaction and success are

considered key elements of any aspect of a person's life, such as a work role. Mental health rehabilitation technology has been designed to help people focus and reflect on their experience in a role or setting, without pre-empting or directing their answers. As the researcher I used my training in this approach to design the prompt questions to access participants' experience of their work setting and role.

Establishing trust set the scene for participants to feel safe to share, and this was initially established by giving the participants full information about the study purpose and process prior to consent. Shared interest and commitment to exploring the topic enhanced the relationship and redressed the inherent power imbalance between researcher and participants. Attention was paid to temporal and contextual factors such as time of day, length of interview, setting, removing distractions, privacy and personal needs, all of which set the scene for trust and focusing attention during interviews. Each interview was between 50 and 70 minutes long, and as described in relation to confidentiality, conducted in a neutral place at the university in a quiet private interview room at a time convenient to the participants. As explained for nonmalficence, one interview was rescheduled in response to a participant's mental health needs. Refreshments were provided and comfort stops offered, with one interview paused twice while a participant took important phone calls.

The quality of the relationship between the interviewer and interviewee, in this case the researcher and participants, was deemed crucial in inhibiting or enabling participants to open up. I was mindful of facilitating the participants to tell their story in their own words. 'Connecting skills' were employed to establish and maintain rapport (Anthony et al., 2002). In particular attending, paraphrasing and reflecting meaning were used to demonstrate understanding and support the participants to keep sharing without guiding the content in any direction.

Data Analysis

Data analysis means a search for patterns in data which are then interpreted (Neuman, 2003). A general or typical inductive approach was used to systematically analyse the qualitative data gathered during the interview (Huberman & Miles, 1994; Thomas, 2006). Prior to analysis I checked the transcribed interviews and corrected any inaccuracies by

reading while listening to the audiotapes. Transcribed interviews were then read and re-read to familiarize myself with the content. In using an inductive approach, analysis was set in motion during the interviews, particularly with the intuitive nature of analysing narrative data. Any initial impressions were succeeded by reflection and formal thematic content analysis (van Manen, 1997).

Arthur Frank's (1995; personal communication, July 13, 2005) extrapolations of narratives and descriptions of narrative types provided background insights as to how the participants might make sense of their work experience and attribute meaning to working in mental health. Whereas narrative analysis includes why and how people tell stories, the analysis undertaken focused on deriving themes and concepts from the content to elucidate participants' experiences. This meant in preference to eliciting and reporting complete stories or vignettes, participant experiences have been grouped into collectively held views and reported experiences in themes and sub-themes. The participants' accounts revealed they had more commonalities than differences in what they had experienced in the workplace, so the majority of the data represents collective experiences.

Huberman and Miles (1994) offered a set of 13 tactics to guide analytic processes and generate meaning. Some of these incremental steps were used throughout the study to move from initial impressions to making conceptual coherence within and across the data. In particular patterns and themes were noted, and contrasts and comparisons made within and across the transcripts. The plausibility I saw from initial intuitive sense was clarified when clustering the raw data by conceptual grouping to see connections. These conceptual groupings were assembled to give a coherent understanding of the data through building a logical chain of evidence in which themes are described and supported by participant quotes. Finally conceptual coherence of the findings was compared with constructs in the literature, which will be reported in chapter five.

Inductive thematic content analysis allowed the frequent, dominant or significant themes inherent in the raw data to emerge (Thomas, 2006). Data was analysed to gain an understanding of the meanings from the participants' stories, in preference to analysing the linguistic meaning of individual words, phrases and speech. Detailed readings and coding organised the data into categories on the basis of themes, concepts or similar features

(Neuman, 2003; Thomas). A combination of holistic and selective approaches helped arrive at the overall meaning of each theme (van Manen, 1997). A holistic approach enabled understanding of each transcript as a whole in its own right and how it sat with the other transcripts. Selectiveness involved highlighting certain phrases as being particularly revealing about the experience being described, and is shown in the findings with participant quotes reported which support the themes and sub-themes.

In keeping with the view that some analytical forms are quite intuitive, typically taking the narrator's perspective (Manning & Cullam-Swan, 1994), care was taken to keep the language and emphasis true to how the stories were told. The participants' own words informed the choice of headings for themes and sub-themes, and in some instances these are named as direct quotes. I have used participants' phrases and expressions directly in the descriptions of the concepts being explored, discussing further and explaining what is meant in order to relay to the reader a clear understanding in keeping with the participants' intent.

Coding the data was inevitably influenced by how I saw or recognised themes. The trustworthiness of the themes derived are supported by my sound conceptual abilities in recognising patterns in the data and thinking systemically, combined with in-depth background knowledge and possessing relevant information (Neuman, 2003). While independent coding or member checks were not carried out, I practiced reflexivity, engaged in regular supervision and stayed aware of preconceived notions. Affirmation of the themes was received when the findings of this study were presented to a group of academic colleagues. The members of the audience with mental health expertise were visibly relating to the themes and feedback confirmed the participants' experiences resonated with examples they had been privy to in their own practice.

Stories can entertain, inform and enlighten, with the potential to be transformative in touching the hearts and minds of others. Excerpts of the interviews are produced in the findings for interest, readability and believability, with these quotes deemed valuable for the first hand insights they offer (Finlay, 2004). This is essential in enhancing the reader's relating to and understanding of the participants' experiences (Creswell, 1998). It has been

said “the nice thing about quotes is that they give us a nodding acquaintance with the originator” (Tolich & Davidson, 1999, p. 169).

Rigour

Lincoln and Guba’s four tests of rigour provide for the constructionist equivalents of internal and external validity, reliability, and objectivity which are applied to positivist research (Denzin, 1994; Koch, 1998a). Lincoln and Guba define four criteria: credibility, transferability, dependability and confirmability, which are frequently cited in qualitative research literature (Finlay, 2006; Koch, 1998b; Nolan, 1995). These four criteria have been applied as tests of rigour to ensure this study stands up to scrutiny. This section on rigour is completed with acknowledgement of and an account of my role in the research. How I was reflexive is discussed in support of the study’s confirmability, demonstrating I was mindful of the methodological issues at stake (Finlay; Koch, 1998a).

Credibility

Credibility or truth-value refers to how closely the interpretation conforms to what the participants are trying to convey and can be seen as parallel to internal validity (Nolan, 1995). Applying this criterion begins by considering the appropriateness of the methodology and design to the question. Qualitative descriptive methodologies are widely used and accepted in mental health research, providing a way to gather, interpret and report consumer staff perspectives, whilst recognising the participants as key informants and retaining their meanings. Telling one’s own account can be deemed a universal human activity through which people make sense of their world (Kirkman, 1999) and can be carried out in non-threatening ways. The interview method facilitated access to understanding experiences that may not have been as readily reached using other means. Social constructionism emphasises contextualisation, and provided internal consistency between the philosophical perspectives, methodology, methods and the practical reality of inquiry into consumer staff experiences of working in mental health.

Integrity when carrying out the methods adds to credibility. Firstly the participants’ accounts were accurately captured on audiotapes, transcribed and then checked by both myself and the participants. During the interviews the intersubjectivity of the elicited

narratives and social constructionism was acknowledged, with awareness that I was part of the relational process so may have shaped the stories. Accordingly I adopted an open listening and focussed awareness approach (Jack, 1999), which helped ensure listening in a neutral manner and really hearing each participant's intended meanings.

A good story needs to convince the audience of its likeliness and a sound argument needs to convince of a truth. Martin-McDonald (1999) used the term verisimilitude, creating shareable emotional feeling and cognitive understanding which she considered to be fundamental in narrative research, as the goal is to build sharable understandings of the life experiences of another. As conveyed earlier, the reaction of a relevant audience confirmed the findings as recognisable to and congruent with the experiences of others in this field, therefore credible to readers.

There is an understanding in social constructionism that people select which part of their stories to represent and that making sense of their experiences is dependent on their everyday language. For authenticity the participants' own words have been retained and quoted excerpts included to support the interpretations made during analysis.

Krefting (1990) described several strategies by which qualitative research can be made trustworthy. One is participant or peer review of the final themes. While that was not specifically undertaken, external input was proactively and regularly accessed. This included debriefing straight after the interviews with the research supervisor about the emerging concepts and themes, frequent research supervision, and ongoing discussions with the participants and colleagues familiar with the topic.

Transferability

Transferability refers to how applicable or useful the research is to readers. This mirrors external validity and is concerned with the degree to which results can be applied in similar settings. Mattingly and Lawlor (2000) described narratives as being located in a particular time and place. This study was not intended to be generalisable as empirical research aims to be. Transferability is dependent on the degree of similarity between two contexts (Koch, 1998b). Enough information about the participants and their contexts has been given to

enable readers to judge for themselves if the findings reported and interpreted have relevance for their own settings.

Aside from the potential generalisability or transferability, prior to considering if this study would have applicability to others a decision was needed as to whether the research was worth doing at all. When considering any proposed research topic one needs to reflect on whether it will either add to the knowledge base or inform how existing knowledge is currently regarded. In this way applicability can be determined by the interest shown in a study. An early check was made by speaking to people who are well informed in New Zealand mental health policy, planning, funding and service delivery, including four consumer staff. These approaches met with overwhelming enthusiasm, reaffirming the assertion this is a topical issue that the sector needs to understand better.

Dependability

Dependability can be considered parallel to reliability and has been created in this study by having auditable study processes which are open to scrutiny. Established research processes and well described methods were used. Participants and their stories have all been treated equally contributing to the dependability. An auditable decision trail contained in the supervision notes was created by discussing explicitly decisions taken about the theoretical, methodological and analytic choices throughout the study (Koch, 1998b). How decisions were arrived at are openly reported in the findings and the final report, providing interpretive rigour to enable the reader to see a direct link between the data gathered and interpretations derived.

Confirmability

Confirmability is the extent to which conclusions are real as opposed to imaginary (Nolan, 1995). This criterion was satisfied when credibility, transferability and dependability were addressed (Koch, 1998a).

Reflexivity

It is recognised that researchers in the interpretive paradigm relate to and interact with the participants, with this intersubjective relationship impacting on the data collection and

interpretation (Grant & Giddings, 2002). Reflexivity was employed to make explicit my own position as the researcher, not to eliminate bias but to highlight any contribution. The term reflexivity is used in multiple ways in research: here it is taken to mean critical self-awareness and reflexive awareness of the historical connections that link to the subject matter (Finlay, 2006; Koch, 1998a). This included exploration of my existing beliefs, assumptions, experience and knowledge through a presupposition interview carried out by a peer who is knowledgeable and skilled in both mental health and research. This hour-long interview was taped and assisted in exploring my existing understandings prior to commencing the research process. This was followed up by being constantly reflexive in supervision throughout the study. Pre-existing notions about consumer staff experiences and the meaning they make from working in mental health were uncovered, some of which were borne out in the findings while others did not feature. Among these were the notions that consumer staff: are drawn to this work by a calling or quest narrative (Frank, 1995); are motivated to make changes for the better in the future; do not want others to have a repeat of their own experiences; want to help others and share what they have learned; consider they had a good deal from the mental health system and want to give back; feel they need to use what they have learned for some greater good, otherwise their suffering was for nothing; and believe they have experienced mental illness for a higher purpose and have a spiritual duty to give back.

My intentions for undertaking the study were also taped in the presupposition interview, with the most predominant view being that the workplace experiences of consumer staff would be more similar than divergent from those of the non-consumer staff. This precipitated my ideal that any learning resulting from the study to bring about improved workplace practices for consumer staff could have a positive impact on the whole mental health workforce.

Limitations of the Study

While never intended to be generalisable or transferable the small sample size, as dictated by the parameters of a dissertation, limit the findings. The three participants corroborated each other, but more people would have developed the main themes and possibly created sub-themes. The study did not reach saturation, whereby the information being gathered

had ceased providing new insights or understandings (Depoy & Gitlin, 1994). While enough data was obtained to gain an understanding of the participating consumer staff experiences, more participants and repetition in the interviews would have assured that the point of saturation had been reached. In the process of obtaining data from a larger sample group sub-themes may have been judged idiosyncratic to one person's experience or may have developed into main themes.

As previously discussed in relation to credibility and dependability, a decision making trail was created but not formally peer reviewed. In the absence of such an audit my thinking and actions have been described in this chapter, enabling readers to follow the logic and manner in which I developed the findings.

The study is set in the New Zealand context only, where a recovery oriented community mental health system has been adopted. The sample group all identified as belonging to one culture within this bicultural country and multicultural society. While some important aspects of consumer staff experiences in this context are shared, the findings cannot be deemed representative with no Maori or other cultures included. The three participants had integrated their mental illness with their sense of self as part of a coherent, lived identity consistently across their lives. It cannot be claimed that this would be the case for non-Pakeha, or in other countries where a different cultural paradigm and mental health ethos exists.

Conclusion

This chapter provides information about the qualitative descriptive methodology and the philosophical positioning of the study. How the research was carried out has been described, with a general inductive approach used to complete thematic content analysis of the data to arrive at the findings. The reader is referred to appendices which were used in the research process. Additional safeguards have been taken to protect the identity of the participants, while ensuring adequate information has been supplied to orientate to the sample group, topic of inquiry and context to make sense of the findings. While the findings are not intended to be transferable, this description will allow readers to decide if the study is of interest, relevance or applicable to their situation. My ethical conduct as a

researcher and the steps taken to ensure trustworthiness are openly explained, presenting the reader with full and transparent information from which to judge the credibility of the research. Finally the limitations of the study are noted.

Chapter one introduced the study topic, area and process, setting the scene as to the relevance and interest of the research. Chapter two reviewed literature furthering the understanding of the topic area and provided an understanding of existing knowledge which the study aimed to build on. In the following chapter, the analysed data is presented as the findings, which are in four themes relating to how consumer staff members experience working in mental health. The themes are: ‘being paid to be myself’; ‘the mixed blessing of being a consumer’; ‘actually making a difference’; and ‘benefits gained from the job’.

Chapter Four: Findings

Four themes related to how consumer staff members experience working in mental health emerged from the analysis of the interviews. The first theme was ‘being paid to be myself’, the second theme was ‘the mixed blessing of being a consumer’ and the third was ‘actually making a difference’. The fourth and final theme related to ‘benefits gained from the job’ which included learning and other opportunities afforded. Within each theme various sub-themes were apparent. These are discussed below. Anonymous illustrative quotes from participants are included.

Theme One: Being Paid to be Myself

Just getting to on a daily basis, work out of my point of power. And it really was incredibly liberating to think that I was getting paid an hourly rate to be me, rather than getting paid an hourly rate to be a [staff member].

The first theme, of being paid to be themselves, captures participants’ feeling of working in a place that suited them and opened the door to what motivated them. The experience of working in a job that fitted was encapsulated by one participant.

I really had a deep sense of peace, about being astounded, and I used to talk about this a lot with the people around me, that I’m getting paid not necessarily to fulfil a role, but to be who I am and to live out of my values, and I was full of gratitude that I actually got paid to do that, and that thinking that there were a lot of people out there who hate their jobs, that are just in there for the money, that don’t feel fulfilled, yet I was actually getting paid to be who I am, and that was quite an accomplishment.

Participants found that being able to integrate what mattered to them into their work overrode considerations such as earning money. The role had more to do with being themselves than what activities they did. Participants provided insights regarding how they came to develop their core values as people and the rewards they gained from being able to enact these values to make a positive difference.

Four sub-themes emerged within the theme of ‘being paid to be myself’. The first, ‘needed a job’ addresses how the participants came to work in mental health, while the remaining

themes, ‘real relationships’, living out values’ and ‘sense of purpose’ give a sense of the nature of their experiences. The themes are discussed below in chronological order, from deciding to apply to work in mental health, factors that enabled and maintained them in the workplace, to reasons for staying.

Needed a Job

Although participants’ overall experience of moving into employment as a consumer staff member was that it allowed them to be themselves, this was not what brought them to the job. Rather, they identified having the job brought to their attention at a time they ‘needed a job’ as the explanation for how their entry to the mental health workplace came about. Prior to accepting their first mental health position, all participants were either unemployed or faced with losing their job. The decision to work in mental health was governed more by lack of confidence or inability to enter the paid workforce elsewhere, than a particular desire to work in this sector. One stated that “*being led into paid mental health was a purely pragmatic situation*”. Another explained:

I got into mental health really by default. I was working with [disabled] children and through my job I got a serious injury. I wasn’t able to do the job at that stage, because of my injury and no-one would employ me. As soon as they found out about my injury, because it increased my risk of needing ACC [workplace compensation], employers weren’t wanting to take that risk. So, I basically gave [agency name] a call and I met with [manager’s name], who was the manager of one of the services and he took me on. So for the first couple of months I was working with [agency name] and doing an ACC programme, and then [manager’s name], offered me a full time job, once I’d completed all my ACC stuff.

Each of the participants heard about a job in mental health, by chance, at an opportune time. All of the participants confirmed needing a job, combined with the timeliness and mode of finding out about an opportunity, as the prompt for entering the mental health workforce. One participant subsequently repeated this pattern when changing jobs to another mental health agency.

Anyway I was saying about the support group, so this woman, she cut the advert out, the [agency name] advert and she just gave it to me. At that stage I’d never worked before and wasn’t considering work at all. What had happened also was that three to four months ... about 4 months ... prior was when my Dad died,

and I got into even more of a rut and umm she just brought me the advert and the advert said you know this is what we're looking for.

One participant had described giving to others, helping and caring, as core values enacted in their personal life. This was explored as a prior motivation for working in mental health however this was not the case. The participant had never worked in mental health, but due to organisational restructuring had ascertained that their current contract employment in a similar field would come to an end as a consequence of not holding the desired higher qualifications.

The team leader of [service name] said to me one day that she could offer half of a job ... I did that for a time and that service, agency, couldn't provide a fulltime job and I actually needed a fulltime job, or full time hours anyway ... And I bumped into the general manager of the second agency, through her work and then I heard that there was a support worker job going in this team in the second agency as the person I replaced graduated off to become a key worker ... It was fulltime work, it was not miles and miles away from home, working in the area where I live, and that service had a very, very good reputation.

Even when contemplating applying for the job participants moved beyond purely wanting or needing a job to recognizing that the employment situation might suit them. This sense of fit was felt either in finding out more about the job prior to commencing, or over time, such as for the participant who initially entered the workplace in a 'placement' arrangement. For the two participants who had past vocations in other social services, this meant their work experiences held similarities with mental health. The openness of the agency to employing people with lived experience of mental illness was an important statement that made it feel possible for one participant to apply and envisage working there.

No, it just said we're open, no I think they phrased it a bit more than just open, but we support people with lived experience. ... Huge! A huge one, because I needed that, really, really needed that, just to have a little bit of feeling somewhat comfortable even entering there in that workplace.

As opposed to other work environments where social stigma existed and they perceived the need to keep their mental illness concealed, being able to be open and have people around them know about personal consumer experience was significant in the decision to apply: "*absolutely. It's a big reason! It's the reason why I even applied for the job*". For another

participant coming out about their consumer experience was significant in how things unfolded afterwards.

I didn't tell anybody about my lived experience when I first started working at [agency name]. I was quite nervous about the stigma involved and it took me about six months after working for [agency name] when I first came out about my own lived experience. From there I got involved in the group that [agency name] ran for staff who have lived experience and it went from there.

Being able to not only have people know, but actually feeling their consumer experience was regarded as a useful and valid reference point for the work, was key to the theme of 'being paid to be myself'. As their accounts reveal, once working, the participants moved beyond the pragmatic circumstances that surrounded their initial commencement as mental health workers. They found the nature of the job and people suited them, and tended to downplay practical considerations such as working for money in favour of other benefits that emerged which they attributed to their work.

Yeah I do work for money, but I have most of the things I need now already, but I want to be able to have, just not some lavish lifestyle at all by any means, just comfortable and whilst doing what I can do, sorry whilst doing the career that I want to be doing.

And I'm really grateful, ultimately very grateful to [manager's name], for taking me on even when I was still hobbling around with an injury, he saw something in me, and hiring me enabled all this other stuff to happen.

Real Relationships

The participants started from a place of liking the people they met in mental health: "*I think it is a really satisfying job as a job, in terms of what kept me there; you meet a whole lot of fabulous people, right across the spectrum of the people that you meet*". It was from this basis they moved into providing a more in-depth understanding of the nature of the relationships that they experienced in this line of work. The impact that the type of work had on continuing to choose to work in mental health was synthesized by all the participants in their experience of their work-related relationships. Relationships were deemed essential for meeting their needs as staff and for their work to be successful.

People's mental health prohibits, or people's ill health prohibits their contribution to their world. So there has to be good services to help them move out of that, become well and get their medical clearance in their pocket and go off into the world and live. And that takes a whole lot of people and a whole lot of different layers of work that's all interconnected and able to be interconnected according to the client's need, and also to the staff member's need.

They described at the core of relationships the duality of being able to be real, genuine, honest and authentic, whilst this was reciprocated by others such as work colleagues and managers. They identified the importance of these core elements being present as a critical decider for staying in their job. In reaching this conclusion they were well aware that not all relationships operate along these lines, making comparisons with other environments or having experienced culture shifts to other relating styles in their own work settings. Being themselves and being around people who are honest and genuine made them feel comfortable, and was a key part of experiencing the job as satisfying. In addition to feeling at one with themselves and others, for one participant the desire to be genuine in every facet of their life had been a conscious and deliberate process with working in mental health contributing to this.

It's real, it's authentic. A lot of corporate environments are totally the opposite, you can get people who will be genuinely themselves in corporate environments, I'm not branding all of the corporate environments as being that way, but it feels so much more authentic because it is, it's very, very real, dealing with people's, you know, people who have had wanted nothing more out of their life other than being dead. I mean you can't get much more real than that.

Initially I didn't think of that when I was working for [agency name] but in the end it really enabled me to become more authentically me.

Being real epitomised the theme of 'being myself', which was based on working in a job that suited their own values, as clearly stated by one participant: *"It meant that I was being more real and I was being intrinsically me, as opposed to living out a role as a worker. Because I lived out of my values whether I was at work or not it was more about who I was, not what I was doing"*.

Being able to be themselves was facilitated by having a sound relationship with their manager that included elements of coaching and feedback. Such relationships were viewed positively, and thought to have a flow on effect to the quality of the service participants gave to clients.

I think it is also important that the person I am reporting to is honest, by their own definition and says I'm really happy with this bit over here, but I'm not happy with this bit over here, and here's what I want you to do to alter it or change it, or stop doing it or whatever the case may be. Because the client gets disadvantaged if the worker and the people they report to don't have an open and an honest relationship, you know.

Associated with feeling comfortable in their workplace environment, largely due to the nature of the relationships, one participant had developed an implicit sense that mental health was understanding of them. They conveyed a haven in which they could perform and learn to work.

One, a very basic one, is that I feel comfortable in the role of working in mental health. As being sick for basically 10 years and having not worked, not even been able to finish my degree due to my illness, I feel a lot more comfortable in the environment because compared to some corporate environment that would expect so much of me that I may not be able to deliver at the moment cause I'm still in that stage of recovery. I'm still in my own awareness of how I should be in the workplace.

The need to feel comfortable around managing their mental illness for one participant became much stronger and related to needing to feel safe, with the mental health workplace nurturing them as they faced their insecurities about being out in the real world: *"Yeah the insecurity is so much, so much better than what is used to be, but it's still pretty much alive and well within me, that insecurity. Sometimes I could just go mad and literally be ill, and I did feel more comfortable in the organization but it's different now, but I always felt comfortable when I got ill that they would stand by me"*.

Living Out Values

All participants had an awareness of how they had developed or identified their values. They recognized their values as important to them, considered their values relevant to others, particularly in mental health, and rated enacting these as the key to meeting their

own needs. Helping others was a value shared by all the participants and working in an area where this was inherent in their work provided job satisfaction and fulfilment.

In describing how they came to hold or know their own values it was apparent that this was a personal process, and fitted with descriptions of the importance of integrating themselves personally and professionally, consistent with the value they placed on authenticity as already discussed. One participant identified the values they hold as being important for mental health. This participant attributed their values formation to their family as a child, and proposed this would be the case for others working in the sector.

I have always tried to be respectful of every client and whatever their situation is ... that was the way that Mum and particularly Dad, brought us up was to respect every person. Also a part of that is it brings honesty. We were always brought up to believe you be honest with all people at all times. ... And I think that probably just like all of us working in mental health, our own upbringing, our own experiences and life as a child, and then as an adolescent, until we become an adult, those are the kinds of core experiences that help us to be respectful and to be honest and to be understanding and to help people where we can.

For another participant, formation of values was less clear, and contradicted the view that everyone in mental health who operates from a helpful value base brings this from their life growing up. However this participant affirmed the emphasis other participants put on the personal importance of upholding values. In describing how they enact their values both in their personal and professional activities, a sense of consistency between the parts of this participant's life came through, showing how at work they were being paid to be themselves.

I tried to live out of my values when I was on the job and when I was off job as well. ... The values that I have as an adult weren't taught to me by my biological family, so I don't necessarily know or remember where I got these values, but I'm very proud of them as an adult.

While the origin of their values might not have been clear, the value of helping people was very evident for all participants, providing the core reason for working in mental health. This was exemplified in one participant's statement about themselves "*wanting to help, genuinely wanting to help*". It was as if this provided the motivation for doing the work,

while other sub-themes like feeling comfortable with the nature of the relationships enabled the participants to stay present in the setting in order to fulfil this desire. As a constant underlying agenda, 'helping' feeds into having a sense of meaning and purpose which will be explained in the next sub-theme. Helping others fitted with a core belief about who they are as people and what type of work they should be doing.

There is always something more I can be doing, so I might not for example be able to do volunteer work, but I can spend a couple of hours with a friend who's really distraught and we can talk about life affirming things. So doing my bit is really, really important to me.

For one participant 'helping' was confirmed by a career assessment many years earlier and they had held onto this as being true for them.

I remember I was 21 when I had my first [episode of mental illness], I'm 31 now, when I had my first encounter, that was ten years ago. I remember doing a sort out your personality type for what job you could do. ... I remember I had put in my qualities of my personality, and this was in the very beginning of my third year of uni before I crashed a few months later. I remember doing that and the lecturer was a psychologist and she did it for me and we were in the room together and her conclusion was that there's no such personality as yours. It doesn't fit into the categories of that, but I was getting ill at that stage, at the same time so it could have been an incorrect version of me anyway, because I wasn't too well. But the reason I was bringing that up was ... what did come up a lot was helping people.

While helping people certainly explained wanting to work in a role that involves helping clients, two of the participants indicated helping on a bigger scale. Though tempered by realism about their sphere of influence, they spoke of a drive to affect a wider group of people now and in the future beyond those in their immediate vicinity.

I understand that I can't necessarily change the world in one day but if I build enough relationships and speak the truth to enough people then maybe the values that I consider are important not only to me, but to humanity as a whole, will filter out.

Let's just say in theory, hypothetically speaking, I became a CEO in an organization like I currently work for. I think that I could make so much, really think I could contribute so much to people getting well! I just want to have an impact that can help people.

Sense of Purpose

For one participant the fulfilment and sense of purpose garnered from their role had a spiritual quality, though they are yet to realize this. In alluding to a spiritual dimension of doing this work for a higher power, they clarified at this stage their purpose is helping themselves and others. The purpose remains grounded in gaining a direction and focus for themselves, rather than responding to a calling. This ‘sense of purpose’ was particularly instrumental in both coping with their mental illness and assisting in their current recovery journey.

And I want to do it because I have this feeling I want to do it, that my soul screams out to want to do it. But I also want to do it, without going into the details of any particular religious connotations, but I want to help people for me, and I do want help people to please my creator, whoever that Creator may be. ... I have direction. The illness was swallowing me whole before. It swallows me now, but I can come up again. Before I stayed down, which is what all these clients we deal with have, they are swallowed.

The theme of ‘being paid to be myself’ explained how the good fit they felt between who they perceive themselves to be and features of the job environment enabled the participants to continue to work in mental health. This is coupled with some of the underlying reasons that emerged as to why the participants worked in mental health, which they discovered after entering the field. The next theme ‘the mixed blessing of being a consumer’ explores further why they worked in mental health. This looks at how the rewards gained from ‘being myself’, including their consumer experience is personally validating and useful in the work.

Theme Two: The Mixed Blessing of Being a Consumer

Although participants were not asked about how their own lived experience of mental illness and using services related to their work role, they all spontaneously offered these perspectives. Thus while questions did not seek to address this aspect of their lives, it is highly likely this was prompted by the project subject and participant criteria being focused on, that is staff with consumer experience. Participants broached this topic early on in their interview, with one person beginning with their consumer experience. This seemed in part

due to the participant having interpreted this as the subject of sole interest, rather than this quick entry to the topic reflecting a significantly greater emphasis placed on this over other themes in their work role experience. All participants articulated the ways that being a consumer themselves impacted on their work and how they felt about this. However this did not form their whole identity, in that it was described as only one part of them and their life experience that was informative, as illustrated by the following statement “*I have lived a lot of years and had a lot of experiences that may well support clients’ progress, including my own [psychiatric] disorder*”.

For two of the participants, for whom being able to be open about their consumer status had eased the process of entering the mental health workforce, this part of their experience was a given in their identity in the main. For the remaining participant the decision to ‘come out’ and be open about their consumerism had been highly significant. Making the decision to inform others was described as nerve racking, but this emotional response was short lived. The hesitance towards coming out was fuelled by fear of workplace stigma: “*initially I was concerned about being judged by my peers as not competent because I had lived experience*”. A precursor to this concern was this participant’s conditioning to not let people know things that could cast aspersions on them or their family, and while acknowledging this as an assumption identified:

...another issue might be with maybe a member of my family being concerned that if I was out about my lived experience that that meant I would be dumping our family dirty laundry out, that other people would know or other people would find out.

A key consideration in coming out for this participant, for whom getting to the point of being open had been a bumpy ride, was weighing up the real or perceived risks and being very aware that the decision would be irreversible: “*ultimately when I stepped out of the closet, once you’re out you can’t kind of turn around and go back in*”. The statement “*once it was done for me, it was done*”, epitomizes that they had put their concerns to rest. Once this step of being open had been taken they too, like the other participants, were able to move to a point where their lived experience was taken for granted. The dilemma this participant held about whether to come out illustrates the ways in which being a consumer is a mixed blessing.

Much like a cultural worldview, all of them conveyed their consumer perspectives as an embedded part of their knowing and acting, inextricably tied up in their whole self identity. One way they made this more conscious and overt was in comparing themselves with other staff who do not share consumer experience. This comparison had empowering as well as negative connotations, with one participant experiencing both in different ways. The positive side as described by all the participants came in to play particularly when working alongside clients and is beautifully illustrated by one participant:

I find it very beneficial, to get some type of scenario of comparing myself with other workers. Without being judgmental, I can say that there's a definite edge and it's quite a big edge when it comes to working with the clients, helping the clients, understanding the clients.

On the flip side this participant also compared themselves unfavourably to other staff. They spoke about being with colleagues who have higher qualifications and how they feel they should be there, alluding to these staff enjoying greater value and status in the system than they do. This participant identified having a big hang up linked to seeing these staff as somewhat better. This signalled a sage moment in the interview when they deviated from the emphasis that participants had placed on the positive benefits of their consumer experience. They gave an insight into a deep sadness as they touched on the cost of their illness:

In one respect I am grateful for having experienced what I've experienced for the last 10 years. On the other hand I feel totally robbed of the 10 years in certain respects and I'm not saying I would have had the discipline to do a lot of postgraduate study, but I am saying that I do feel robbed.

The disruption to their lives attributed to illness did not negate the positive aspects of participants' consumer experience, and while often skimmed over as a taken for granted given, it emerged as an ever present phenomenon for all of them.

Another participant demonstrated this 'ever presence' by explaining why they would always be open about their consumer status with any prospective employer. They realized others may see their mental health history as a mixed blessing, so did not presume a

prospective employer would feel neutral about it. This insight that their history might be a pro or con from the employer's perspective meant it was presented as a factor in a person's makeup which is worthy or significant enough to be the decider (between applicants) in whether they would succeed in gaining a position. The following statement shows the complex and mixed realities of consumer experience as an everyday phenomenon which is a given and only makes up part of the person, through to an ever present significant consideration.

I feel so strongly about not disclosing. It isn't disclosure for me in the sense that it is something to disclose, it's just a normal part of the job interview and I would always bring it up. Because I feel that it's a responsibility to tell them. That's something they would need to know in their deliberations after I've gone, after the end of the job interview, I don't know that but it could be an important factor in that employer's determining. Yes I'll have that one over there, or no I'll have this one over here, and I'll try this one on a trial basis.

In the next section, the mixed nature of being a consumer is further explored. To begin, participants' view that their consumer experience is useful and helpful, particularly in working alongside clients is discussed. The knowing and information they have gained through their consumer experience supports the first sub-theme of "I've been crazy myself": advantages of consumer experience'. This sub-theme hinges on the valuable perspectives and valid knowledge gained from their consumer experience. An extension of having knowledge is empathy with clients, implicit understandings and being a role model. The second of four sub-themes is 'responsibilities of being us', in which by identifying as co-members of a consumer culture alongside clients, all participants enacted their obligation to advocate for individuals and for political change. The third sub-theme, 'down side of being out', locates a prevalent negative experience resulting from their consumer status being known, and leads onto the final sub-theme "I haven't had a year free of illness": attending to own mental health'.

"I've been crazy myself": Advantages of Consumer Experience

Once I realized that my lived experience wasn't a liability, and that my lived experience was actually an asset and my lived experience enabled me to open doors into people's lives, where other people without lived experience may not be able to go. And once I actually realized that, it was a lot easier to be able to sit down and actually say to someone "You know I haven't lived your life, but I

have been crazy myself and I know what it's like to not be able to trust your mind I know what it's like when you're burning bridges because you're distressed and you're not sure what's going on". And that was incredible and it enabled quite close connection, to be in quite close relationship with the people that I was working for which created the environment for change, and it enabled other people to see that if I can do it, they can do it and it's really only getting the right kind of support that people need to be able to live out of their dreams, whatever that dream is, and no-one has the right to say "No you can't be an astronaut, no you can't be a nurse". So that was amazing but it did take me a while, I was very nervous about coming out with my lived experience and that, my lived experience getting blamed for things that weren't about that.

This quote exemplifies how all the participants spoke of their consumer experience as an advantage when working with clients. This participant articulates the special understanding present among consumers and how being a role model was enacted. The participants' presented the advantages of their consumer experience as being most beneficial in the relationships they had with clients. This elevates the significance of this benefit, as they identified the nature and quality of relationships as the most crucial aspect of supporting others recovery. The emphasis they placed on relationships will be explored further in the third theme 'actually making a difference', as a key element in how the participants believed they helped clients achieve. One participant, who had learned on the job that to be effective they needed to work alongside clients supporting their process rather than doing for or to them, explains:

So it becomes less about solving people's problems, which is what I thought when I first started working with [mental health agency], I am here to solve people's problems. It became more about, through our mutual sharing we can find solutions that are going to work, together. Rather than, you've got a problem here and I can fix it. So my perspective kind of changed a bit, it was less about solving people's problems and more about building that relationship and seeing where we can go.

The knowledge gained from participants' own consumer experience, that proved useful in their work, spanned pure knowledge, such as about mental illness and recovery, through to felt understandings. All the participants made statements which replicated this quote: "*it's been working with clients when I feel that I do have important knowledge that I can use to help them directly*". Accordingly this sub-theme primarily relates to how this knowledge and understanding positively influenced the participants' work with clients. In the

following a participant tells about the knowledge they hold, comparing this to learning others get academically.

I've got a knowledge, it's basically as if I had studied, let's just say hypothetically speaking for the last 10 years since I've been experiencing my illness, I'd put all that time into studies I could have got quite really far at a post-graduate level, and I have just done learning that's been formulated in a different way, I've learnt it directly. So I do have a lot of knowledge, I do know what it is like to experience certain things, and even other people, for example [colleague's name], when we're talking about certain things, we will bounce my ideas of what I think is relevant and they will take them in and may not agree with all of them, but they know that it's coming from a perspective of having lived through all of that. And I know that [psychiatric condition] is different from schizophrenia, but that's beside the point, the thing is that I've experience that I've gone to such dramatic levels of pain and anguish, mental, actually a lot of physical pain also as a result of it. So I have definitely got this knowledge, yes it has only been experienced by me, yes some of it is subjective, but there's a hell of a lot in there that is objective. I mean I have experienced things all by myself that I see in textbooks for example.

In describing felt understandings the participants moved away from knowledge that could be attained by means other than through lived experience, for instance through professional education. The participants placed greater importance on the kind of knowing which had stemmed from their own consumer experience. In the following statement one participant lays claim to having knowledge that could not have been learned in any other way but through their own consumer experience:

I think my experience is really shared according to what other people ask me but it is important that I did have that successful experience for me, it was two years before I got a diagnosis, but that is not the point, like what I learned in the big hospitals, in [hospital name] I wouldn't have learned that in any other kind of context.

This included participants having learned things which are useful to pass on directly to a client in a similar situation, making interpretations or having experiences resonant to their own, for example:

... Justifiably or not justifiably some clients feel observed, and that is a real feeling. When I came out of the hospital that is how I felt for a little while, is observed. People don't know where you've come from. But you still have that feeling, that the butcher is watching you as he wraps up the meat. So my

experience at the butchers may help a client today even though my experience was in 1968 or something, because they might have the same feeling and so they are not going out.

For all the participants, having an implicit or intuitive understanding with clients was the greatest emphasis in this sub-theme of ‘advantages of lived experience’, fulfilling the key point of difference in how they saw their value to clients versus people who do not share this common bond. Founded on shared identity as co-members of a consumer culture, this understanding was described as having a more universal relevance and applicability than being able to directly transfer one’s past learning to another’s current need, as is partially the case in the last example. The participants all repeatedly made statements where their own experience was a reference point:

I would like to think that I have a mixture of both those qualities, hard and soft because there are times when a client needs that understanding and basically empathy. On the other hand they don’t need sympathy, which is crippling, it really, really is, when you’re in a bad place and someone feels sorry for you, that’s just absolutely crippling.

While this participant began identifying desirable mental health worker approaches which would typically be given by anyone oriented to best practice in the field, they quickly conveyed their own experience of receiving others sympathy as their focal point.

The participants were clear everyone’s consumer experience is unique and identified that they work with clients whose diagnosis and experience is different to their own. Notwithstanding this, there were some core experiences such as having a mental illness regardless of the actual diagnosis and hospitalization which rated as being common ground despite other personal variations:

I just relate to them as a human being who happens to have gone through major illness and I can empathize with that because I have experienced major illness of my own, and you know, being hospitalized and what not.

The participants asserted that the sense of mutuality of consumer experience that prevails in the consumer staff and client relationship leads to a very genuine empathy. The following

quote shows the mutuality in what helped the consumer staff member is now being enacted by them in the client relationship to positive ends, with the strong empathy evident.

It was surprising as first, but it was quite life affirming really in the end and just how being with someone who has lived experience, how good that can actually feel. Knowing that I haven't maybe been in and out of hospital as much as some of the people I have worked with, but going back to what I said earlier about knowing that you can't trust your mind sometimes, knowing that you can't really trust what is going on around you, how scary that is. And how comforting it is to be with someone who can actually say you know what, I know what that feels like and that really sucks.

The participants were definite there is another dimension to their relationships with clients because they have similar experience. They experienced the rapport that develops as happening quite spontaneously once this common ground is established:

It probably happens naturally, and after a client knows that you have a diagnosis, whatever it is, then they would be more likely probably to ask you, so it's important that I can share it, if it's asked for. But I don't leap around the world saying to everybody "I'm [mentally ill] what about you?" or trying to advertise it.

As this quote shows, for the consumer staff member to get onto this plane in relationships with clients they have needed to share their own lived experience. Reciprocity in sharing their experiences helped create trust, maximising the benefits of implicitly understanding what clients may be going through.

The just knowing described by participants both created and enabled a deeper level of understanding. Having set the scene for the relationship, the trust engendered led to clients sharing more. While the participants still interpreted this knowing as intuitive, they indicated their knowledge was being informed through this two way exchange. Whether this dimension remains unconscious or is analysed by the consumer staff member through a reflective reasoning process, either way it is deemed extremely useful in increasing their ability to assist clients.

It's an understanding of the feelings part; it's the understanding and the empathy, and the feelings, and the relationships. That's been a very important factor in my working relationships with clients, is that sort of intangible, if you

could call it that, the just being able to identify and knowing when to do something and when not to do something, is really important.

For the theme of ‘the mixed blessing of being a consumer’ one of the ‘advantages of consumer experience’ was this phenomenon of just knowing and implicit understanding. Built on sharing consumer experiences a special trust and mutuality develops which the participants considered allows them to get alongside and support clients. The following quote from one of the participants positions their own consumer experience as a distinct advantage. Being out about their consumer experience, the subsequent trust or confidence felt by clients accordingly and the dimension of unspoken, implicit understanding is summarised beautifully.

One of the advantages that my mental illness, ..., has allowed me to experience is the number of clients who feel differently once they have known that I have a mental illness as well and the majority of them feel more comfortable or more at ease. That I am less one of those and more one of them, for those people are not very well it has provided a source of confidence for quite a lot of the clients, and it also means that there's a lot we don't say to each other, because we don't need to. Each knows how the other might be.

The final advantage of their consumer experience touched on by one of the participants was being a role model to clients. Again fulfilling this role with clients depended on the consumer staff member sharing their own lived experience of mental illness as stated by one participant: “*it is important to share it [own consumer experience of illness and recovery] because of the confidence factor for them*”. This related to clients gaining a sense of confidence to attempt things having observed the consumer staff member.

While the participants alluded to their own recovery providing them with useful reference points from which to understand clients, the only direct reference to being a role model was framed by this participant in the reverse. Rather than role modelling how to behave or go about something in order for the client to adopt, this participant described a process of enabling client choice. This participant presented a scenario of a client choosing to do things differently to the way modelled: “*Sometimes maybe we could be a role model in the sense of I don't want to be like that, that could be part of it, that's not how I would choose to do it*”. Another participant spoke about a range of collaborative activities undertaken with clients as part of recovery. In this explanation of working with clients the participant

referred to ‘we’ and ‘our’ in a process of people with consumer experience claiming their own power. While this construct fitted somewhat with role modelling it crossed into an advocacy role and introduces ‘the responsibilities of being us’, which is the second sub-theme.

The Responsibilities of Being Us

In addition to their consumer history being useful with clients, participants also told of using this reference point to be informative to other staff. This underlies the second sub-theme of “responsibilities of being us” in which the participants impart perspectives gained from their consumer experience to bring about systemic changes in addition to sharing for the betterment of individual clients, staff and others.

One participant claimed the relevance of their knowledge in that their views have been mandated by being sought out by other staff: “... *it feels absolutely great because it legitimizes some of my knowledge*”.

So we did all vocational building and life skills, how to look at power and how we can hold onto our own power as with people with lived experience. I was involved in clinical meetings, meetings with our clients, key workers and psychiatrists, and that was about really supporting the people that I was there to serve, to be able to speak their truth and to speak up with support if they needed to rather than feeling overwhelmed by a lot of professional people in their lives that held a lot of power. So that was probably one of the main things that I worked towards, encouraging insight and encouraging people to hold onto their power even if it was quite difficult and uncomfortable.

This quote demonstrates the strong ‘us’ factor in the relationship between the consumer staff member and a client. In this description of the advocacy role being enacted and of the empowerment process, there is a real sense this has been as vital for the participant as it has been for clients. The conviction with which this participant spoke about this role and the priority they placed on this aspect of working with clients was driven by an appreciation of the importance of this gained through their own lived experience. They went on to describe advocating for clients’ recovery, breaking down barriers and counteracting stigma.

All the participants spoke about supporting and advocating as part of their role with individual clients. This will be explored in theme three ‘actually making a difference’ in which the participants’ experience of a client’s achievements is analysed and described.

One participant articulated their sense of responsibility to take on a broader advocacy role to counter discrimination and improve the lot in society of people with mental illness: “*I feel a need within me to educate the people around me that it is normal that it’s okay, that I am a good citizen, all that stuff to try to break down the barriers. Yep I might be psychotic, but I’m not bonkers forever, that kind of thing*”. This participant explains how their responsibility takes on a political advocacy role, working for a greater good beyond the individual clients being worked with.

Being I think, more forward, being a little bit more political even when it was uncomfortable standing up and saying the things that were difficult for people to hear because they needed to be said. And so I felt like I had quite a lot of responsibility to not only work well with the clients that I was there to serve, but also to educate the people around me about what lived experience was like and what was valued and what wasn’t valued and I talked a lot about language, and how language can either bring life or bring death to somebody.

This quote illustrates how the participant is informed by their own lived experience and able to speak from a position of authority on the subject due to their own consumer status.

The two sub-themes already discussed, ‘advantages of consumer experience’ and ‘responsibilities of being us’, are reliant on the consumer staff member being out about their lived experience. While this is not essential for utilising some knowledge gained from their own consumer experience to inform their practice, the other factors identified as advantages are dependent on other people knowing the participants’ consumer status. This was particularly the case to actualise the advantages with clients of forming a common bond and fulfilling consumer role modelling. So whilst pure knowledge, such as the impact of illness symptoms, gained from their own consumer experience which replicates the knowledge that could be attained by other means might be useful, the greater advantage the participants described comes from mutuality in their relationships with clients, implicit understandings, and creating a sense of us. However, having their consumer status known

by others in the workplace also contributes to the next sub-theme, the ‘downside of being out’.

Downside of Being Out

All participants were aware of stigma as being very real and present, both for clients they worked with and themselves, within and external to mental health services. This was a consideration for the one participant, as described in the introduction to this theme, who made their decision to come out after starting work in mental health. Another participant considered they are open and out about their lived experience but not totally: *“I’m not out to all colleagues; I choose who I want to [tell] and who I don’t want to”*. This participant explained how there are staff members they have not talked to directly, but as they have spoken about it to other colleagues then their consumer status is probably pretty well known in their workplace. When asking this participant about bringing their lived experience to the table as informative for other staff, they identified that this is not always welcome: *“to some people at that table, some people don’t like it, like one staff member in particular who I work with now”*. The following quote from another participant shows how stigma has been part of their experience, and in this example talks about stigma in the context of working in mental health.

I felt the stigma at times and I felt how easy it is for people to put problems onto a mental health issue when it’s not about mental health, it’s about normal life. I confronted that reasonably often.

For this participant, stigma played out in the work place when they felt it was implied the effects of intrinsic stressors of the job, as faced by all employees, were blamed on their mental illness. For example, if they were tired: *“if I was really tired, it wasn’t that I was tired because I wasn’t [mentally] well, it was that I was tired because I was overworked and under supported”*. The implications of this stigma became more serious when management was involved and the participant being mentally unwell was inferred in whether they were doing their job properly. This left the consumer staff member vulnerable in defending the need for support or resources, not related to their mental illness but in order to perform their work role.

I really think that probably the only issue that I have with what others think is my management line, and being concerned like I said earlier that it's easy to dump a member of staff with lived experience, to dump it in the lived experience box rather than looking, doing a bit more creative thinking about it being actually maybe about resources, or maybe about not being available to support your staff, or being about how easy it is to say "oh we're concerned about your roles". That was really the only issue that I had and it had come up a couple of times with me which it made a bit difficult for me to figure out how I could hold my own power with management.

This pathologising, whereby everything undesirable or inconvenient to others about a consumer is put in the illness basket, was experienced as disempowering. Pathologising has the potential to inhibit consumer staff requesting needed support, whether their need for support is unrelated to or due to their lived experience. In the next sub-theme the issue of participants attending to their own mental illness is raised and linked to staying well to do the work. This points to consumer staff seeing to their own mental illness, prioritizing their wellness, noticing when they might be becoming unwell, and taking action. Attending to one's own mental illness has implications for feeling able to seek out resources and support.

"I haven't had a year free of illness": Attending to Own Mental Health

The participants were aware of the interplay between employment and their own mental illness. For one participant, as discussed in the introduction to this theme of the 'mixed blessing of being a consumer', their lived experience had cost them dearly. This participant attributed their 10 years of unemployment prior to entering the mental health workforce directly on repeated episodes of mental illness: *"It's limited to even get into the career in the first place, and when I'm in the career it's greatly limited my progression, as I said because I haven't had one year free of illness"*.

In being upfront that mental illness poses challenges in holding down a job, the participants drew no distinction between the type of job or workplace: *"...that is just part of normal life and that would happen in any job really in any kind of circumstances"*. In the following quote one participant qualifies that attending to their own mental illness applies to any employment situation and is not limited to working in mental health.

From a selfish point of view, I would want to stay home and get it sorted out ASAP in any job. I would feel the same responsibility if I was a pilot or a panel beater or a support worker or a drain layer. Because it's likely my perception, my anticipation, and my judgement will have gone for a holiday when I'm unwell and therefore I am not going to be able to perform the job.

Notwithstanding the participants' predominant view that attending to their illness is important in any work situation, the additional responsibility of the possible effects on clients was considered by one participant in the importance of staying well to do the work. This provides an insight as to the ever-present nature of lived experience for this participant. The mutuality and interrelatedness between staff and clients earlier cited as an advantage of lived experience, is now indicated as requiring additional precautions.

What I have said [in job interviews] is that, even when I've known the interviewers have known that I have a [mental illness], my prime responsibility is to love it and keep it warm and look after it properly. But if it gets out of hand I will not come to work. And I think that too is a strength but it's a responsibility I feel to the employer as well as to the client, because if you've got unwell staff plundering around the world doing all kinds of damage, you know, to clients and that's one thing I have learned very early on in the piece was you must know when you are well and when you are not well, 'cos if you have a responsibility like a job, and when the unwellness appears you have to get it sorted real quick.

As discussed earlier the participants needed to be out about their consumer status to capitalise on the advantages of lived experience and creating a sense of us. The above quote demonstrates how a participant attends to their wellness as self care. Whilst the participants were out in the workplace, they did not place any onus on their employer to cater to any of their illness related needs. Participants taking responsibility for caring for their own consumer needs is consistent with how they described having embraced their own recovery. In turn their process of recovery combined with lived experience of mental illness was the reference which they believed informed their work and gave them an edge with clients.

The dichotomy of the participants' consumer experience being useful in the ways explained as advantages and on the other hand a disadvantage, described as the down side of being out and the challenges posed for having a job, encapsulates 'the mixed blessing of being a consumer'.

The participants' experience of working with clients gives insights as to why they worked in mental health, including their persistence in overcoming some of the adversities identified in this theme. Their motivation for this work is further explored in the next theme, 'actually making a difference', in which they talk about the immense rewards gained from assisting clients' recovery and witnessing clients' achievements.

Theme Three: Actually Making a Difference

This theme is about the participants' experience working directly with clients, and shares their immense sense of satisfaction through making a positive difference in people's lives. By way of introduction to this theme one participant's words echo the others in experiencing an incredible feeling when working with clients in recovery: "...*this is really great; I am actually making a difference*".

One of the participants deemed their work with clients as "*very, very rewarding*", encapsulating both the experience of clients wanting to engage with them and the outcomes clients attained. These rewards resonated with the sense of privilege which was described by another participant.

The elements of a 'good relationship' including closeness and trust that characterize participants' relationships with clients were elaborated on and form the basis for being effective in assisting people in their lives. The following quote shows how being let into someone's life, both in closeness and in being in their home, sets up the helping relationship to assist the client to reach their goals. The second quote supports this closeness with the element of personal sharing and being entrusted with very private information.

And the ability to have close relationships with the people that I was working with made all the difference. Working with people in their own home and actually saying that the relationship, having that good relationship, was the first step in helping people's dreams come true.

You have a very close, but you have a broad experience with them, in terms of your relationship which is very personal. Most of the clients talk very personally, such as if they get a letter from Great Aunt Susan and she is coming and asks can she stay for two weeks. Great Aunt Susan, lovely as she is to the

world, drives this client straight to hospital. That's something that's very personal. They won't want to discuss that with the man in the dairy, but they will discuss it with their worker.

Along these same lines one participant highlighted trust within the relationship and introduced the notion of the client accepting, trusting and engaging with them as being intrinsically satisfying:

He [client] will come to me, he's...I'm trying to remember how old he is, but he's basically a decade and some change older than me, but he comes to me like I'm a parent almost, and I think that's very rewarding, it really, really is. Because it shows that he trusts my judgment, he trusts my help.

This participant talked about being happy to help all clients, and revealed the positive experience participants had in the process of working with clients, even prior to or in the absence of achieving identified goals. The participants believed they could make a difference, having experienced first hand or heard about the critical difference others can make in one's life, especially in times of difficulty. The possibility of changing another person's life for the better is categorically claimed by one participant in the following quote:

Even in the beginning when there's a lot of blackness and darkness and blame and anger and grief, there was always really talk about one person that maybe had had a huge impact in their life. Or their Grandma who used to actually make sure that they were clothed and fed. You know I hear stories of that one person that made the big difference... I have had people like that in my life at times. I've been in a place of total darkness, and they've said one thing or they've given me a hug at the right time and it's made the world of difference.

In tapping into personal experience of being supported and what that meant, this participant provided a link between having someone profoundly influence them and working in mental health: *"I guess part of my motivation is to keep giving back"*. They would like it if they are the person who made a difference for someone at a crucial time, adding this as a contributor to their job satisfaction.

I think, feeling really, feeling full of gratitude, not like grateful that I owe people, not that kind of "You've done something for me so I should do something for you." Not that kind of obliged gratefulness. But really a gratitude

that just being me can make a difference, 'cause I know people just being them in my life has made a difference to me.

Another participant, in speaking about being the one from whom a client accepted and appreciated help, identified that part of the reward and satisfaction for them is in others being aware of and recognizing their input:

It's so great coming across somebody who wants to and appreciates my help...which is very rewarding because I'm doing something that is going to help them and they're aware of that and if need be others are aware of it too, but that's not so important.

This participant returned to this vein later in the interview, when asked what motivates them to work in mental health: "*Being recognized for my work, whether that be from the clients, or whether that be from like a CEO for example, it's getting the credit for my work*".

In positioning their relationships with clients, the participants all spoke in terms of we, togetherness and being present. They described empowering processes in which inspiring or instilling hope was key to facilitating clients to determine and move towards their future. The following quote illustrates this 'being with' in creating a hopeful vision:

All of the time that I would be with a client, whatever activity we are doing or wherever we are, is to help them secure and believe that they are not going to be unwell forever and a day, and that we determine together some accessible and affordable projects in their future that they determine. And sometimes they have run out of hope, so you become the surrogate keeper of the hope and just keep on feeding it into the situation, so that every time you meet after that they should be a little more confident and a little bit more hopeful and have some things they are definitely going to try and do before you meet them again. It's a lot of, I believe, non verbal support. You know, when they're in a snowstorm all by themselves, their dog's run home and they see another human being coming over the horizon, they can move forward because they have some hope and they have the presence of another person.

Understanding the nature of the relationships formed and the value placed on setting a course in motion with clients of equipping them to live successfully without the mental health system or professional support sets the scene for the ultimate sense of satisfaction these staff feel when this end is reached. One participant explained working with clients to

prepare them to leave their service, making this a “*perfectly normal, natural part of support*”. Alongside talking about the eventual prospect of disengaging from professional support, they assist the client to build up a repertoire of other supports and resources:

...not do it until they feel accepting and comfortable with exiting and not having a worker anymore. And they also have a page full of alternative places or people that they can access, to be with other people of like mind or whatever.

In the following quote a participant gives an example, showing how they derive rewards and satisfaction during the process, both by enjoying the individual and by envisaging what a client can achieve in terms of independence from the mental health system:

He’s a great client to work with, fantastic client to work with. I mean the best that I’ve come across in the two years that I’ve worked for [agency name] in that he wants to move ahead. He’s not abusive and he genuinely has a desire to improve his life and his lifestyle and his illness etc... He’s got that desire to move forward and as a human being of course some bias will slip in and I will in a way favour him. I will do a lot more of course because he wants to be helped, versus another client who I’ve been his key worker since I started there, who is not as willing, well just not willing full stop to work and is abusive etc. I think people can, clients can, come out of the mental health system like that first client will be at some stage soon.

Another participant revealed the absolute satisfaction they felt when a goal is achieved or the outcome of leaving the service is actualized:

You know when you knock on the door and it flies open, and they tell you that they have bought a bicycle because that is how they are going to lose their weight that we were talking about last week. It’s like having a whole lot of people who have just finished making a key for themselves, that you’ve helped them by saying, no, no, no, no, no I don't know how to make keys, but you will. Here's a book about keys and we're off to the library and they [clients] can make keys and they can undo their doors. NOT ME, them. And I guess the biggest thrill of all is when they say, “Don't come back, you know I'm fine now, I'm independent now, and I'm ready to move on and I don't need a worker anymore”.

This participant’s insight into clients’ achievements and attributing some of that difference to their input culminated in the idea of a cathartic moment in which something radically changes for the better with a client. As outlined above, participants held onto disengaging

as a goal and interpreted this as a positive outcome or difference they had made once accomplished. However participants described needing to witness client's progress, almost to complete the process or cycle they have supported. One participant spoke of how the thrill they felt at a client's success needs to be demonstrable from both the client's and their own perspectives. This feedback seemed to cement the sense of satisfaction for the participants that they had been a part of making the difference. This is eloquently summarised in the following quote in which one participant labels this moment as popping a bubble:

There's just a million and one things that people [have missed out on] who have lived in a closed bubble of their own creation and supported sometimes by others, where it pops and here is this wonderful new world in front of their very eyes... I need to be there to see the pop! Because it's something, a project we have done together, like other projects we have done together. And as a worker it's just that kind of a relationship where you share the personal lives of people.

All the participants talked enthusiastically about the kind of roles and activities they undertook when working with clients. It was also clear clients' achievements were a real source of job satisfaction and the key motivator for being in the job. Nonetheless, they consistently rated relationships with clients as the most important part of their role, and all described the nature of these relationships as very personal, close and trusting.

Whereas in theme two they emphasized what and how their relationships with clients are enabled, including the enhancing effect of their own consumer status, in this theme the focus is on the part their relationships played in making a difference with clients and what this meant to them as workers. This relationship dimension placed the participants in an important and special place in relation to client outcomes. It was from this basis that the satisfaction participants derived from making a difference in clients' recovery emerged. That sense of satisfaction included: giving back what they had received from others in their own past; receiving appreciation and recognition; observing clients' achievements; enabling clients to exit the service; and experiencing working with clients as a privilege.

In summary of this theme, the following quote enlightens as to the genuine sense of satisfaction participants gain from working with clients, considering the experience a special privilege, and revealing a real desire to do this work:

It's feels a real privilege for me, to be able to be a part of that person's world and a part of their intent to move forward or move on, and it's really special to be part of someone's success.

Following on from the insights as to how making a difference for clients motivates the participants to work in mental health, in the fourth theme, 'benefits gained from the job', additional reasons they found this work worthwhile and rewarding are revealed. These benefits aggregate around sub-themes related to learning and progressing as a person, particularly in their own recovery from mental health concerns. A final sub-theme picks up on opportunities that were afforded to the participants by virtue of being a consumer staff member in mental health, which would not otherwise have been available to them.

Theme Four: Benefits Gained from the Job

All the participants considered they had benefited from working in mental health, as well as believing their consumer experience is beneficial for clients. One participant who felt they had learned a lot from their illness experience stated: "*related to what I've gone through is I've learnt so much through this pain*". From this participant we hear of this two-way advantage:

Because I'm a consumer, have been for around 10 years, I find it very beneficial for me [having had my own consumer experience], and I honestly feel it is very beneficial for the clients I'm dealing with, to have had that experience with mental illness to really, really see what it's like.

They talked about learning about mental illness and recovery, both in formal training and on the job. Learning deemed useful for working with clients, was also credited as holding great significance for themselves, the whole area being hugely topical and of personal interest due to their own ongoing mental health issues. The following quote demonstrates how learning about mental health took on a greater priority for one participant than the importance one would expect from those who have not experienced their own issues:

I became more aware from newspapers, television, other people's sharings, going to short courses and whatever about mental health because it had a new perspective for me after I lost it. It was more important than it had been before

then when I had never had a day's illness in my life. I had never been in hospital apart from being born.

The interconnectedness between knowledge being useful for themselves and for the people they work with was evident. They did not make a distinction between taking insights on board for their own lives and passing this learning onto others. Whether consumer staff had had similar or quite different mental health experiences was made irrelevant. What mattered was the common denominator of lived experience, particularly of the illness. This common ground set the scene for sharing and reciprocity:

Mine was the old experience, like I was in a big hospital [hospital name], and busy all day and making sheepskin slippers down in the next building and then two weekends leave and if fine then discharged back to work Monday. And there was no community care as we know it now, no community based services. So the illness experience is what is the biggest similarity in the sense that the diagnosis is similar, two [people with mental illness] having tea at the botanical gardens. But I can share things with present day clients from the big hospital days and they can share things with me about having to get well in the community... So I learn from clients all the time, just like you learn that the best teachers in education are your students.

Much like the participants talked about imparting knowledge in a very spontaneous manner, they described acquiring learning in an integrated way from multiple sources. They conveyed a seamless quality between gathering, sharing and enacting understanding personally and professionally. Sources of learning included their illness experience, clients, colleagues, professional and other literature, and training. In particular taking on board learning which has benefited them stood out in this theme of 'benefits gained from the job', and is elaborated on in the first of two sub-themes: 'own recovery'. The second sub-theme is 'other opportunities', and details some additional opportunities two of the participants were afforded due to being a consumer staff member working in mental health, which would not otherwise have been available to them.

Own Recovery

This sub-theme is about how learning from a range of sources accessed due to working in mental health has contributed to their own mental health recovery journey. The use of

descriptors such as discovering, progressing and growth reveal the incremental nature of this learning as part of a personal process of recovery.

One participant gave a very clear account of how the job had contributed to their own recovery. The fact the job provided benefits in terms of their own personal growth and recovery is made more significant as they described themselves as someone who values self improvement: *“Part of me is driven to always be better, to be a better person. I’m always on that journey; there is always something I can improve on”*. The participants explained several core constructs in their recovery including how they have learned from clients to develop their own coping skills, decreased their sense of isolation with lived experience, and had their own hope inspired:

One of the most amazing things that I discovered in mental health was really when I heard the stories of the people that I was here to serve, their courage and their fight to want to live a good life and to be well. I was able to see how other people worked through their stuff to see what was important and that had a really big impact on my own skills...Actually thinking it’s not just me isolated here on this island called crazy, that some of the experiences, the stigma, the judgment, is the same...And just being able to hear people’s stories and to hear the pain and the grief and the trauma and know that there is always hope, where there’s life there’s hope, and even in the darkest places there’s always an opportunity to grow and to find peace and to move on.

Similarly one participant told of their lifelong love of learning:

Education, I’ve always deemed that to be really important ... like some people are hooked on chocolate, I’m hooked on learning. ... I’m a great believer in training and you can never get enough of it and you are never too old to have enough of it, because there are new things coming all the time.

The notion that there is always more to learn fits with the primary interest all the participants had in learning about mental health due to the personal significance this holds for them. Coupled with their passion for learning and interest in the topic, this participant was very enthusiastic about working in agencies where mental health training and other learning resources were readily accessible. Participants ascribed benefits to their work with clients in identifying that: *“what I’ve been able to learn through training either informal or by choosing to go to some particular learning experience, has proved to be helpful for quite*

a few clients". However in considering themselves as having been "*spoilt rotten*" they allude to their learning as being personally fulfilling, as much as it has been of benefit for clients through their work role. The following statement conveys this and gives a sense of how the learning translates into this participant's own wellbeing by meeting a need to keep learning in the field:

There are very, very enticing things, like rows and rows of journals in the library corner. There's lots to learn still, you know, it's not like this area of work is finite and everything to be discovered has been discovered. There are so much new things coming all the time. I think I also was spoiled rotten by both services that I worked for. The first one especially in terms of training, with [overseas experts].

Another participant was more explicit in attributing their personal progression to the job:

I've only worked for the last few years and it's only been part-time, prior to that I basically haven't worked. So being in this present job I am definitely progressing, definitely, leaps and bounds. I've got so much information [from the job].

The most powerful account of how the job had benefited their own recovery was given by one participant who did not know where they would be now if they had not had this work opportunity: "*I really don't know how far along the track I would be because it enabled, that is working with other people with lived experience, really enabled me to put a lot of my own stuff to rest*". While the previous quote claims work as definitely having played an important role in participants' progression, there is an element of their working after a period of unemployment that indicates any work could have been beneficial, rather than this being specific to working in mental health. This participant reveals a strong point of difference, suggesting that working in mental health held elements that enabled their recovery in ways that would not have been accessible in any other vocation. This sub-theme of how working in mental health benefited the participants' recovery is summed up in a final quote from a participant who succinctly conveys their experience as a worker and in turn the personal benefits. This is completed with heartfelt gratitude that provides a compelling argument as to the benefits the participants have felt through their roles as consumer staff.

I am just really pleased and blessed that I've had this opportunity and that my growth and my own personal growth and development has really been huge and if I hadn't of worked in mental health I'm not sure if I'd be at this place. Being inspired by people who have an amazing will to live, who have to deal with huge daily issues, is an inspiration to me to actually keep working and not to become complacent. And I'm really grateful, ultimately very grateful to [manager's name] for taking me on. They saw something in me, and hiring me enabled all this other stuff to happen.

Other Opportunities

Two of the participants had been beneficiaries of other opportunities by virtue of their consumer staff status. They attended national and international conferences, and as such had been recipients of travel, learning and other experiences that would not have been available to them other than through their jobs. Rather than being the icing on the cake or an incidental aside, these opportunities sit at the core of the development of consumer staff in the mental health workforce. They were working in mental health agencies which embraced to some extent the practice of employing staff with consumer experience. Broader than their individual workplace, it is indicative of the timing and the era in the evolution of recovery and the consumer workforce. One participant neatly identifies and explains this phenomenon:

In the middle 90's it was just beginning to come in then, and that was that people with mental health experience of their own may well be useful to present day people who are having mental health problems. That had started to be a like a sort of ideology that was acceptable and it was promoted in some areas and for organisations: "Have a think about this idea as it may hold merit, and it may be useful to the clients you are trying to help".

To actualise these benefits, both the agency and the consumer staff member set the scene by being open and valuing their unique contribution based on their lived experience. As shown above this sits in the context of the mental health field accepting this as a part, albeit not universally accepted and practiced, of the contemporary mental health recovery paradigm.

One participant was pleased to have attended conferences for the opportunity to speak out about mental health, in addition to the other benefits experienced, such as travel. This participant made the link that it was essential for them to have come out in order to receive these rewards:

To go with a client to [overseas city] and to present at a conference, to fly to [national city] to present at a conference, to be more out there and to be more political ... and from my own lived experience perspective, absolutely wouldn't have happened if I hadn't been able to be upfront and out in [agency name] about my own lived experience.

Another participant attributes the opportunity to travel abroad, having been on at least two overseas trips within their work role, to the agencies where they were employed holding particular beliefs. Such professional development opportunities can be accessed by all staff in the mental health workforce, meaning this not a unique benefit associated with status as a consumer staff member. That this participant was openly known in the workplace to have consumer experience is not mentioned in this segment, but that was the case and positively influenced them receiving these trips. However they were clearly glad to have had these opportunities and experienced them as job related benefits which would not have happened had they worked elsewhere.

I went overseas to give a paper with one of my colleagues; no rather it was a presentation. Now I would have never, never of had those opportunities if it hadn't been that service had that philosophy that staff attending and learning from those particular places, and those particular people and those particular services. If that service didn't have that philosophy I would still be thinking "One day I'll go to [overseas country]". It was an extraordinary opportunity and an extraordinary experience. It's not a payback situation for me, but it's part of the reason why I would always continue whenever asked to be in there, somehow even in a voluntary capacity, to keep giving.

In this theme, the analysis and quotes show the participants gained benefits from the job. In terms of benefiting their own recovery, they acquired learning from a range of sources and experiences. Their exchanges and relationships with clients had the greatest impact on them personally and held the key to benefits they got from the job that would not have been available to them in any other life role or line of employment. Other opportunities highlighted in the final sub-theme, conferences with associated travel, were experienced by two of the participants partially due to their consumer staff status. These opportunities were afforded them in the context of an emerging consumer workforce within the current mental health recovery paradigm.

Summary

This chapter describes the participants' experiences as consumer staff in mental health and provides insights from their work-related stories. The thematic analysis provided insights and explanations as to why the participants worked in mental health, their motivation for doing this work; meanings they interpreted from their role fulfilment, and how they benefited. On the whole their experiences were positive, and it is apparent their reasons for doing this work relate to both what they have to offer and the benefits they derived.

The data was analysed into the themes of 'being paid to be myself', 'the mixed blessing of being a consumer', 'actually making a difference' and 'benefits gained from the job'. In the first theme of being paid to be myself, the participants revealed their initial reason for taking a job in mental health was fairly pragmatic in that they needed a job. However they subsequently found that the work suited who they are, with one of the strongest features being the nature of the relationships in the workplace and the value they placed on these. They provided insights as to how being a consumer themselves has shaped the perspectives they bring to the work, leading onto the second theme in which their mental health history and consumer experience is presented as a mixed blessing encompassing positive and negative connotations. Relationships feature again in this theme and the participants all claim a distinct advantage getting alongside clients on the basis of shared consumer status. They conveyed predominantly good feelings about identifying themselves as a consumer in the workplace. Notwithstanding that they also had experiences that were conflicted or negative, on balance they deemed their consumer experience as helpful. This provided one of the over-riding explanations as to why they worked in mental health and this notion is built on in the third theme about feeling they were making a difference. They shared getting satisfaction from client's achievements and progress, whilst feeling they had contributed to bringing this about, giving meaning to them in their work role. The final theme tells of benefits they consider they have gained from working in mental health, in particular the contribution to their own personal progress and mental health recovery.

Chapter Five: Discussion

This research set out to run a qualitative enquiry to address the question of how consumer staff members experience working in mental health. The research subject was prompted by current developments and trends in the mental health sector. There is spreading recognition in the mental health sector of the important part consumers can fulfill in the workforce with stated intent and the actual practice of employing consumer staff increasing. This has paved the way for new entrants and existing members of the workforce to be open about having lived experience of mental illness. In this study three consumer staff participants shared their experiences in semi-structured, audio taped interviews. They provided a range of insights and information that was thematically analysed and interpreted into themes and sub-themes, which have been described and illustrated with quotes and examples in chapter four. These findings answer the original research question by imparting an understanding of consumer staff members' mental health work role experiences.

This chapter will discuss the study results in relation to the literature reviewed; highlight the most salient aspects of the findings to the research question; propose new or expanded conceptual contributions to the existing body of knowledge; and make recommendations for practice and further investigation. The initial discussion will demonstrate the alignment between these findings and the literature, and then point out where the findings contrasted with what is already known due to different interpretations or new insights arising from this study. The research methodology will be recapped briefly to show rigor in how the research findings were arrived at, with provisos regarding the limitations of this small scale study. The trustworthiness will be supported by scrutinizing my presuppositions on the topic and reflecting on the part I played in the analytic process to assure that the findings were driven by the participants.

Synopsis of the Findings

The findings are organized in four themes, which reveal various aspects of the participants' experience in their work roles. The participants' mental illness experience and consumer status were not specifically sought or tapped into as a separate construct. While this aspect featured throughout their narrative accounts and became the focus of theme two, the

participants had integrated their illness experience with their sense of self as part of a coherent identity.

The first theme ‘being paid to be myself’ reveals the participants’ motivation for their work and the satisfaction they derived from working in a job where they could be themselves. From initial entry into the mental health workforce for pragmatic reasons outlined in the sub-theme ‘needed a job’ the subsequent three sub-themes ‘real relationships’, ‘living out values’ and ‘sense of purpose’ give explanations as to their reasons for staying in their job role based on the intrinsic rewards.

The second theme ‘the mixed blessing of being a consumer’ presents the participants as having integrated their consumer experience into their lived identity, in that it is a significant aspect of who they are and what they bring to the work. The mixed nature of this theme pertains to the participants’ variety of experiences and resulting emotions attributable to their mental health status and others’ responses to this. On the positive side is the first of four sub-themes “‘I’ve been crazy myself’: advantages of consumer experience’, which is mostly around the benefits perceived when working alongside clients. In the second sub-theme, ‘responsibilities of being us’, the participants consider they have obligations as a consumer to make a positive difference and bring about change in the system. The negative experience of others’ stigmatising treatment of the participants, the emotional costs of having a mental illness and the issues associated with maintaining their own wellness are covered in the third and fourth sub-themes ‘down side of being out’ and “‘I haven’t had a year free of illness”: attending to own mental health’. While this second theme introduces a special quality derived by the participants from the uniqueness of the illness experience and consumer status, they concurrently live and work with challenges this poses. All the participants conveyed managing this tension and juggling the flip sides arising from their consumer identity, while valuing and keeping this part of their lived experience well integrated with their sense of self.

The third theme ‘actually making a difference’ adds further understanding to the participants’ motivation for working in mental health. This theme centres on working with clients who are achieving and recovering, knowing that they [the participant] have assisted. This theme has an optimistic and hopeful quality, with rewards and achievements on the

part of both the client and the consumer staff member. Having been there themselves, helping clients progress holds an element of giving back for the participants. The overriding satisfaction the participants felt seeing clients improve was a significant driver in continuing to work in their role. While this is rewarding enough in itself, gaining recognition for their efforts from clients and others is appreciated.

In the fourth and final theme, 'benefits gained from the job', the participants identify learning and progressing as a person as additional rewards from their work role. Being in employment was in and of itself beneficial to their own recovery, with reciprocal benefits when assisting clients, which would not have happened in another line of work. In addition to on-the-job learning, opportunities for development included training and conferences, some of which were accessed by virtue of being a consumer staff member. All learning and growth was highly valued by the participants, with this benefit being especially pertinent due to the personal relevance and interest in subjects pertaining to mental health.

On balance, the participants experienced working in mental health as positive. They feel a good fit between who they are as people and the nature of the work, the workplace and the people they interact with in the course of their duties. They hold a strong conviction they make a valuable contribution, which they believe is enhanced by their lived experience as a consumer. They find their work role rewarding, satisfying and personally beneficial.

Discussion of the Findings

Employment as a Component of Recovery

There is a good deal of alignment between the findings of this study and the literature that has been reviewed in chapter two. The literature upholds being employed as a contributor to recovery should individuals have a desire to work (Anthony et al., 2002). Benefits of working for consumers have been identified as having an income, purposeful activity, social connectedness, sense of belonging to a team, and gaining a first position as a stepping stone to gain work experience and skills to take onto other employment (Besio & Mahler, 1993; Doherty et al., 2004; Yuen & Fossey, 2003). The findings of this study support these notions, with the participants stating they needed a job and claiming that working aided their progress and recovery. In the first instance the current findings deemed

working as being helpful in and of itself as a practice ground for learning to work and building up work habits.

Benefits for Clients

Bledsoe (2001) described believable hope as a benefit for clients from having consumer staff role models. These findings suggest that hope to be both cyclical and reciprocal, with consumer staff continuously gaining insights and learning from clients in a two-way beneficial process. This typifies the process described in the literature of learning through the job, helping oneself and increasing consumer staffs' ability to help clients (Manning & Suire, 1996; Mowbray et al., 1996).

Benefits of Working in Mental Health Specifically

The relevance of having mental health experience.

The literature has also examined what it is about consumer staffs' own lived experience that is relevant to working in mental health. Consumer staff having things in common with clients opens the way to identifying and relating on the basis of empathy, trust and understanding (Besio & Mahler, 1993; Bledsoe, 2001; Doherty et al., 2004; Frese & Davis, 1997; Mowbray et al., 1996). Studies and accounts have identified beneficial coping skills and knowledge which are attributable to consumer staff members' own experiences (Bledsoe; Dixon et al., 1994; Doherty et al.; Fisk et al., 2000; Frese & Davis). This mutuality of experience between client and worker was considered an advantage of consumer experience by the participants in this study. A theme dedicated to this phenomenon provides rare insights about the special bond that develops between consumer staff and clients. The participants' belief that they struck up rapport with clients and gained valuable understandings is presented as being due to their shared consumer identity. The findings propose these real relationships are built on this basis in a way that would not have been possible through any other means. The connections formed and authentic, genuine relationships they have experienced with a range of people, including clients and colleagues in mental health, feature in the findings as central to the participants feeling comfortable in their workplace. Reported in the sub-theme 'real relationships' this was a key finding both in terms of benefits experienced by the participants and in the unique contribution consumer staff can make to clients.

Promoting recovery.

The participants were not specifically seeking to work in mental health when the opportunity to do so arose for them. Once working they felt their ability to perform was enhanced by the mental health workplace and personnel understanding and being supportive of them, which they considered may not have been the case in other work places. Once in a mental health work role the participants discovered additional benefits specific to this line of work which are consistent with other studies that have identified personal growth, skill development, increased confidence, and improved self esteem (Besio & Mahler, 1993; Manning & Suire, 1996; Mowbray et al., 1996). Current findings support these benefits, with the participants clearly feeling their work role had helped their progression and recovery. In addition to the skill and self-efficacy identified in the literature cited, the participants described feeling less isolated in, and coming to terms with, their illness experience. The learning and knowledge gained through their job, particularly from engaging with clients, engendered a sense of hopefulness that would not have been possible in any other work setting.

Providing a sense of purpose.

A sense of purpose can be garnered from any work setting that holds personal meaning and relevance, and is well documented in the literature (Honey, 1999; Yuen & Fossey, 2003). Purposefulness experienced in the participants' work role is reflected throughout the findings. A small sub-theme 'sense of purpose' is dedicated to one participant's strongly held conviction that their purpose lay in helping themselves and others, and hinted at a spiritual dimension that may become their higher purpose in the future.

The personal benefits for consumer staff of working in mental health previously identified in the literature are extended in the findings of the current study, with a sub-theme dedicated to the importance the participants placed on getting to live out their values in their work. One example was enacting their value of helping others and having this as inherent in their work provided fulfilment and emerged as one of the core reasons for doing the job. This exemplifies the findings of a similar study in which consumer staff derived rewards and satisfaction from helping others (Yuen & Fossey, 2003). In both the literature and these findings consumer staff members' belief in their own helpfulness is aided by

receiving positive feedback and appreciation from clients and others (Mowbray et al., 1996).

A very significant source of satisfaction for the participants, not previously identified in the literature, came from seeing clients' achievements. Clients' success combined with knowing they had assisted in the process was a dominant part of their experience, becoming the theme of 'actually making a difference'. All the participants shared this theme in the interviews in some detail with real passion and conviction, making this stand out as a predominant reason for working in mental health with personal and professional rewards.

Experience of Being a Consumer in the Mental Health Workforce

The findings of the current study suggest that the participants' experience contrasts between the positive advantages their status as consumer staff members affords them and challenges faced, by virtue of their consumer status and ongoing symptoms of mental illness. Literature supports the notion that consumer experience enables this staff group to bring unique perspectives which can be an advantage in working with clients and beneficial for influencing the mental health system (Dixon et al., 1994; Felton et al., 1995; Fisk & Frey, 2002; Frese & Davis, 1997; Lyons et al., 1996; MHC, 2005). Findings in this study concur with these perspectives and, while the participants integrated their illness experience alongside other life lessons, they rated this aspect of their learning as informative for their work. All the participants considered their consumer experience an advantage when working with clients as demonstrated in the following quote:

Once I realized that my lived experience wasn't a liability, and that my lived experience was actually an asset and my lived experience enabled me to open doors into people's lives, where other people without lived experience may not be able to go.

A feature unique to working in mental health, as opposed to other job settings, which was a match between the findings of this study and reports in the literature is consumer staff feeling they can be open about their mental illness. Mack (2001) experienced openly sharing about her illness at work as a privilege and a benefit in her own account, including being out without fear of repercussions. The participants in this study concur but they also identify the down side of being out, in which stigma and other attitudes projected onto them

can have a negative impact subsequent to their being open. Whilst these findings touch on stigma and discrimination, these issues have been discussed in the literature to an extent that surpasses anything these participants have experienced, particularly in settings where openly employing consumer staff is a new practice (Besio & Mahler, 1993; Fisk et al., 2000; Middleton et al., 2004).

The participants' decision to be open about their consumer status was particularly fraught for one participant who feared repercussions. This finding taps into the mixed feelings all participants portrayed about this aspect of themselves in relation to their work role. This particular participant's experience sheds light on how risky disclosure can feel and their vulnerability at the time of coming out typifies descriptions given by others (Bledsoe, 2001; Fisk et al., 2000; Frese & Davis, 1997). Fisk et al (2000) suggested disclosure may be best held off until after consumer staff members have demonstrated their ability to do their jobs, which is exactly the approach this participant took in disclosing six months after starting the job. However having taken to the step to come out this person joined the other two participants in presenting an open integrated view of their own identity. The findings suggest that being openly identified was necessary to utilise consumer perspectives in their work and capitalise on the benefits of shared experience as a point of connection with clients. A review of literature presents conflicting views on whether it is essential for consumer staff to be openly identified as such. Fisk et al. presented the view that consumer staff disclosure is not necessary for the benefits of perspectives acquired through lived experience to be enacted in the workplace.

One of the reservations about disclosure cited in the literature is the concern of discrimination and stigma which studies have found exists within and external to the mental health system (Doherty et al., 2004; Fisk et al., 2000; Manning & Suire, 1996; Middleton et al., 2004). While the findings of the current study do not reveal generalised discrimination and stigma, participants were aware of instances when they had felt their consumer perspectives were not embraced as useful or wanted, and they checked their contribution and openness accordingly. One particular aspect of stigma is pathologising, which has been described by authors as occurring in the mental health workplace, frustrating staff when their behaviour is misinterpreted as a manifestation of mental illness and they feel monitored for signs of ill health (Manning & Suire, 1996; Middleton et al., 2004). This

phenomenon typifies one participant's experience in which tiredness or stress was attributed to their mental illness, as opposed to lack of workplace resources or support. The findings extend this understanding in pointing out the ramifications can be more serious for consumer staff when management are involved in minimising their concerns as legitimate, blaming their illness and threatening job tenure.

Again dwelling in the realms of mixed experience, the findings reveal instances of consumer perspectives being validated and mandated, with the participants feeling very positive about their contributions. This carried with it a certain sense of responsibility to authoritatively speak out from a consumer perspective to improve things for both individuals and the system as a whole. This absolutely endorses the line being promoted by the consumer movement and other advocates of increasing the consumer staff workforce (Frese & Davis, 1997; MHC, 2005). The study also found working as consumer staff and having the opportunity to use lived illness experience within a work role was predominantly satisfying and empowering. Again, this aligns with the work of other authors who have identified consumer staff empowerment is associated with work that is meaningful and purposeful, personally enriching, holds a sense of contributing to the system, and involves helping other consumers or where their contributions are valued (Honey, 1999; Yuen & Fossey, 2003).

Additionally, attending to maintaining mental wellness was revealed in the findings as an ongoing part of life where ever one is employed, but carries with it extra connotations when working in mental health. The participants recognised the importance of being in good form to do their work, especially with clients. The consumer staff participants in a study by Doherty et al (2004) identified the extra effort required to remain mentally well, which others may not be aware of. This was more of a factor for one participant in this study who had been unable to work previously due to mental illness and was very mindful of the toll re-current relapses take on employment.

Claims about Consumer Staff

The findings highlight that the participants experienced the most significant point of difference compared to non-consumer staff in their relationships with clients. This was the

factor that stood out as most marked in the examples the participants gave about client reactions to them as workers. The special nature of the relationships they formed by virtue of having consumer experience in common with clients enabled a mutually beneficial process to take place. The practice of consumers fulfilling direct service delivery roles based on the qualification of their lived experience is built on the assumption that this special relationship can form and benefit clients. This assumption is borne out in these findings as, unprompted, the participants provided examples of and elaborated on this special connectedness. The detail provided in this study adds to the existing knowledge, and gives insights as to how the conditions under which this special relationship can be produced in order to benefit service delivery.

While the literature remains inconclusive about whether disclosure is necessary for the benefits of consumer experience to be realised, there is also debate in the literature about the usefulness of demarcation between staff groups on this basis. The motivation and reasons for working in mental health located in these findings do not resonate as unique to consumer staff. Likewise the benefits the participants derive from employment can be said to apply to all workers. Authors have challenged the labeling of consumer staff proposing rigid definitions of who is a client, consumer, or staff member may promote division, and suggest releasing people from the exclusive roles of client or employee (Doherty et al., 2004; Stephens & Belisle, 1993). These findings support blurring of the experiences and qualifications that staff bring to the workplace. One of the participants compared their learning through lived experience as reaching similar understandings as other staff have got through academic or professional training, arriving at the same point though different journeys. Whilst the participants identified they had lived experience of mental illness, they treated this as only one part of themselves and did not place this on a pedestal above the other knowledge and skills that come to bear in their work role.

It is acknowledged that members of the mental health workforce have, and probably always have had, lived experience, spanning an array of personal experiences and patterns of disclosure. This study supports treating consumer status as useful and valuable but not necessarily a defining feature in the rewards staff get out of their work or what they require to function in their positions. This suggestion is supported by a study comparing consumer and non-consumer staff which concluded both groups have similar needs, and all staff need

appropriate adequate training, support and supervision (Basto et al., 2000). A recognized New Zealand consumer leader M. O'Hagan (personal communication, February 16, 2007) concurred that all workers have different needs and limitations at different times, which she interpreted as indicating the relevance of universal accommodations rather than reasonable accommodations targeted at minority groups.

Critique of the Study

Limitations

This was a small scale study set in one urban location in New Zealand and the findings need to be considered in that context. With only three participants, there is an acknowledged risk that the findings may have been skewed by their particular experience and the parts of their work role they chose to relate in their personal account at interview. In addition, with such a small group participant features such as age, gender, ethnicity, professional qualifications and socioeconomic status could not be factored into selection. The defining features for inclusion were consumer experience and working as a staff member in mental health with no attempt to ensure participants were representative of the consumer staff workforce. Recognising the restrictions in the breadth of experiences participants could bring to the study, the interview questions were designed to be broad to facilitate as much sharing as possible in the least prescriptive and directional way. In spite of the open ended nature of the narrative being elicited, the participants could only tell about what they had experienced. It is hard to judge if their experience and circumstances are typical of others in New Zealand. The participants all identified as Pakeha and held similar work positions in mainstream organisations. None had specifically sought work in the mental health sector. There were no Maori included or participants working in other cultural contexts. Accordingly, consistent with how the findings of research conducted by naturalistic means are used, the findings of this study are not presented as being generalisable.

Recruiting more participants would have added depth to the thematic analysis, possibly confirming and elaborating on the emergent themes. It is possible that, if more perspectives had been represented in the data, that more themes may have been introduced and new categories formed. The significance of certain themes may have been heightened or

diminished as more participants shared in the experience being interpreted and analysed. Alternatively, what has been reported as sub-themes may have become themes in their own right, as these concepts were added to or emphasised by more participants.

Rigour

The primary intent of qualitative enquiry is that the findings arise from listening to the participants, rather than from the researcher. As well as other strategies which included open auditable processes, reflexivity and regular supervision as described in chapter three, I undertook a presupposition interview to guard against my own perceptions having an undue influence and to ensure a rigorous research process. Several notions I held prior to commencing the study are not reflected in the findings, upholding the trustworthiness that the findings were driven by the participants not by my own interpretations. For example, one of my presuppositions as to why I believed consumers might work as staff was that they are driven by a spiritual calling generated by and explaining why they had their illness experience. This did not feature as such and rather the participants were motivated by their values, in particular the value of helping others. While they considered they had something special and unique to bring to their work as a consequence of their consumer experience, they did not reveal believing their illness had been bestowed upon them so they could later fulfil a calling. Another presupposition I had was that consumer experience was generally treated as a plus in mental health services, especially by other staff, but may be rejected as a valid reference point by some clients who will negate the consumer staff member as an expert practitioner and query how a peer can assist them. While these dynamics with others, both staff and clients, have been identified in other studies and documented in literature, none of the participants told about any adverse reactions from clients along these lines.

Implications

Acknowledging the special contribution consumer staff can make on the basis of understandings and alignment with clients they have gained through lived experience implies that having consumers as staff is worth striving for. Having established the advantages to clients and the mental health system, further research is indicated to identify how mental health organisations can mitigate the factors that inhibit consumer staff functioning and promote their successful work role performance.

A further implication of this study relates to the finding that knowledge and skills gained through lived experience of mental illness and using services is only one part of the repertoire of competencies that consumer staff bring to their work. That is, the findings provide insights into experiences that the participants all had in common, but also perspectives that were held individually. It can be concluded that if these three participants each presented as unique and different, then this will be the case for all consumer staff and can be logically extended to apply to all staff. Rather than creating set protocol for employing and enabling consumer staff in the workplace, this observation implies a need for individualised employment practices for the whole mental health workforce. Furthermore, the findings describe workplace experiences, motivations and reasons for being in their roles, and satisfaction and rewards derived from success in the work that were not necessarily specific to being a consumer staff member and could be relevant to all staff. Further research comparing consumer and non-consumer staff is needed to lend support to this hypothesis and uncover what it is that drives and enables all staff to successfully fulfil their functions. This line of enquiry would have the potential to identify ways to improve the work experience of all staff, and holds the promise of providing useful insights that could help in a workforce that has a dire shortage of skilled staff.

Albeit a tentative finding, this study implies treating all staff as individuals, with consumer staff members' mental illness being viewed as only one feature alongside their culture, personality, skills, interests and other characteristics. In practice, this would mean rejecting standard menus and solutions being applied to particular subgroups within the workforce, such as being a consumer staff member. Implications include individualised employment conditions and packages that take into account each staff member's particular motivators, needs and circumstances. Tailor-made arrangements are required for training, supervision, support and career pathways, which are responsive to each staff member's needs and changing circumstances. If this approach were adopted, rather than reasonable accommodations restricted to the domain of workers who identify as having a disability, universal accommodations that meet different needs and limitations at different times would become part of flexible enabling employment for all. Unless accommodations are closely matched to an individual's needs these will miss the mark.

A recommendation from this implication is that mental health organisations, and leaders within those organisations, might take a leaf out of the recovery book. Recovery oriented services are recognisable by their flexibility and responsiveness to individual clients' needs and rights. While practicing in recovery promoting ways creates an empowering enabling experience for clients, so a parallel process might engender a mutually beneficial relationship between employer and staff member.

Conclusion

This study addressed the question: How do consumer staff members experience working in mental health? This question was developed in a context of increasing numbers of people with identified mental health experience being employed in a variety of roles across the sector. It was therefore timely to seek the wisdom of those at the centre of this practice: consumer staff themselves.

The final chapter has presented a concise synopsis of the findings. Informed by three participants, the frequently voiced view that consumer staff have a valuable place in the mental health workforce has been upheld. The overall finding is that the practice of employing consumers as staff moves the rhetoric of empowerment and validation of a mental illness experience into tangible reality in the current recovery paradigm and sets a mutually beneficial cycle in motion. Through consumer staff members' work, and particularly the special relationships they form, they make a positive difference to clients' recovery. At the same time, fulfilling their work role gives these staff a sense of satisfaction and success that contributes to their own wellbeing. This employment practice is worthy of further investigation to ensure endeavours are directed at making sure this workforce initiative is successful for individuals and the mental health sector as a whole.

A key implication of this study is that consumer experience is only one aspect of a complex multitude of personal qualities and professional competencies that staff bring to the workplace. The conclusion has been drawn that consumer staff are already an integral part of the workforce as a whole. On the basis of the findings presented, it is proposed that applying recovery oriented thinking to designing employment practices that respond to all

workers as unique individuals will have more merit than devising set workplace practices to address the needs of a group of workers who are defined by their consumer status.

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Appendices

Appendix A: Participant Information Sheet

Participant Information Sheet



27th April 2006

Project Title

Narratives of consumer staff members experience working in mental health services.

I would like to invite your voluntary participation in this research study.

What is the purpose of this research?

I am completing this research to meet the requirements for the degree of Master in Health Science as a student of AUT. This study aims to provide an understanding of the stories and experiences of three people who hold positions as mental health workers and who also identify as consumers. Currently consumers are being employed as staff in the absence of a fully documented understanding of how this works in practice and the related issues. Part of the intention is to generate understandings that may contribute to improving the employment experiences of consumer staff.

How are people chosen to be asked to be part of this research?

People who work as staff in mental health and also have consumer experience will be chosen by word of mouth. Participation is entirely voluntary and providing you do not have a potential conflict of interest with me as the researcher your participation will be welcomed. If closer to the time of your participation you are experiencing any distress, perhaps related to mental illness, I will talk to you about whether you still want to proceed.

What happens in this research?

If you agree to participate you will be telling me your story of working in mental health in an individual interview. This will be in your own words and will include only what and how much you want to tell. We will arrange to meet in a quiet private room at AUT for about an hour. You will be welcome to bring another person or people with you, like whanau or a support person. This will not be a formal interview but I will bring along some questions to help you think about your work experience and what it means to you. I will be taping the interview and getting it typed after. Anything you share will only be used for the purposes of the study. What you tell me will be analysed along with the stories of the other people and I will check back with you as the study progresses to make sure I am understanding your story as you intended.

What are the discomforts and risks?

While I want this to be a positive experience for you, I cannot rule out the possibility of you feeling any discomfort. As in any situation where you are asked to talk about your own experience there is the possibility of this stirring up uncomfortable or unhappy feelings.

How will these discomforts and risks be alleviated?

I will do everything possible to endeavour to make this research process a good experience for you. I have worked in mental health for many years, and developed sensitivity and skill in relating to people. Together we will use our judgement and stop the interview if you would like to. Nothing will proceed without you being totally agreeable. I will talk to you about what support people you have available and help you locate your own resources, which you can get in touch with after the interview if you want to.

What are the benefits?

It has been my observation that a lot of us work in mental health services because we want to make things better. We are used to reflecting on ourselves and our work to make improvements. We encourage others to talk about their experiences as a way to learn, gain insight, and make sense of things. In all these aspects of talking and reflecting you may find it quite empowering to tell your story, knowing this will be shared for the benefit of others.

How will my privacy be protected?

I will treat confidentially everything you tell me and not share it with anyone apart from the typist and my supervisor, without your expressed consent. I will only use the things you tell me for the purposes of this study. I will store your interview tape securely, and destroy this at the end of the study. After the interview your account will be transcribed and I will send this to you in writing for you to check. You will be able to remove parts at this stage. I do need to point out that once I go past this stage and I am writing up the final report it will be too late for you to pull out or remove parts of your story. In all aspects of the study and reporting the findings your name, the name of your workplace(s), and any identifying features will not be used. I will ask you not to refer to your managers, colleagues, clients and people associated with clients by their real names during the interviews to protect their privacy. However as mental health is a small world I cannot give you an absolute guarantee someone won't recognise your story and make the connection back to you. However, if anyone speculates I will not confirm their guesswork, and you will have the choice not to do so either. As an additional safeguard I warn you to think carefully who you tell about your participation, to limit the ways in which your identity can be linked to the findings in the final report.

What are the costs of participating in this research?

There will not be any payment for participating, but you will receive \$20.00 towards covering the cost of your travel. I am asking you to give your time. This will be at least three hours, depending on how long it takes you to get to the interview. The interview will be for an hour, and reading your transcript when I send it to you will probably take you at least an hour to go over this carefully.

What opportunity do I have to consider this invitation?

Take your time to think this over, and please come back to me if you would like to discuss this request or get more information. I will call in about a week to ask you if you would like

to participate. I expect to complete the interviews over the next two months, but it will be a big help if I know who is willing to participate from the start.

How do I agree to participate in this research?

If you decide you would like to participate please let me know by using my contact details below. Once you are sure you would like to take part I will get you to sign a consent form.

Will I receive feedback on the results of this research?

Yes, you will definitely get feedback about the study findings. Firstly you will get your transcript. Later on if you would like, I will give you a copy of my final report.

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, Dr Clare Hocking, clare.hocking@aut.ac.nz Phone 921 9999 ext 7120.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz Phone 921 9999 ext 8044.

Who do I contact for further information about this research?

If you would like to know anything else about this study or me please do not hesitate to contact me as the researcher. If you would like I can give you the names of people from my work, who you can contact to find out more about me.

Researcher Contact Details:

Christine Rigby
Blueprint Centre for Learning
P O Box 108182
Symonds Street
AUCKLAND
christine.rigby@blueprint.co.nz
Phone 376 1094

Project Supervisor Contact Details:

Dr Clare Hocking
Occupational Therapy School
Auckland University of Technology (AUT)
Private Bag 92006
AUCKLAND 1020
clare.hocking@aut.ac.nz
Phone 921 9999 ext 7120

**Approved by the Auckland University of Technology Ethics Committee
on 9th May 2006
AUTEK Reference number 06/63.**

Appendix B: AUTECH Approval**MEMORANDUM**

To: Clare Hocking
 From: **Madeline Banda** Executive Secretary, AUTECH
 Date: 9 May 2006
 Subject: Ethics Application Number 06/63 **Narratives of consumer staff members' experience working in mental health services.**

Dear Clare

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH) at their meeting on 10 April 2006. Your ethics application is now approved for a period of three years until 9 May 2009.

I advise that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/research/ethics>, including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/ethics>. This report is to be submitted either when the approval expires on 9 May 2009 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented.

Please note that AUTECH 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.

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 Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M Banda', with a small flourish at the end.

Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Christine Rigby christine.rigby@blueprint.co.nz

Appendix C: Participant Consent Form



Consent to Participation in Research

Title of Project: Narratives of consumer staff members experience working in mental health services.

Project Supervisor: Dr Clare Hocking

Researcher: Christine Rigby

- I have read and understood the information provided about this research project (Information Sheet dated 27th April 2006).
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed, and that the typist doing the transcribing will sign a confidentiality agreement.
- I understand that after the interview has been transcribed, I will be given a condensed version of my story to check it is an accurate representation.
- 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 withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one: Yes No

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 9th May 2006
 AUTEK Reference number 06/63.**

Appendix D: Typist Confidentiality Agreement



Typist Confidentiality Agreement

Title of Project: Narratives of consumer staff members experience working in mental health services.

Project Supervisor: Dr Clare Hocking

Researcher: Christine Rigby

I understand that all the material I will be asked to transcribe is confidential. I understand that the contents of the tapes can only be discussed with the researchers. I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Typist's signature:

Typist's name:

Typist's Contact Details:

.....
.....

Date:

Project Supervisor Contact Details:

Dr Clare Hocking, Faculty of Health and Environmental Science, Auckland University of Technology

Email: clare.hocking@aut.ac.nz

Telephone: (09) 921 9999 extn 7120

Approved by the Auckland University of Technology Ethics Committee

on 9th May 2006

AUTEC Reference number 06/63.

Appendix E: Interview Questions**Interview Questions**

Title of Project:	Narratives of consumer staff members experience working in mental health services.
Project Supervisor:	Dr Clare Hocking
Researcher:	Christine Rigby

Trigger Question

Tell me a story about your experience of being a mental health worker?

Prompt Questions

- In telling about your work, describe the **'people'** that you have contact with, the **'place'** itself and the **'activities'** that happen there.
- Comment on how well you think you do in your role and setting?
- What are some of your strengths and the things that you do well?
- What are the responsibilities of your role? Do you think that you meet the required responsibilities?
- What would others' perspectives be? What are their comments?

Note: Satisfaction & Success