Strengthening Our Foundations:

The role and workforce development requirements of service-users in the mental health workforce

Prepared for the Mental Health Commission

by

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Executive summary

Nothing about us without us' has been a motto of the 'consumer movement' for decades. 'People with experience of mental illness can use that experience as part of being good mental health workers. Therefore people with experience of mental illness should be encouraged to be part of the workforce'. (Mary O'Hagan: Consumer Workforce Development- some initial thoughts). However, although people with experience of mental illness are increasingly valued as a part of the mental health workforce at a policy-level, it appears that there are still a disproportionately low number of service-users employed in this sector. Not only do service-users need to be encouraged to view the mental health sector as a career option, but their specific training and on-the-job support requirements need to be scoped before they can be adequately addressed.

Stigma and discrimination associated with mental illness are as prevalent within the mental health sector as in the wider community. It is reported that those with experience of mental illness are not only often actively discouraged from applying for jobs within the sector, but when they succeed, they frequently find they are penalised for their experience of mental illness, opportunities for training and career-advancement are blocked, and there is little or no support or provision made to accommodate periods of unwellness. Consequently job retention issues need to be acknowledged and addressed.

The purpose of this project was to identify, scope and describe these workforce needs, and the gaps and issues unique to service users working in the mental health workforce, in order to provide some evidence and direction for the implementation of Tuutahitia Te Wero. This information is intended to be used for the development of policies and approaches to address the mental health workforce development needs of service users.

The scope *of the project was to*

a) Determine the range of roles service-users currently occupy within mental health services, in terms of existing opportunities, gaps and issues

b) Identify potential roles that can be developed for service users within the mental health workforce

c) Identify and consider recruitment and retention issues including the effectiveness of existing strategies, and the gaps, needs and concomitant issues arising

d) Scope available training and training options, in terms of effectiveness, gaps and issues

e) Identify and analyse discrimination issues.

Research Methods

Information was gathered via a set of qualitative interviews over a period of two months with service-user employees and employers (a group comprised of both service users and non-service users, and those employed in generic roles within

mental health services who also have experience of mental illness). Invitations to participate were sent out via consumer and provider networks, and interviews were conducted in person (individually or in small groups), by telephone, or in writing.

In total, 76 people responded, 54 service users, and 22 employers. 15 of the employers were service users- working in both consumer-run organisations and in non-consumer-run organisations.

Participants were chosen in order to ensure a range of:

a) Occupation: Consumer advisor, advocate, clinical, public health worker, support worker, peer support worker, trainer, networker or consultant

b) Provider organisation: DHB, NGO- (residential, advocacy, training or day-programme), peer support, Kaupapa Maori, Alcohol and Drug services, Pacific providers, Consumer providers, Networking, Public Health provider

c) Geographical location

d) Gender

e) Ethnicity

The purpose of this project is to identify key issues currently facing service users working in the mental health workforce, and to identify solutions to pave the way forward. A deliberately broad range of service users and providers from within the mental health workforce was chosen to scope what roles (clinical, service user, administration, management etc.) are currently filled by service users, the perceived gaps, and concomitant workforce development needs arising from these findings. The group of service users interviewed included both those employed because of their experience of mental illness, and those who were working within mental health services who happened to have experience of mental illness.

Recommendations that emerged from this project as issues to be addressed in order to build a cohesive and effective workforce of service users within New Zealand mental health services were:

1. *That guidelines for employers (both DHB and NGO) be developed for service user roles nationally, outlining:*
   - *Service User Job role options for organisations*
   - *Broad job description templates*
   - *Core competencies*
   - *Recruitment processes*
   - *Competency and skill development*
   - *Payment options*
   - *Payment bands*

2. *Development of:*
   - *An education package on reasonable accommodations and advance directive options for employers*

- *Policy guidelines regarding providing a work environment (within the mental health sector) that encourages a culture of acceptance of experience of mental illness amongst employees,*
- *A union for service users employed in the mental health workforce because of their personal experience of mental illness (e.g. consumer advisors, advocates, representatives, networkers)*

3. *Development of a 'training framework' and 'training needs assessment tool' for:*
   - *Service users employed in mental health services, including the mapping of career pathways.*
   - *Consumer-run organisations*

4 Further commitment to the minimisation of stigma and discrimination associated with mental illness within the mental health workforce for both those employed with experience of mental illness and those utilising services.
Further development of:

- *Recovery training*
- *Strengths –based training*
- *De-stigmatisation workshops*

As core competencies throughout the whole mental health sector, with particular emphasis on ensuring that psychiatrists receive this training as a requisite of employment.

- *Legal/advocacy resources for mental health service staff with grievances related to the interface between their employment and their personal experience of mental illness.*

4. *Development of affirmative action policies by the Mental Health Commission and the Ministry of Health to further develop the service user workforce, with particular focus on the roles of:*
   - *Clinical roles within mental health*
   - *Management*
   - *Supervision*
   - *Auditing and monitoring*
   - *Business planning and administration*
   - *Mentoring*
   - *Peer support*
   - *Advocacy*
   - *Training*
   - *Consultancy*

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1. Introduction:

A commitment to the involvement and employment of service users at all levels of mental health service planning and delivery is a key factor in the driving policy

documents of the mental health sector (Blueprint, National Mental Health Standards, Looking forward and Moving forward). This commitment is evident in the quotes below: Others don't touch- hence the need for this report.

'There needs to be an expansion of opportunities for people with experience of mental illness to take up roles in the mental health workforce. Training programmes and recruitment strategies need to explicitly encourage people with experience of mental illness to apply for training or positions. They can be employed as consumer advisors, in clinical roles, or support roles' (9.5.7. 'Blueprint for mental health services in New Zealand November 1998, ')

This report begins with a description of the composition the consumer workforce within the mental health sector, some of the advantages and disadvantages described by participants of consumers assuming these roles within the present mental health climate, and the effect of their experience of mental illness upon their personal careers.

Section two deals with recruitment, payment and training issues affecting people with experience of mental illness working within the mental health sector, and goes on to address reasonable accommodations, support and training needs, and issues for both individuals and service user run organisations. Stigma and discrimination issues are addressed, and the needs of those who experience episodes of mental illness, whether they be employed in clinical or support roles, or whether they be employed specifically because of their personal experience of mental illness.

Finally, conclusions are drawn, and recommendations made to ensure that services employing people with experience of mental illness optimise the contribution they bring to the delivery of services and to the workplace. In order to ensure and enable the recruitment and retention of this vital and unique group of people, workforce development recommendations are made addressing recruitment, retention, payment, training, stigma and discrimination, and reasonable accommodations.

2. Valuing the employment of people with experience of mental illness within mental health services

If one in five people experience mental illness at some time in their lives, it follows that this means that at least one in five people employed in mental health services will fall into this category.
The workforce group this project covers can be broadly divided into two groups:
a. Those who work in clinical, support or administration roles within mental health services and who *happen* to experience mental illness, and
b. Those who are employed within mental health services *because* of their experience of mental illness.

'The recovery approach requires mental health services….develop and draw on the resources of people with mental illness and their communities. Recovery happens when people with mental illness take an active role in improving their lives…'

(Recovery competencies for New Zealand mental health workers, Mental Health Commission, March 2001).

Service users are not only the reason mental health services exist, but are also the key players in their own recovery process, and in ensuring mental health services maintain a service user focus. Ensuring service user involvement in mental health services requires that the process of recovery thus becomes a community process, built upon the foundation of the needs of those central to mental health services. Mental health and recovery are no longer the sole charge of mental health professionals, and those who are paid to be a part of 'the system'.

All of the participants interviewed as a part of this project (both service users and providers) were asked to reflect upon what they saw as the advantages and disadvantages of employing service users in mental health services.

Advantages:

Participants were asked to describe the advantages and disadvantages of being a service user working within the mental health workforce.

Perhaps the main advantage described was that of providing hope and a role model of recovery in action to both those employed within the workforce who hadn't YET experienced mental illness, as well as to those using the services. True empathy and understanding and an ability to believe in people with experience of mental illness are also key qualities brought to mental health services by those who have used services themselves, thus diminishing the shame, or 'whakamä' which can pervade both communities and the services which are designed to cater for the needs of service users.

The perspective of people with experience of mental illness working within mental health services can help to keep their co-workers in touch with the 'real' issues, keep services honest, and monitor and minimise paternalistic attitudes.

Service users as providers can also redress the imbalance of power, and the resultant powerlessness which can keeps service users 'sick' and helpless.

Disadvantages

Service users employed within mental health service still report experiencing stigma and discrimination both from colleagues directly, and inherently within the current structures (for example, one consumer advisor reported a salary rate $20,000 per annum lower than colleagues with comparable qualifications and experience who were working at the same management levels).

Many cited challenges of being part of a minority voice (getting heard) as an ongoing challenge, and others reported being seen only in terms of their mental illness (all behaviours and reactions were 'symptomised' and scrutinised for symptomology).

Some personal difficulties of working as a service user within mental health services were also mentioned. The challenge of seeing issues beyond the confines of one's personal experience was an issue many had grappled with early on in their employment. Role-strain and boundary issues were also significant issues for some, who suddenly found their friends were now 'clients', former 'clinicians' were now colleagues, and behaviour once tolerated by their mental health colleagues when in a 'professional-client' relationship, was now negated as 'unprofessional' in a 'colleague-colleague' relationship.

For a significant portion of those interviewed, whether employed in mental health services because of their mental illness, or in spite of their mental illness, managing to maintain wellness, and to ensure access to adequate services whilst maintaining professional relationships was an ongoing challenge and potential conflict.

Effects of experience of mental illness upon career-development

People didn't see my abilities; they just saw me as a person with mental illness (interview)

I ricocheted from job to job. I wasn't ever fired- I knew I was unwell, and made sure I left before anyone could fire me. (Interview)

I was held back from senior positions… (Interview)

Although some participants had experienced little or no career disruption, the vast majority of respondents reported their experience of mental illness had created some disruption to their career path and professional development.

The onset of mental illness for many is in the mid-to-late teenage years to mid-twenties. For many this can result in a loss of educational opportunities, the chance to be able to choose a career and to be able to develop some of the basic work skills most people take for granted.

Frequent job loss through episodes of mental illness had also affected many of those interviewed. This resulted in not being able to move into more senior positions, and for some, feeling 'stuck' at a junior level when professional peers were being promoted to positions of higher responsibility.

3. Current roles and positions specifically for service users within the mental health sector

Standard nine of the national mental health standard states that service users need to be involved at all levels of service planning, delivery and implementation. To this end, service users have been employed by DHB provider arms as consumer advisors since 1990, and many NGO providers are following suit and employing service users in advisory, representative and advocacy roles. However, because there are few guidelines or policies governing these roles, the range of interpretation of roles and processes has 'growed like Topsy', and is hugely diverse and inequitable.

DHB consumer advisors

For the purposes of this project, 13 service users employed as 'Consumer advisors' were interviewed.

'Consumer advisors' have been employed within mental health services in New Zealand since 1990. The role of a consumer advisor is to provide service user advice and perspective to management, and to act as a conduit of information and advice between mental health services (DHB provider arm) and service users in the community.

It is now standard practice to employ consumer advisors within DHB mental health services and in some larger services with more than one consumer advisor, roles are delineated according to seniority or service (e.g. forensic, Maori mental health).

Consumer positions within NGO sector

There is a growing awareness within the NGO sector of the requirement to involve service users in the planning, implementation and evaluation of service delivery (National Mental Health Standard nine). However, few readily-available guidelines on what this means exist, and consequently many of these roles seem to have evolved in an ad-hoc and haphazard fashion.

It needs to be noted that some NGO provider organisations have well-developed roles and policies for service users to ensure effective participation within their organisation. These organisations could well be employed to serve as role-models or mentors to providers whose roles and policies for service users are less developed.

Service user roles in supported accommodation and day programmes, for instance, had various titles: 'consumer advisor', 'client representative', 'client advocate', 'consumer worker' and 'consumer liaison'. Some of these positions were remunerated, and others were not.

One organisation involved in this study operated as an independent external contractor to the DHB. It was suggested by a number of participants that an alternative model of service user participation within mental health services is for an external body of service user 'consultants', or a service user-run organisation to contract their services to a DHB or NGO provider requiring service user advice and

participation. The advantage of this model is the external and objective nature of a contractual arrangement, thus eliminating the possible 'conflict of interests' arising from expressing views that challenge or differ from the organisation an individual is employed by. Foreseen disadvantages to this model were the comparative lack of security, as a DHB then had the choice to cancel the contract, and the possibility that those working outside the organisation may not be privy to as much information as those working within the organisation.

Advocates

Any form of advocacy should have as its goal the empowering of people to formulate, voice and achieve their individual needs and wants. The advocate's role is to ensure that the individual's needs and wants are voiced and addressed ('Setting up an advocacy programme. A policy and procedure manual'. Barbara Disley, Jane Abernethy, Mental Health Foundation of New Zealand, June 1990, ISBN: 0-908727-16-X)

'Individual advocacy' organisations provide support, advice and mediation for individuals to ensure their service, recovery and community support needs are met. This can include assistance to make complaints or raise concerns regarding service provision, or family or community support.

'Peer advocacy' addresses systemic, policy and political issues faced by people with experience of mental illness as a group. In this role, service users are represented within organisations, networks, and at a policy-making level (for example on Local Advisory Groups), or in the media.

In one organisation, this role of 'consumer advocates' (providing individual advocacy) was clearly defined, with job descriptions, and a pay scale.

But in other organisations, a number of people employed in 'advocacy' roles had no job description, and had been shoulder-tapped either by management or as a client of the service by a democratic process amongst the client group. There was some confusion regarding expectations of the role. One interviewee had been employed for two hours a week to be the 'client advocate' in a supported accommodation service where she had previously been a resident. She was chosen and asked by the manager to fill the role, for which $80.00 per month would be deposited in her bank account. There was no job description or discussion about the role of an advocate, or the expectations of the organisation. No training, supervision or mentoring was offered. The woman employed to do this job contacted the interviewer shortly after the interview to say that she had resigned as a result of anxiety around the lack of resources, training, support, and lack of clarity regarding what was expected from the role.

The observation was made by two interviewees and one provider that service user advocacy roles had declined markedly in numbers over recent years. The reason given was that it was possibly due to the increase in DHB consumer advisor roles, and a common misconception that these were advocacy positions.

Some advocacy was occurring in 'consumer advisor' or 'consumer representative roles, though the appropriateness of assuming an advocacy role within the organisation an individual was employed by was questioned.

All DHBs are now advised by a Local Advisory Group representing stakeholders within the mental health services to provide strategic and planning advice. It is assumed that these will include service user representation, yet four people interviewed stated that their roles within the Local Advisory Group were unclear, and two participants resented the fact that they were not paid for their time.
It was felt by many of those interviewed, however, that service user advocacy within the mental health sector still had a significant role to play, but that the role was more appropriately assumed from outside the service.

Networkers

Perhaps the most recently-evolved positions are those of networkers within the service user movement nation-wide. These positions have been established to provide links and channels of communication and information between service users and service user organisations.

Each of the four 'regions' in New Zealand (Northern, Midland, Central and Southern) now has a 'Regional Consumer Network/Group'. Although these are diverse in structure, they serve to ensure that service users within the region have a role and a voice, as well as access to information regarding regional and national policy, issues and initiatives.

Two regions currently employ a person to manage their networks, and both of those people were interviewed for this project.

Kaupapa Maori service workers

Service users employed in Kaupapa Maori services included cultural support workers, cultural assessors, a kaumätua and a kuia.

All of the service users interviewed who were working within Kaupapa Maori services stressed the importance of enabling a holistic recovery journey that could entwine Tikanga Maori, whänau, hapu and iwi, with the spiritual and cultural needs of Maori with experience of mental illness. The importance of being able to provide appropriate cultural assessments, and interventions supported by kaumätua and kuia was stressed by a number of the participants involved in Kaupapa Maori services..

Reference and advisory group members

It is a common practice amongst DHB, NGO and Public Health providers to employ or pay a fee to service users as reference or advisory group members. Service users and providers interviewed generally considered this a useful model for providing service user input and perspectives into a wide range of mental health services, particularly because it draws upon a range of views and experiences. Consumer advisors in some DHB's were using advisory groups to ensure a range of service user views and input into many aspects of their role. A number of Like Minds Like

Mine Project providers use advisory groups to aid with decision-making processes, and both governance and management aspects of the contract.

Consultancy

As the perceived value of the voice of service users has grown within the mental health sector, so has the opportunity for contract and project work at a national (e.g. Ministry of Health, Mental Health Commission) and regional and local levels (DHB provider and funder arms, Regional Advisory Groups, NGO's). Two participants interviewed were self-employed consultants providing contract and project work.

Training

A number of those interviewed were providing training to groups of people. These roles varied from those who were new to public speaking and relating their experiences as service users for a few minutes in public, to those who were designing, marketing and delivering training programmes to groups of service users, providers, community groups, or social service professionals.

Many of those interviewed did some training as a part of their role. However two participants were working full-time as teacher/trainers facilitating workshops and seminars from their service user perspective.

Clinical roles

Two psychiatrists, one MOSS, four mental health nurses, two social workers and one occupational therapist (mental health) were interviewed in the course of this project. All had personal experience of mental illness, and acknowledged that this brought significant advantages to their effectiveness in their roles.

The majority of participants interviewed believed that service users could and should be more widely employed in the mental health sector as clinicians.

Roles to be developed

It was the opinion of most participants interviewed that service users could occupy any role within mental health services. Many participants expressed a desire to see more clinician and managerial roles filled by service users who were open about their personal experience of mental illness.

The suggestion was made that a policy of affirmative action for service users within mental health services be adopted. Affirmative action is defined as 'the encouragement of increased representation of minority-group members, esp. in employment (Britannica), or 'efforts to increase participation of historically disadvantaged people in institutions or societal activities' (the Centre for Health Professions, University of California). Because the population group of service users of mental health services have many similar characteristics to other social movements and minority groups (e.g. women, ethnic minorities) this was viewed as a

positive method of redressing both the disadvantages experienced and stigma and discrimination issues.

Roles that were specifically identified as needing development were:

- Clinical roles within mental health
  - Psychiatrists
  - Psychologists
  - Social Workers
  - Occupational Therapists
  - Support Workers
- Management
- Supervision
  - Of service users employed within mental health
  - Of providers and clinicians to ensure effective practice service user participation
- Auditing and monitoring of services
- Business planning and administration
- Mentoring
  - Of service users in service user positions
  - Of providers and clinicians to ensure effective practice and decision-making
- Peer support
  - Strengthening of local, regional and national initiatives
- Advocacy
  - Development of further individual advocacy services
  - Further development of systemic advocacy
- Training
  - Development of service user trainers
  - Development of service user training organisations- local regional and national
- Consultancy

4. Recruitment

I always identify that I entered the mental health system through the consumer movement. They can go figure! (interview)

'I would like to see more people consulted and wider feedback, rather than just asking the 'favourite' consumers who get all the jobs…responsibility needs to be shared'(interview)

'I overheard a manager saying that the emphasis was on consumer participation- because they hold ward meetings' (interview)

Recruitment processes varied widely between roles. The range of recruitment methods used was:

- Word of mouth
- Shoulder-tapping/personal contacts
- Demonstrated competence
- Nomination
- Advertising
    - Externally- in newspapers, websites etc.
    - Internally within the organisation or sector.

Although the process of recruiting by word-of-mouth or by shoulder-tapping worked well for some service users and providers, others expressed concern that it was limiting, and tended to perpetuate a few people getting all the work.

The recruitment process tends to be strongly correlated to the type of job being recruited for, whether it is full or part-time, and payment arrangements. Shoulder-tapping or word-of-mouth recruitment occurred more commonly in NGOs or public health settings where the nature of the job was a short-term contract, or where a representative was being sought from within a service (e.g. consumer representative within supported accommodation).

Where consumer 'representation' of a group of service users was required, a process of nomination and/or voting by the group of people to be represented was generally favoured. The point was made that it is difficult to truly represent a diverse group of people with only an experience of mental illness in common. One service user observed that it may therefore useful to distinguish between 'providing a service user perspective', and 'providing representation'.

Advertising for a position was favoured by service users as the most objective and fair way of employing service users- particularly for full-time positions that are well-remunerated. For part-time or short-term contract work, it is acknowledged that this is not always feasible or practicable.

However, an open, transparent and clearly-defined process and a conscious awareness of the reasons behind the choice of process can serve to create a vehicle for transparency and a collective sense of justice.

5. Job descriptions

"Employers and those providing service user participation need to be very clear about the difference between representation, and providing a service user perspective" (interview)

"I think my organisation knew they needed consumer participation and just took a stab at how that might happen. When I was first asked to do the job there were no instructions on what I had to do, and I wasn't paid" (interview)

Although there is a burgeoning awareness of the need to incorporate service user participation at all levels of service planning, implementation and delivery, there is broad interpretation of what that means. Some service users have been chosen by the service provider they currently use to attend the odd meeting to provide 'consumer participation'- others are employed and paid at a senior management level for their skills and expertise in policy planning, writing and analysis to provide a service user perspective into all levels of organisational planning and service delivery.

Both DHB consumer advisors and those working within the NGO sector identified the need for job descriptions and guidelines that clearly set out day to day tasks and responsibilities.

A lack of appropriate job descriptions mainly affected new service-user roles in organisations which had not to date employed service users.

All of the DHB consumer advisors interviewed (13) had job descriptions. However, half of DHB consumer advisors interviewed mentioned the diversity of expected outcomes between people employed in the role of DHB consumer advisor around New Zealand. Some consumer advisors were very clear that their role was a management, procedural and policy one aimed at service planning, delivery and implementation. Others were engaged at a front-line level in roles that resembled clinical or support work. Some were involved in loosely-defined advocacy- dealing with complaints or difficult clinical situations.
Two interviewees suggested that generic (but flexible) job description guidelines be developed to ensure consistency of expectation, process and outcome.

Although there is a growing commitment to ensuring consumer participation in the NGO sector, there are few resources available for providers to enable consistent implementation.
Nine of the 15 participants employed to provide consumer advice by service providers within NGO sector who were interviewed had no job description at all. Those with job descriptions tended to provide advice and input at a management and decision-making level. Those without job descriptions were more likely to perform tasks more commonly aligned with a 'support worker' role or individual advocacy.

Both DHB and NGO providers and employers interviewed expressed a desire to ensure adequate service user participation, but some were unsure as to how to appropriately implement this requirement, and indicated a desire for some external guidelines on both positions and process

6. Payment

Rates and methods of payment of service users within the mental health sector reflected a diversity of both philosophy and approach. For example, participants reported that payments for a public speaking engagement ranged between reimbursements of a $10.00 petrol voucher, to $250.00 for two to three hours' work.

A recurring theme was the need for guidelines, job-sizing and 'banding' of positions specifically for service users within the mental health sector. It was felt that this needed to reflect an individual's prior qualifications, training, experience and skills, and to be sized alongside jobs of similar responsibility, skill level and outcome in the open job market.

Issues around payment were the inconsistencies, and expectations that wages for service users could be lower than for other open market jobs of similar complexity. DHB consumer advisors reported pay rates ranging from $28,000 to $63,000 per annum. Many participants felt under-paid for the type of work they were doing compared with others with similar skills, qualifications and experience who were employed at similar levels.

The lack of suitable union representation and support for service users employed because of their personal experience of mental illness was cited as being an issue by DHB and NGO employees alike. It was also noted that there is little adequate union support for community support workers available.

The majority of consumer advisors interviewed expressed the view that these positions needed to be nationally job-sized and banded according to qualifications, skills, experience, and level of responsibility. Concern was expressed at apparent inconsistencies and anomalies between positions and DHB's. One consumer advisor with no prior experience or qualifications was employed on entry on a salary higher than another in a different location who was employed in a senior role, and who had worked in the sector for many years.

Within the NGO sector payment rates for consumer advice and representation within service providers were as variable as the types of roles service users assumed. People interviewed who were working in these roles tended to be paid at the lower end of the payment scale, although there were two notable exceptions.
One person interviewed commented: *'It's like there is a pay scale for service user experience but not the person's overall training/experience'.*

'*Sometimes it seems consumer experience is a **negative** qualification- instead of seeing it as an attribute that should have some sort of value, people seem to think they can pay me less than market rates because of it…'(Interview)*

Concern was expressed regarding the lack of clarity around expectations and employment arrangements, and therefore a lack of appropriately-scaled remuneration.

Considerable difficulty and debate occurred around payment for those in receipt of a benefit. Two people interviewed were paid $20.00 per week to supplement their invalid's benefits, even though they stated they worked between four and fifteen hours a week. A number of service users interviewed were paid $80.00 per week, which is the maximum income a beneficiary can receive before their benefit is significantly abated. Although genuine efforts to ensure the minimum benefit abatement occurs are made by employers, issues arise when the rate of pay is not linked to a job description or even expected hours of work. This was viewed as tokenistic by some of the people interviewed, and not as 'real work'.

Two interviewees were employed via 'task force green'- a government-subsidised work-scheme, and two had income and work assistance from Workbridge. One employer suggested that more effort to employ people under these government-assisted employment schemes would enable both more effective work to be done, and people with experience of mental illness to transition to work more easily. Payment methods, like payment rates, need to reflect the nature of the outcomes required for work performed, and the relationship with the contractor, organisation or employer providing payment, and the reasons for choosing this method of payment.

Reimbursement is a popular mode of payment, especially for one-off contracts. However, reimbursement is a method of covering costs incurred only, and does not imply payment for work done.
It is useful to ask 'who benefits from this mode of payment, and why?'

It may be seen as a means of avoiding taxes, particularly for those in receipt of a benefit, or to reduce the amount of administrative work within the employing organisation.

Similarly, some service-users were 'contracted' and expected to organise their own taxation arrangements. Whereas this is entirely appropriate for some individuals who customarily work as contractors, it can set up for failure those who do not have the required resources or experience .

It is perhaps worthy of note that in one case, an employer had gone to DWI to discuss the part-time employment of someone in receipt of the benefit who stood to earn considerably more than $80.00 per week. A special arrangement had been made to enable the employee to work part-time without undue abatement of his income.

Three interviewees commented that it would be worthwhile having some work done around outlining options for employing those on benefits.

Perhaps the greatest range of roles, responsibilities, skills requirement and payment arrangements can be seen in facilitation/presentation/training. In some settings, this involves a service user telling their story in public for three minutes to half an hour. Others who were interviewed had teaching qualifications, ran and organised workshops, seminars and trainings for large groups of people, and worked as

training contractors. Facilitation rates varied from $15.00 per hour to $120.00 per hour or $950.00 per day for a training contractor.

Within the Like Minds Like Mine project, some work is occurring around producing guidelines within both the wider project and within the speakers' bureaux.

7. Support resources and reasonable accommodations

The American Disability Association has defined reasonable accommodations as modifications to a job or the work environment that enable a qualified applicant or employee with a disability to perform essential job functions. Reasonable accommodations can ensure that a qualified individual with a disability has equal rights and privileges in employment to those of non-disabled employees. Examples include:

- restructuring a job, i.e., giving marginal functions to other individuals;
- implementing part-time or modified work schedules;
- providing qualified readers, writers or interpreters;
- redesigning work areas or equipment or acquiring new equipment'

Although considerable lip-service is given to the need to value the contribution of people with experience of mental illness within the mental health sector, many service users found that there was little adequate provision for them when they experience an episode of mental illness. Some felt they were treated punitively. A number told of losing jobs within mental health services pursuant to becoming unwell, of being demoted, or of losing some responsibilities without being consulted.

The following quotes illustrate the experience and opinions of service users:

"While people want to contract service users they are not all so keen when you get sick – they want a nutter, but not a nutty nutter!!" (interview)

"I feel torn between not wanting exceptions made and the need for the difficult times to be recognised" (interview)

"Management need to take supportive role and responsibility for role-modelling good support" (interview)

Perhaps the greatest fear expressed by service users was of losing their job. Providers expressed difficulties with the challenges of trying to balance contract requirements and budgets against the need to respect their service user employees' needs when they become unwell. Those in organisations with clear policies and

transparent procedures around sick-leave arrangements and boundaries appreciated knowing what to expect, and what the boundaries were.

A number of participants stated that they experienced difficulties with concentration and filtering out external stimuli. A dedicated personal office space was important to some participants, although not all had had their desire honoured. Two participants required a 'writer' to take notes for them, as the side effects of medication made note-taking difficult.

The group of service users interviewed who expressed the greatest feelings of loss and injustice were those employed in mental health services in roles that did not require service user experience, but who happened to also bring their own experience of mental illness as an additional qualification to the job. Almost all of them had experienced losing a job because of episodes of mental illness, and had felt their career pathways had been negatively impacted upon due to both discrimination (fear-based attitudes), and punitive treatment by management as a result of episodes of unwellness.

Sick leave

'*Too much currently is left to the managers "generosity" which also infers beholdenness and gratitude necessary by the worker. This is unacceptable" (interview)*

If experience of mental illness is a quality expressly valued within the mental health workforce, then it needs to be viewed as a 'given' that People with experience of mental illness will be prone to occasional episodes of mental illness for which they may need to take time off. It seems anomalous that an experience of mental illness is seen as a desirable quality, and in many cases a pre-requisite to employment in mental health services, but many participants reported feeling they had been treated harshly and punitively when they experienced an episode of mental illness. It seems that frequently little thought or contingency planning goes into catering for the unique workplace needs that come with an individual's experience of mental illness.

A major concern was 'what happens when/if I run out of sick leave'? Several participants had lost jobs, or had been required to go onto a benefit with concomitant stand-down period.

Although the tension for providers to meet contractual and budget requirements is acknowledged, a number of service users interviewed expressed the view that some provision and discussion in advance with employers was preferable to having surprises during an episode of illness (when one is often more vulnerable). If choice is power, then to be able to plan and negotiate options for sick leave in advance not only enhances recovery, but helps to redress an imbalance of power.

Several participants had extra sick leave provisions or unlimited sick leave, and all stated that this arrangement worked very well. One organisation amalgamated all available leave (sick leave, annual leave, bereavement and domestic leave), to be

taken at the employees own discretion. This arrangement was viewed favourably by all staff involved.

"Knowing that I have unlimited sick leave available takes the stress and anxiety out of trying to juggle my own mental health and a job. I work doubly hard to ensure I don't 'abuse' it, and in fact it means I probably take fewer sick leaves, because I do not have to deal with the anxiety and fear of trying not to get sick…" (Interview)

"Mental health days" had also been built into a number of participants' work contracts. The number available ranged from four days per annum to one week every three months. This option was viewed favourably. One participant reported, however, that he found having to justify his need for a mental health day more stressful than not taking a mental health day at all.

Hours worked

"I don't have a set starting and finishing time. I'm only required to work the amount of hours per week I am contracted for. The medication I am on makes it difficult to get up and working some mornings, so it is wonderful to not have to come in to work until I'm ready. Sometimes I need a sleep in the afternoon, so I go home and come back later. I'm so glad to be able to do this that I am very careful to make sure I work the right number of hours".

Several participants expressed the need for flexibility within the hours worked. Those who were able to work 'flexi- or glide-time' were enthusiastic about its merits.

One participant was job-sharing, and had a workable flexible hour's arrangement with her partner if one of them became unwell.

Another participant had a fold-down couch in her office which she could sleep on, if needed.

Choice of service for personal mental health needs

Service provision becomes an issue for people who work within the service from which they are most likely to receive treatment should they need it. Some services had a policy of treating people within other services. There were stories of trauma and difficulty both with being treated within one's own workplace, and also with treatment in other services (particularly when they were geographically remote). However, some of those interviewed reported positive experiences of needing and receiving treatment for episodes of mental illness while working within mental health services.

The key issues seemed to be ones of choice and planning. Several participants believed that these issues needed to be discussed at the time of employment. It was suggested that giving all prospective employees (whether or not they had current personal experience of mental illness) the opportunity to indicate their preferences

not only reduced the risk of discriminatory practice, but also acknowledged the fact that if 'one in five people experience mental illness at some time in their lives', that applied also to one in five mental health staff…

8. Supervision, Peer support and Mentoring

The value of supervision was widely endorsed by those interviewed. The vast majority of service users interviewed stated that supervision was 'vital' for their professional and personal development and safety.

Those employed in full-time positions were most likely to have some sort of supervision. Those in full-time positions who weren't supervised unanimously expressed a desire for supervision (apart from one, who had different arrangements that suited).

Those least likely to receive supervision were those employed in part-time positions and on reference or advisory groups.
External supervision was viewed to be the safest and most appropriate option. However, providers interviewed varied in agreement regarding whether supervision should be external, most citing the high cost of external supervision as a significant limiting factor.
Internal supervision was provided in a number of instances, and some participants had group supervision arrangements in place. Two participants stated that they did not find group supervision a satisfactory option because of difficulties being open, or conflicts with peers in the group.

Working in a service user role can be isolated, particularly for individuals working in mainstream organisations. Peer support was strongly favoured as a positive resource for dealing with service-user specific issues- whether work-related, or personal.
Those who were currently involved in a peer support arrangement were unanimously favourable about its merits and benefits
Many more participants cited potential perceived benefits of a peer support arrangement.
Peer support was not, however, seen as a viable alternative to supervision, but as an independent and valuable resource.

Some provider organisations used a mentoring, or in one case a 'buddy' system to orientate new staff for as long as they needed. Two service users reported having used a mentor to aid with skills acquisition. One service user participant had used a job coach, and found this a very positive arrangement.

Mentoring or 'apprenticeship' was seen as a very effective way to enable skills acquisition, with the added advantage of having one-on-one support in the process. One organisation reported using a mentoring or 'buddy' system for all new employees, whether service users or not. Mentoring can occur internally, from within and organisation, or externally, with a peer in the same or a similar role in a similar

or parallel organisation. Mentoring can provide the best of both training and supervision, ensuring hands-on experiential learning.

9. Training needs

I think employers need to do a training Needs Assessment of all staff against their job descriptions and make sure people actually know how to do what they are being asked to do.
I think service users in employment need to have great communication skills, conflict resolution skills, knowing their rights, recognising and dealing with role strain, knowing themselves-boundary setting…. (Questionnaire)

'The onset of mental illness is in mid-to late teens to mid-twenties for many people. That is when most people gain their workforce skills and training. For many of us who become unwell at that time our work skills development becomes bruised or stunted. We have to learn things later in life that other people consider basic' (interview)

"It's not enough just to have experience of mental illness. Employers need to be very clear what set of pre-requisite set of skills they require employees to have, otherwise they are set up to fail" (interview)

Perhaps the only generalisation that can safely be made about the training needs of service users in the mental health workforce is that one is ill-advised to make generalisations. Service users interviewed ranged from those who had had limited secondary school education and no further training, to some with many years tertiary and post-graduate education.

It therefore needs to be acknowledged that:

- Individuals come into service user positions with a wide range of prior qualifications, skills and experience
- Many individuals have unique training needs to enable them to fulfil the tasks required

Common issues that arose, though, are:

- The need for a flexible training framework for people employed in 'service user' positions.
- The need for a strengths-based training needs assessment tool to ensure that an individual's skills and strengths are acknowledged, and that they also get the training they require.

When employing service users because of their personal experience of mental illness, it is important to acknowledge and identify their unique training needs. Service users often come into the workforce after a prolonged period of unemployment, and therefore find there are some basic skill-deficits which are not necessarily linked to their ability to do the job for which they have been employed. It

is useful to identify these training needs as soon as possible to avoid 'setting an individual up for failure'.
It is also important to acknowledge the strengths inherent in each person employed- particularly when employment has required the courage to admit publicly to an experience of mental illness- which for many has been the negative experience that has primarily defined their identity for some time. Skill deficits need to be identified in the context of the acknowledgement of a whole persona with concomitant strengths and abilities.

Suggested training areas are as follows:

Work skills	• Te Tiriti O Waitangi • Cultural training • Assertiveness • Using office equipment • Record keeping • Time management • Committee roles/processes • Problem-solving • Conflict resolution • Negotiation • Negotiating a work contract • Networking • Boundaries • Running focus groups
Business skills	• Business and strategic planning • Quality systems • Clinical pathways • Project management • Leadership and management • Governance • Organisational theory • Establishing a trust • Accounting/bookkeeping • GST and taxation • Administration and management • Writing job descriptions • Human resource issues • Interview panel training • Fundraising • Memorandums of Understanding • 'Umbrellaing' organisations
Understanding legislation	• Mental Health (Compulsory Assessment and Treatment) Act • Privacy Act • Human Rights Act

	• NZ Bill of Rights Act • Consumer law • Employment law
Service user specific training	• Is consumer work for you? • History of the 'consumer' movement • Social change theory • Advocacy • Gaining feedback from service users
Mental Health Services	• Structure of mental health services o Nationally o Regionally o Locally • Key mental health documents • Mental health policy • Recovery Training
Specialist role training	• Auditing and monitoring • Supervision • Research and analysis skills • Policy writing and analysis • Training

Organisational training needs

'When we first started our consumer-run service, none of us knew how to keep books or even how to run a meeting. There were some very basic admin skills that none of had because we had all just come off the benefit. No wonder it didn't work out' (interview)

There has been a burgeoning growth of service user run organisations, many of which operate with considerable success. However, some service user run organisations have not succeeded, for a variety reasons.
It is not within the scope of this paper to discuss this in detail, other than to make some broad observations gleaned from the interviews conducted for the purpose of the project.
The growth in service user run organisations has also resulted in an increasing number of 'umbrella' organisations- contracted to hold a contract for a fledgling organisation, and to provide administrative services and mentoring. Problems can arise when there is no clear and transparent communication process between organisations, or where administrative processes are not clearly negotiated.

A training package for service user organisations and their umbrella organisations could serve to forestall much of these issues. Training areas it would be useful to cover are:

- Establishing a working inter-organisational relationship
- Policy writing and analysis
- Business, strategic and annual plans
- Budgeting/accounting/bookkeeping

- Filing contractual reports
- Record-keeping
- Writing job descriptions
- Employment processes

Career pathways

Career pathways are clusters of occupations/careers that are grouped because of shared skills and aptitudes. All pathways include a variety of occupations that require different levels of education and training. Selecting a career pathway provides you with an area of focus, along with flexibility and a variety of ideas to pursue. (http://www.aea10.k12.ia.us/stw/pathways/index.html-ssi)

There has been little acknowledgement to date of the need for the development of career pathways for service users employed within the mental health workforce specifically because of their personal experience of mental illness. However, the 'consumer' movement has been active in New Zealand for nearly two decades, and many service users have forged their own paths into management, clinical work, consultancy, and many other careers.

The need for service users at all levels of mental health service planning, implementation and delivery was strongly endorsed by the majority of participants. Almost all expressed a desire to see career pathways developed. The more service users are visibly employed in all roles and at all levels of management, the more the mental health services role model messages of hope and recovery.

10. Stigma and discrimination issues:

I think it was dreadful when I first started there were a lot of people who thought that employing people to bring a consumer perspective was a politically correct waste of money, time and space. I was told I wouldn't last long and that I shouldn't bother too much. No need to understand or contribute as I could add no value. Some members of the senior management team were actively rude and obstructive. I considered resignation several times in the first three months.
There was also no office, desk, chair, phone etc for me to use. I got an office by taking over an empty room. We poked a hole through the wall so that I could have a computer and phone. (Interview)

When I first started work as a consumer advisor:

- *I was asked by a staff member if the briefcase I brought to work was 'to carry my lunch in' (interview)*
- *A nurse I was introduced to announced 'aren't YOU functioning well'! (interview)*

I find that every difficulty I have, or expression of emotion is scrutinised and diagnosed as being 'unwell'. The staffs I work with are hyper-vigilant to any fluctuation of mood or behaviour' (interview)

The section of this project on stigma and discrimination revealed two significant points:

1. Stigma and discrimination are still alive and well within mental health services.
2. Progress is being made in eliminating stigma and discrimination within mental health services.

Participants were asked to recount personal and anecdotal stories of stigma and discrimination within mental health services. Whereas the majority of service users interviewed recounted multiple stories of their own and others' discrimination and stigma whilst working within mental health services, it is also pertinent to note that there were a small number of participants who stated that stigma and discrimination were not part of their experience.

Stigma and discrimination experiences can be broadly divided into three categories:

Inequity

'Because my keyworker was on the staff of the community team I work in, I wasn't invited to a function at her place' (interview)

'I was made to use the oldest vehicle to travel in because I was just the consumer advisor' (interview)

Service users told of instances of being treated as 'less valuable' than other staff members. These instances included not being invited to staff social functions and of being the only member of a review team not to be given a copy of a report the group had worked collectively on, because of 'confidentiality' concerns!.

Penalisation

'When I became sick and was put in hospital, I was treated as if I was bad, and hadn't been trying hard. When I got back to work some of my responsibilities and roles had been taken from me with no discussion. The way I was treated by my fellow staff was worse for my recovery than the episode of illness itself' (interview)

Service users frequently reported feeling penalised for their personal experience of mental illness. All of the clinicians interviewed had lost or felt forced out of either a job or a role because of episodes of mental illness. The greatest distress seemed to arise around decisions made without negotiation or consultation, on the basis of assumptions.

Labelling

'If I was happy, I would be asked if I was elevated. If I was feeling sad, I would be told I looked as though I was depressed. All my behaviour is seen as a symptom. I feel as though I'm seen as a mental illness, rather than as a human being with feelings' (interview)

A common experience to those interviewed was that of feeling viewed as ‘a mental illness’ only, and of having all difficulties and behaviours seen in that light. Boundary issues arose with staff or peers who felt an obligation to proffer unsolicited comment upon a service user’s perceived state of mind.

Ongoing education was the most favoured mode of redress for these issues. There was some cognizance of the success of the women’s movement, and the Maori rights movement and other ethnic minorities. Parallels were made with Te Tiriti ö Waitangi workshops that are now an integral and core workforce development component in much of our New Zealand workforce.

There was strong endorsement of three existing education programmes, and a desire to see them integrated as core competency training within the whole of the mental health workforce. These are:

1. Recovery training
2. Strengths-based training
3. Like Minds Like Mine Project stigma and discrimination awareness training.

A number of providers and clinical staff acknowledged the ‘Driving recovery’ workshops delivered to many DHB mental health services around New Zealand. These were seen to be positive and effective, but ‘only scratching the surface’. Effective attitude change was deemed to require considerably greater depth and ongoing, sustained input, evaluation and monitoring.

Advocacy for service users employed within mental health services

‘My boss, who is a manager of a large mental health service, didn’t know how to talk to me when I became unwell’ (interview)

My colleagues were afraid to talk to me openly when I got sick, and made lots of decisions about me behind my back. They sectioned me, and the trauma of that process and the betrayal I felt took a long time to recover from’ (interview)

I find it really difficult when one of my staff becomes unwell. I feel torn between wanting to make sure their personal recovery happens, and the contractual obligations of the organisation. I have had to let a number of staff go because things have got difficult after they became unwell. (interview)

When a service user becomes unwell within mental health services, it can be a lonely process. Recovery and job retention can be dependent upon the response of immediate superiors. Implementation of specific policies and advance direction options may provide for some of these requirements.

However, a need for advocacy and legal services specifically for People with experience of mental illness who are working within mental health services was expressed by both those employed in ‘mainstream’ roles, and those employed in specific ‘service user’ roles.

11. Recommendations: Strengthening our foundations

Much workforce development for service users working within the mental health workforce to date has been developed on an ad hoc basis. It is the recommendation of this report that service user roles be viewed collectively as part of a larger 'discipline' or profession, (in much the same way that nurses, secretaries or psychiatrists are viewed collectively).

1 Development of guidelines for service user roles

If consumer participation and input is to be taken seriously, some consistency needs to be developed within the mental health sector. A lack of consistency or guidelines for service user roles in mental health services was a recurring theme arising from interviews with both employers and employees throughout this project. Core competencies, including expectations, processes and outcomes for service user roles within mental health services need to be clearly defined. This need was apparent within both the DHB consumer advisor roles as well as amongst the diversity of roles existent within the NGO sector.

It is the recommendation of this report that core competencies and guidelines be developed to describe the recommended roles, job descriptions, recruitment processes, payment rates and processes for service-user specific roles throughout the mental health sector.

Sector/role	***Job role***	***Job description***	***Recruitment Processes***	***Competency and skill development***	***Payment bands***	***Payment processes***
DHB consumer advisor						
NGO sector consumer representatives						
Reference/advisory groups						
Advocacy						
Networker						

Recommendation:

That guidelines for employers (both DHB and NGO) be developed for service user roles nationally, outlining:

- ***Service User Job role options for organisations***
- ***Broad job description templates***

- ***Core competencies***
- ***Recruitment processes***
- ***Competency and skill development***
- ***Payment options***
- ***Payment bands***

2 Development of:

- ***An education package on reasonable accommodations and advance directive options for employers***
- ***Policy guidelines regarding providing a work environment (within the mental health sector) that encourages a culture of acceptance of experience of mental illness amongst employees,***
- ***A union for service users employed in the mental health workforce because of their personal experience of mental illness (e.g. consumer advisors, advocates, representatives, networkers)***

A service user working in mental health's personal experience of mental illness can 'add value' to mental health services, and needs to be valued as such.

It is the recommendation of this report that an education package or 'toolkit' be developed to educate employers to cater for the mental health care needs of service users employed within mental health services (within the confines of their professional boundaries).

It is important for services to plan to have resources available for the eventuality of an episode of mental illness of those in their employ, or one of their immediate family members. 'One in five people experience mental illness at some time in their lives'- which thereby implies one in five staff in any mental health service, regardless of their position. Planning for incidence of an episode of mental illness must not, therefore, be limited to those employed because of their service user experience, but needs to include all those employed by a mental health service.

'Recovery plan' in this context is used in much the same way as 'advance directives'- an opportunity to for an employee to state such details as:

- Preferred service for mental health care
- Choice of treatments
- Preferred actions to be taken by others
- Who to be involved in care and treatment
- What works
- What doesn't etc.

It is not envisaged that an employer necessarily has access to any of this information, but that the individual is given the resources to think through the issues and make choices in advance. Who is involved, and when, is entirely up to the

individual, and some may make the choice not to avail of this process. However, it may prove a useful tool for employers and employees who choose to use it.

It is also recommended that this education package include information on 'reasonable accommodations' for people with experience of mental illness, and their implementation.

Attitude change requires a 'top-down' approach in mental health services, and serves to provide a role-model to the communities they serve. It is recommended that organisational policy and service quality guidelines for countering stigma and discrimination be developed specifically for the mental health sector.

3 Development of a 'training framework' and 'training needs assessment tool' for:

- ***service users employed in mental health services, including the mapping of career pathways.***
- ***Service-user run organisations***

Each service user employed in mental health services comes with a unique set of strengths, skills and training needs. It is vital that all are acknowledged, to ensure that the potential in both the employee and the organisation are maximised.

It is recommended that a 'training framework' with individual units be developed to cater for the diverse training needs of service users entering the mental health workforce, and linked into the mapping and development of career pathways.
A 'training needs assessment tool' will serve to identify individual training needs, so that skill development packages can be tailored to the individual.

Suggested training areas are as follows:

Work skills	• Te Tiriti O Waitangi • Cultural training • Assertiveness • Using office equipment • Record keeping • Time management • Committee roles/processes • Problem-solving • Conflict resolution • Negotiation • Negotiating a work contract • Networking • Boundaries • Running focus groups	

Business skills	• Business and strategic planning • Quality systems • Clinical pathways • Project management • Leadership and management • Governance • Organisational theory • Establishing a trust • Accounting/bookkeeping • GST and taxation • Administration and management • Writing job descriptions • Human resource issues • Interview panel training • Fundraising • Memorandums of Understanding • 'Umbrellaing' organisations	
Understanding legislation	• Mental Health (Compulsory Assessment and Treatment) Act • Privacy Act • Human Rights Act • NZ Bill of Rights Act • Consumer law • Employment law	
Service user specific training	• Is consumer work for you? • History of the 'consumer' movement • Social change theory • Advocacy • Gaining feedback from service users	
Mental Health Services	• Structure of mental health services o Nationally o Regionally o Locally • Key mental health documents • Mental health policy • Recovery Training	
Specialist role training	• Auditing and monitoring	

	• Supervision • Research and analysis skills • Policy writing and analysis • Training	

A training-needs assessment tool and training package for service user organisations and their umbrella organisations including:

- Establishing a working inter-organisational relationship
- Policy writing and analysis
- Business, strategic and annual plans
- Budgeting/accounting/bookkeeping
- Filing contractual reports
- Record-keeping
- Writing job descriptions
- Employment processes
- Understanding governance, management and their specific accountabilities

4 Further commitment to the minimisation of stigma and discrimination associated with mental illness within the mental health workforce for both those employed with experience of mental illness and those utilising services.

Further development of:

- ***Recovery training***
- ***Strengths –based training***
- ***De-stigmatisation workshops***

As core competencies throughout the whole mental health sector, with particular emphasis on ensuring that psychiatrists receive this training as a requisite of employment.

- ***Legal/advocacy resources for mental health service staff with grievances related to the interface between their employment and their personal experience of mental illness.***

Although strides to counter stigma and discrimination have been made, there is still evidence of stigma, discrimination and punitive attitudes towards people with experience of mental illness within the mental health workforce.

5 Consideration of affirmative action policies to develop the service user workforce further, with particular focus on the roles of:

- ***Management***
- ***Supervision***
- ***Auditing and monitoring***
- ***Business planning and administration***
- ***Mentoring***
- ***Peer support***
- ***Advocacy***
- ***Training***
- ***Consultancy***
- ***Clinical roles within mental health***

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Appendix:

1. **Interview schedule for service users**
2. **Interview schedule for participants**
3. **Demographics of participants**

Interview schedule for service users

NB- All information will be confidential, and nothing in the final report will be written in a way which will identify either individuals or organisations. If you would like to sight a draft before publishing, please let me know.

Please do not feel obliged to answer questions you don't feel comfortable answering.

(Please, if possible, supply a job description)

1. ***Your job***

   1.1 What is your job title?

   1.2 What do you do?

   1.3 Do you do tasks that are not in your job description? If so, what are they?

   1.4 How long have you been employed in your current position?

      1.4.1 How long have you been working in the mental health sector?

      1.4.2 What other positions have you held within the mental health sector, and for how long?

      1.4.3 What were your reasons for changing jobs?

      1.4.4 What was your previous position or employment status immediately prior to getting this job?

   1.5 How has your experience of mental illness affected your employment history? (Include how it has affected what jobs you have got and any disruption to employment).

   1.6 What advantages do you believe there are in employing People with experience of mental illness in the mental health workforce?

   1.7 What disadvantages do you believe there are in employing People with experience of mental illness in the mental health workforce?

2. ***Support***

   2.1 Do you have any specific clauses about keeping yourself mentally healthy or about work-related stress in your employment contract?

   2.2 Are there any unique needs (including sick-leave provision) created by your mental illness that you would like to be able to plan or negotiate about with your employer?

   2.3 Do you have/or have you had supervision, mentoring or peer support arrangements in place?

      2.3.1How effective is these?

2.4 What extra supports (if any) would you like to have available?

2.5 How important do you believe these options are for people with mental illness who work in the mental health workforce?

2.5.1 How should these options be made available?

2.6 Do you think there are there any other provisions that should be made available for people with experience of mental illness who are employed in the mental health workforce?

3. Hours of work

3.1 Are you: Permanent/ Temporary/ Fixed term/Full time/Part time/Contract worker/ Casual

3.2 How many hours a week do you normally work? _____

3.3 Would you rather work more, fewer or the same number of hours?

4 Payment:

4.1 Hourly rate:_____

4.2 Are you salaried/waged/voluntary

4.3 Frequency of payment: Weekly/fortnightly/monthly/casual/other

4.4 *Does this payment arrangement suit you? Explain*.

4.5 *What payment issues (if any) do you believe exist for Service Users in the mental health workforce?*

5 How did you get your job?

5.1 Did you need experience of mental illness to get this job?

5.1.1 If not, have you disclosed your experience of mental illness to your employer?

5.1.2 How and when did you disclose your experience of mental illness to your employer?

5.2 If experience of mental illness was a requirement in applying for this job, how did your employer ensure that you had personal experience of mental illness when you were recruited?

5.2.1 How effective do you think this was?

5.3 What do you think are the important issues around recruitment for people with experience of mental illness?

6 Training

6.1 Have you had any training while you have been in this job?

6.1.1 What training have you had?

6.2 Would you like to receive more training?

6.2.1 What training would you like to receive?

6.3 What sort of training opportunities do you think would improve service-user's opportunities for employment, promotion or career-development within the mental health workforce?

7. Stigma and Discrimination

7.1 Have you personally experienced stigma and discrimination associated with your mental illness in the workforce? Please explain.

7.1.1 If so, what was done about it? How and when did this occur?

7.1.1.2 How effective was that?

7.2 Are you aware of other people with experience of mental illness being discriminated in the workforce? Please explain.

7.3 How do you think these stigma and discrimination issues could most effectively be addressed?

8. Job options and opportunities

8.1 What existing job options for people with experience of mental illness within the mental health workforce can you tell me about?

8.1.1 What other jobs or roles could or should be available to people with experience of mental illness?

8.1.2 How does this need to happen?

9. Your career

9.1 What do you consider would be the job most suitable for you?

9.1.1 What would need to happen for you to enable you to get that job? (Include training needs, and on-the-job support needs, if any).

9.2 Have you been given the opportunity in your current or past roles to have a career-path developed?

9.2.1 How important or useful do you think the opportunity to have career-paths developed would be for service users in the mental health workforce?

Interview schedule for providers/employers

(If possible, please supply job descriptions)

1. ***In what positions do you currently employ people with experience of mental illness? (Include people employed in all roles- clinical, administration, consumer, support etc.)***
   Please give the job-titles and key tasks required in each role:
   1.2.1.1. Job-title
   1.1.2 Tasks

   1.2.2.1 Job-title
   1.2.2 Tasks

   1.2.3.1 Job-title
   1.3.2 Tasks

   1.2.4.1. Job-title
   1.4.2 Tasks

   1.2.5.1 Job-title
   1.5.2 Tasks

   1.2.6.1 Job-title
   1.6.2 Tasks

   1.2.7.1 Job-title
   1.7.2. Tasks

   1.2.8.1 Job-title
   1.8.2 Tasks

1.2.9.1 Job-title
1.9.2 Tasks

1.3 What do you see are the advantages of employing service-users in the mental health workforce?

1.4 Are there any unique challenges involved in employing service-users? Please explain.

2.1 Do you have any specific clauses about keeping your employees mentally healthy or about work-related stress in their employment contracts?

2.2 Are there any unique needs created by your own or your employee's experience of mental illness that you think need to be negotiated or planned for?

2.3 What are your views about the importance of supervision, mentoring or peer support in the workplace?

- *2.3.1 Do you have supervision, mentoring or peer support arrangements in place?*
- *2.3.2 How effective are these?*
- *2.3.4 What extra supports (if any) would you like to have available?*
- *2.3.5 How important do you believe these options are for people with mental illness who work in the mental health workforce?*
- *2.3.6 How should these options be made available?*

2.4 Do you believe these needs differ in any way for people with experience of mental illness?
2.5 What are your views about how these options need to be made available to the service-users you employ?

3. How many people with experience of mental illness are you aware that you currently employ? (Include all roles)

3.1How many hours a week does each employee with experience of mental illness work?

Employee	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
Number of hours worked per week										
Part-time (P), Full-time (F) or voluntary (V)?										
Permanent (P), Fixed term (F) or casual(C) position?										
Hours Increased (I), Decreased(D) or stayed same(S)										

5. Payment

5.1 How do you pay people?(e.g. Taxed via IRD, vouchers, cash, they are voluntary, other)

5.2 What do you think are the issues around payment of people with experience of mental illness working in the mental health sector?

6.1 How did you become aware of these employees experience of mental illness?

6.2 How do you recruit people with experience of mental illness for positions where that experience is required (e.g. word-of-mouth, advertising, shoulder-tapping, networks) Is this any different from the ways you recruit other staff?

6.2.1 How effective has this been?

6.3 What improvements do you think could be made to existing arrangements?

6.4 What do you think are the important issues around recruiting people with experience of mental illness?

7.1 What training opportunities do you provide for service-users in your workplace?

7.1.1 What other skills (if any) do you regard as important for service-users working in your workplace?

7.2 What sort of training opportunities (if any) would enhance people's chance of getting jobs within the mental health workforce?

7.3 What sort of training opportunities (if any) do you think would enhance service-user's opportunities for promotion or career-development within the mental health workforce?

7.4 Do service-users have different training needs to other employees? If so what are those training needs?

8.1 What on-the-job supports (if any) does this organisation provide for people with experience of mental illness in the workforce? (e.g. supervision, mentoring…)

8.1.2 k. What has made you aware of these support needs?

8.1.3 What sort of measures would most effectively address these needs?

8.1.4 Whose responsibility is it to implement these measures?

8.2 Are there supports that you would like to provide but cannot at the moment? What are they? Why can't you provide them?

9.1 Are you aware of any discrimination experienced by service-users in your workplace?

9.1.1 If so Please explain

9.2 Are you aware of any discrimination experienced by service-users in other mental health work-places?
9.2.1 What has made you aware of these issues?
9.2.2 What are your views about how should these issues be addressed?

10.1 What existing job options for people with experience of mental illness are there in this organisation that are not currently being filled?

10.2 Are career pathways developed for the people in your service employed in positions where experience of mental illness is required? If not, why is that?

10.3 What other jobs or roles do you think should be made available to people with experience of mental illness in the general mental health workforce?
***10.3.1** How do you think this could be enabled to happen?*

Demographics of Participants

Total number of participants	77
Ethnicity:	
Maori	30
Pacific People	6
European/Pakeha	38
Other	2

Geographical Location:	
Northern Region	23
Midland Region	18
Central Region	19
Southern Region	17
Type of Organisation:	
DHB	26
NGO	32
Like Minds Like Mine	9
Ministry of Health	2
Mental Health Commission	2
Self-employed	5
University	1
Role/Job title:	
Administrator	4
Advocate	2
Chairperson	3
Client Representative	3
Consumer Advisor:	
Alcohol and Drug	2
DHB	13
National	2
NGO	3
Contract Consultant	2
Cultural Support Worker	2
Education Officer	1
Executive Officer	1
Kuia	1
Manager	11
Networker	3
Nurse	2
Project Manager	3
Psychiatrist	3
Reference Group Member	5
Researcher	1
Service Co-ordinator	1
Social Worker	2
Support Worker	4
Trainer	3
Employers	23

Employers who are also service users Service Users	17 54
People managing or employed in Service User-run organisations	18