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**Who cares about carers?
Experiences of community mental health support workers
from a feminist perspective**

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
Masters of Applied Psychology
at
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by
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Abstract

Research regarding care labour is a relatively new area of interest. The long-term availability of a robust community care workforce has recently become a topical concern amongst many policy makers, scholars and activists in western countries as the demand for care is expected to expand rapidly over the next few decades. Care workforce shortages are likely to pose a significant problem as the demand for care is escalating at the same time as traditional sources of unpaid care are diminishing. A high proportion of both paid and unpaid care is still undertaken by women. Research indicates that labour undertaken by workers in caring occupations is generally undervalued, unrecognised and unrewarded, which contributes to on-going discrepancies in society such as the gender wage gap. This research focuses on the care work carried out by community mental health support workers. The aim of this research was to explore a feminist perspective, which states that care work is devalued by society due to it being similar in nature to the unpaid domestic labour that has traditionally been undertaken by women. More specifically this research aimed to explore the extent to which this feminist theory can be applied to community mental health support work in New Zealand and the impact that such an association may have on the value placed on this work. Fourteen in-depth, semi-structured interviews were conducted with community mental health support workers from regions across New Zealand. In order to determine the value placed on this work, support workers were asked questions designed to elicit information about their working conditions. A thematic data analysis was carried out on the interviews. The results of this research indicate that support workers are extremely dissatisfied with the low wages attributed to this work. Working with service users and other colleagues are the most rewarding aspects of support work, which may have a buffering affect on the marginalising work conditions. Problems inherent in the mental health system were identified. The high staff turnover of mental health support workers and the associated problems with this are also highlighted. Low levels of supervision is characteristic of support work and training is commonly perceived as too bland and generalised. The safety of support workers is often not a high priority. The presence of hierarchy within health care

organisations was also a common theme to emerge. Poor mental health funding is deemed an important contributor to the issues related to community support work. Suggestions for addressing the working conditions of support work are put forward. Further research with larger sample sizes is required to validate the findings. However the results are consistent with previous literature and lend support to the notion that mental health support work is not a valued occupation. This research contributes to the limited scientific knowledge base regarding structural gender discrimination and New Zealand based community mental health support work. Moreover this research provides a unique and rare insight of this work from the perspective of mental health support workers themselves.

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Chapter One: Research context

Autobiographical information

The importance of clarifying the researchers role and partiality at the outset of study has been recognised by academics (Barker & Pistrang, 2005; Campbell & Wasco, 2000; Cosgrove & McHugh, 2000; Dahlberg & McCaig, 2010; Riger, 1992). The medium for conveying the experiences of community mental health support workers in this research will be qualitative data collection and analysis. Qualitative research is based on interpretive inquiry whereby the primary research instrument is the researcher. Therefore decisions made throughout the research process are inevitably embedded within the researcher's own assumptions, personal experiences and history. It is therefore essential that the researcher is able to identify and provide details about their culture, gender and any other biographical information that will inherently bias and influence interpretations made during the research process (Barker & Pistrang, 2005; Campbell & Wasco, 2000; Cosgrove & McHugh, 2000; Dahlberg & McCaig, 2010; Marshall & Rossman, 2006).

I am New Zealand European and although I experienced different cultures growing up, I have always predominately perceived the world through a western, Pākehā cultural lens. It was not until I went to university that my ethno-centric worldview was, through academia, really challenged. The ideologies of western culture are so pervasive and taken for granted that it is often not even perceived as a value system by people from the dominant culture. I moved around a lot as an adolescent and travelled around different countries, having lived in three different European cities due to my mother's work opportunities, as well as Australia and New Zealand. Another aspect of my up-bring that I think has significantly influenced my worldview was being raised by a single mother and exposed to strong female role models my whole life.

The motivation for this research project comes from my own experiences working as community mental health support working for a number of years and my concern over the working conditions, people in female dominated professions, are being subjected to. I wanted to identify

whether the negative experiences I faced in this work were more wide spread and I wanted to investigate the sources of these issues and how they could be addressed. While there were many features of community mental health support work that were positive such as the invaluable work experience and skills I gained, the lack of value I felt that was associated with this work was something that really struck me. Some of the ways I feel this low value is manifested, is through the low wages relative to the expectations of the role, no overtime pay, the absence of appropriate supervision and training, the vulnerability of staff and the disregard for support workers and their skills and knowledge despite working on the front line with some of the most chronically mentally ill people in society.

While some may argue that my personal experiences biases the research process, I believe that it is advantageous because it gives me an insiders perspective into a field of work in which minimal research has been conducted (Barker & Pistrang, 2005; Dahlberg & McCaig, 2010). My background may also have helped with developing a rapport and trust with participants. I was able to use my own insights to guide the initial undertaking of the project however it was intended that the participants' responses would eventually guide the conclusions drawn from the findings. I needed to be mindful that my own experiences did not weigh too heavily on the interpretation and conclusions drawn from the data and that I was open to findings that contradict my expectations.

The high proportion of female workers in this occupation combined with the relative lack of value placed on this work was the main impetus behind choosing to examine this issue from a gendered perspective. As I believe the low value attributed to support work is the result of it's association with 'women's work' and thereby structural gender discrimination, a feminist approach for this research was most fitting. Whilst this research is being conducted from the perspective of a Pākehā middle class female, I have a critical perspective. The epistemological assumptions that underlie the critical feminist approach of this research resonate strongly with my own beliefs about the socially constructed, contextualised nature of reality (Campbell & Wasco, 2000; Riger, 1992).

The feminist movement incorporates a system of values and principles that challenges prevailing male dominance in society and argues for equality of men and women in all facets of the social domain (Campbell & Wasco, 2000; Harding, 1987). Psychology itself has also historically and continues to be a male dominated discipline (Cosgrove & McHugh, 2000; Riger, 1992). Until around the 1980's when the feminist movement in psychology started to gain greater impetus, women had been routinely ostracized from psychological research. For example women have been systematically excluded from every aspect of the research process by neglecting the experiences of women in the formulation of research questions and as participants in experiments (Campbell & Wasco, 2000; Harding, 1987). In the field of psychology, the main concern of feminist scholars has been to address the marginalization of women's experience in social science research and the subjugation of women in society (Campbell & Wasco, 2000; Cosgrove & McHugh, 2000).

Aim

The aim of this research is to explore a feminist perspective, which states that care work is devalued by society due to it being similar in nature to the unpaid domestic labour that has traditionally been undertaken by women. More specifically this research aims to explore the extent to which this feminist theory can be applied to community mental health support work in New Zealand and the impact that such an association may have on the value placed on this work.

Research questions

1. In what ways the job tasks involved in community mental health support work are commonly perceived as 'women's work' (i.e. similar to the unpaid domestic labour that has traditionally been undertaken by women?).
2. What are the practical consequences of community mental health support work being perceived as similar to (and therefore associated with) the unpaid domestic labour traditionally undertaken by women, on mental health support workers' working

conditions?

3. What can be done to address any implications of community mental health support work being associated with the unpaid domestic labour traditionally undertaken by women?

Stakeholders

Community mental health support workers – Community mental health support workers are the primary participants and their experiences will be shared in this research. The results of the research could help to illuminate structural gender discrimination that is conveyed through the working conditions of female dominated care occupations such as mental health support work. The results of the research could potentially be used to help address some of the issues facing community mental health and other low waged care workers. In order to protect the identity of support workers, the participants will be entirely anonymous throughout the report.

Mental health service users – Service users are stakeholders in this research as they are the primary recipients of mental health support work care. Service users are also affected by the working context of the staff caring for them. Literature suggests that the working conditions of staff can impact the quality of care provided to service users (Acker, 2012; Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011). Support workers may also refer to service users in the research. Staff may recount positive and negative experiences of working with service users that could impact on stereotypes currently held about mental health service users. However this research does not intend to focus on service users and individual behaviours. All information about service users will remain completely anonymous.

University of Waikato – My ethical conduct throughout the research process is important as my actions will reflect on my affiliation with the University of Waikato.

Mental health services - The results of this research have the potential to reflect positively on mental health organisations, if mental health support

workers provide favourable information about their role and working conditions. However mental health support workers may also give negative accounts of their job and working conditions. Mental health organisations may not be aware of the perceptions staff have about their work. This research aims to gain greater insight into the gendered nature of support work, the structures and systems that underpin this work and the sources of the issues facing mental health organisations and support workers. Therefore this research may help to shed a greater light on issues relevant to community mental health organisations. The specific mental health organisations participants work for will also remain entirely anonymous throughout the research in order to protect both the workers' and the organisations' reputation.

Unions – Unions advocating on behalf of community support workers may utilise the results of the research to support action that could potentially enhance the conditions of community mental health support work.

Justification for current research

It is evident from the review of literature regarding community mental health support work that more research is needed which advances reform of the work related concerns of support workers. Moreover, further research is required which focuses on the insights of care workers themselves (England, 2005; Knijn & Kremer, 1997; Salyers, Rollins, Kelly, Lysaker, & Williams, 2013; Stacey, 2005). This research is warranted, as it may help to build up the limited knowledge base of low waged health service workers in general. Support workers from Non-Government Organisations (NGOs) have been chosen as participants in this research, as NGO support workers appear to experience the lowest pay and working conditions in the mental health workforce.

Chapter Two: Literature review

Introduction

Recent media news items have highlighted serious issues with the care of people with disabilities living in the community in New Zealand. Investigations into a number of residential facilities made headlines after the occurrence of systematic abuse of service users was discovered. For example in one case a service user had been left in a paddock to eat grass and in another, a young woman had been locked in a toilet cubicle as a form of respite for her care workers (Johnstone, 2013). Another case came into the public eye when a worker took her employer to court. She claimed the mental health organisation she worked for had not provided a psychologically or physically safe working environment after she experienced abuse and bullying from co-workers (Cowlshaw, 2013). An historic court case by a female employee was recently won after it was claimed that people working in female dominated professions such as caregiving are discriminated against through low remuneration and substandard working conditions (Moroney, 2013). Furthermore, a poignant media article highlighted that within one year from mid 2012, one hundred and thirty four people receiving mental health services committed suicide in New Zealand. Each of these service users had been visited by a mental health worker within the previous month (Duff, 2013). A National Radio news article in 2011 reported how a man with experience of schizophrenia was found dead in his apartment, in an extremely unhygienic environment, despite being regularly visited by mental health workers (O'Donoghue, 2011). These incidents all indicate problems within the community support care system in New Zealand.

Research regarding care labour is a relatively new area of interest (Caird, 2001; England, 2005). The long-term availability of a robust community care workforce has recently become a topical concern amongst many policy makers, scholars and activists in western countries as the demand for care is expected to expand rapidly over the next few decades (Charlesworth & Marshall, 2011; Engster, 2010; Knijn & Kremer, 1997; Stone, 2000). The growth of the aging and 'baby-boomer' population, increasing geographic separation of family members and career pressures

are all factors underlying an anticipated burgeoning of the care sector (Engster, 2010; Stacey, 2005; Stone, 2000). Women have traditionally provided unpaid care for children, elderly parents or disabled family members. Rising rates of women's employment means that considerably more care is being carried out by paid carers (England, 2005; Engster, 2010; Folbre, 2006). Care workforce shortages are likely to pose a significant problem as the demand for care is escalating at the same time as traditional sources of unpaid care are diminishing (Engster, 2010; Stone, 2000). This means that people who require care may not be able to receive it (Stone, 2000). Stacey (2005) asserts that if the current situation remains unchanged, people entering the care workforce will continue to lack the training, remuneration and adequate support required to effectively carry out their work (Elwér, Aléx, & Hammarström, 2010).

Research indicates that labour undertaken by workers in caring occupations is generally undervalued, unrecognised and unrewarded (Charlesworth & Marshall, 2011; England, 2005; Engster, 2010). Health service literature has validated the stigmatised, and physically and emotionally onerous nature of paid caring roles as well as the low pay associated with this form of labour. Studies have found that heavy workloads, low pay, emotional and physical strain and exploitative work conditions restrict home care workers ability to provide a good service or derive long term satisfaction from their work (Elwér et al., 2010; England & Folbre, 1999; Stacey, 2005). Marginalising work environments and the undervaluing of care work impacts the wellbeing of care workers who are predominately women (Aronson & Neysmith, 1996; Denton, Zeytinoğlu, & Davies, 2002; Elwér et al., 2010; Public Service Association, 2008; Stacey, 2005; Stone, 2000).

A high proportion of both paid and unpaid care is still undertaken by women (England, 2005; Folbre, 2006; Stacey, 2005). The lack of social value and reward attributed to care work is therefore a form of structural gender discrimination (Bourgeault & Khokher, 2006; Elwér et al., 2010; Stone, 2000). The poor wages received by workers in care occupations is the most tangible example of the low esteem with which this work is often afforded (Charlesworth & Marshall, 2011). Low remuneration of care

workers contributes to on-going discrepancies in society such as the gender wage gap (Elwér et al., 2010; Stone, 2000). Gender pay disparities are more of a consequence of people working in female dominated occupations being paid less, rather than from men and women in the same jobs being paid unequally (England, Budig, & Folbre, 2002; Stone, 2000). Prejudice against care workers also pertains to issues of racial discrimination as a large majority of low paid care work is carried out by ethnic minorities (Aronson & Neysmith, 1996; England, 2005; Platform, 2013).

This research will focus specifically on the care work carried out by community mental health support workers from Non Governmental Organisations (NGOs). According to the latest workforce data collected approximately 70% of NGO community mental health workers in New Zealand are women, 22% identify as Maori and have an average age of 45 years (Platform, 2008).

Existing literature indicates workers from NGO mental health organisations may face stigma, demanding labour, unsupportive and unsafe work environments and earn minimal wages from providing direct care to the most chronically mentally ill people in society (Denton et al., 2002; Paris & Hoge, 2010; Spencer & Munch, 2003; Stacey, 2005; Te Pou, 2010). However there remains a large gap in knowledge regarding community mental health support workers, which reflects the invisibility of this workforce. There is scant empirical evidence that focuses specifically on the work conditions and institutional practices mental health support workers from NGOs in New Zealand experience.

Community mental health staff work with the most marginalised individuals in the country and are on the frontline of the mental health and addiction sector (Peters, 2010; Platform, 2013; Public Service Association, 2008). Community services are an intrinsic aspect of the fabric of society (Platform, 2013). The core function of NGO mental health organisations is to support people to live autonomous and worthwhile lives in their communities, which serves the interests of society as a whole (England, 2005; Knijn & Kremer, 1997; Peters, 2010; Public Service Association, 2008). Community services intend to enhance service users' lives from a

holistic perspective, however the effectiveness of service delivery depends on the approach, skill level and capabilities of an organisation and its employees (Peters, 2010; Public Service Association, 2008; Salyers et al., 2013).

The value of investing in mental health on an individual's quality of life and a countries' socioeconomic development, has been identified by policy makers in high-income countries in recent years (Bebbington, 2001; McDaid, Knapp, & Raja, 2008; Peters, 2010; Rössler, 2012). Mental health disorders constitute forty percent of all disabilities and make up 5 of the ten most common causes of disability (Bebbington, 2001; Peters, 2010). The social and economic costs of mental health disorders are vast and therefore investment in mental health should be a significant part of any economic development agenda (McDaid et al., 2008; Peters, 2010). However the link between mental health and economic development is complex and difficult to measure (England, 2005; England & Folbre, 1999; McDaid et al., 2008; Peters, 2010). Whilst worldwide, the need for mental health care is growing, the availability of a mental health workforce is diminishing (Platform, 2013).

Approximately ninety percent of people with mental health and addiction problems receive community services only, with around ten percent of people accessing both community and acute services (Peters, 2010). Seventy percent of funding goes to the DHB provider arm that support people in episodic periods of acute illness. Thirty percent of funding goes to NGOs who support thousands of people on a day-to-day basis to prevent them from needing inpatient or acute services (Peters, 2010; Platform, 2013). Community services offer social support which compliments the services delivered by clinical mental health teams and prevents the use of more expensive and acute services (Platform, 2013). The community is the preferred location for receiving mental health support and the most effective for carrying out health intervention activities at all levels such as health promotion and prevention (Peters, 2010).

Charlesworth and Marshall (2011) maintain that inadequate funding leads to low levels of remuneration relative to job demands and unjust conditions of mental health workers which are a source of burnout and high worker

attrition (Public Service Association, 2008). Burnout and staff retention difficulties present a challenge not only to individual workers and mental health organisations. High rates of staff turnover are believed to have a deleterious impact on service quality and poses a significant problem for the mental health system as a whole (Salyers et al., 2013).

Richmond and Savy (2005) argue that inadequate support for the community mental health care system is the result of a poorly executed deinstitutionalization process (Public Service Association, 2008). This involved the downsizing of psychiatric institutions and a move towards community oriented models of care, including conjoining psychiatric inpatient care to general hospitals (Cowan, 2008). Many NGOs were established during the period that the institutions were closing and predominately focused on supporting service users with finding accommodation rather than on providing therapy (Peters, 2010). NGOs have successfully adapted to the many changes over time regarding mental health service provision, policy, legislation and restructuring (Peters, 2010; Platform, 2013).

Despite the introduction of alternative models of health care delivery and policy in recent decades, research indicates that there is still widespread dissatisfaction with mental health services (Gawith & Abrams, 2006). One of the main incentives for deinstitutionalization was to enhance the quality of care of people with mental illness (Richmond & Savy, 2005). Deinstitutionalization has minimized the long-term hospitalization of psychiatric patients, but for some chronically unwell clients living in the community it has generated the costly re-occurrence of short-term admission into inpatient hospitals also known as 'the revolving door syndrome' (Kring, Johnson, Davison, & Neale, 2010). Inpatient stays are very expensive and comprise approximately 30% of all mental health expenditure (Peters, 2010). Many service users still rely on community support workers and mental health staff as their only form of socialisation (Shepherd & Meehan, 2013).

Social disconnection and isolation are a reality for many people with severe mental illness (Beebe, 2010; Hocking, Phare, & Wilson, 2005). Mental health service users have been described as living in the

community "...like ghosts - they are dying alone" (Coleborne & Mackinnon, 2006, p. 376). People with mental health problems are being displaced into institutions such as prisons which have been described as the "...new asylums" (Coleborne & Mackinnon, 2006, p. 376) and under resourced for the treatment of mental health issues (Coleborne & Mackinnon, 2006).

Historical development of community mental health support work

Notions of community rather than institutionally based mental health care began materialising in the middle to latter part of the 20th century (Caird, 2001). One of the most influential factors in the establishment of community-oriented care and the closing down of psychiatric institutions was the development of pharmaceutical medication (Caird, 2001; Richmond & Savy, 2005). Psychotropic medication is now a central component in the treatment of all service users and of community care (Cowan, 2008; Richmond & Savy, 2005). Cost cutting was also a strong impetus for the deinstitutionalisation process as in-patient services were becoming increasingly expensive to run (Caird, 2001; Durie, 1999). Knowledge regarding psychosocial and rehabilitation support was developing. Moreover, civil rights movements were becoming more prominent. Ideas relating to human rights were particularly pertinent for service users and their families in the face of snowballing concerns over conventional treatment methods for people with mental illness (Cowan, 2008).

Coleborne and Mackinnon (2006) state that the deinstitutionalization process has been mirrored in many of the western nations such as New Zealand, Australia, the United States of America (USA) and the United Kingdom (UK). In each of these countries, governments failed to match their reduced reliance on psychiatric institutions with the appropriate structures and funding to enable effective care of people living in the community with mental illness (Coleborne & Mackinnon, 2006; Durie, 1999). Deinstitutionalization has thereby increased the burden of care for families, who are often at the fore of accessing appropriate care for their family member. The care of people with experience of mental illness has also disproportionately fallen on NGOs and volunteer organisations

without the appropriate support and services available in the community (Durie, 1999; Gawith & Abrams, 2006).

A poorly implemented and underfunded deinstitutionalisation process led to a breakdown and widespread discontent with the mental health system (Durie, 1999). The period following the closure of psychiatric has been labelled the "...era of community neglect" (Cowan, 2008, p. 47), which was reflected by ministerial inquiries into mental health services. In New Zealand this included the Mason report in 1988 and 1995 -1996 (Coleborne & Mackinnon, 2006; Durie, 1999; Gawith & Abrams, 2006). Immediately after the discharge of psychiatric patients from hospitals, a large majority of people were living on the fringes of society without decent housing, social support and care (Cowan, 2008).

Barriers to successful community integration such as societal attitudes, were not addressed by deinstitutionalisation (Durie, 1999). Instead people with mental illness were often living in segregated residences inside the community and frequently experienced as much social marginalisation as when they had been living in institutions (Durie, 1999). More recently mental health campaigns such as the Like Minds Like Mine and the National Depression Initiative have been implemented to help counter discriminatory attitudes towards people with mental illness and educate the public (Peters, 2010). In New Zealand, Maori had the compounded experience of cultural alienation through the continuing effects of colonisation and lack of access to culturally appropriate care (Cowan, 2008; Durie, 1999).

Deinstitutionalisation, particularly the last 25 years, and the era of community neglect however has resulted in a shift towards more progressive ideologies guiding the delivery of mental health services (Caird, 2001; Gawith & Abrams, 2006). For example there has been a greater emphasis on the principles of 'recovery'. Recovery is a term developed by the anti-psychiatry and 'psychiatric survivor' movement, which began around the 1970s (Cowan, 2008). The concept of recovery originated as a response to the hegemonic psychiatric disease-oriented model (Caird, 2001). Many service users, especially people who had psychiatric treatment imposed on them, felt the mental health system

inadvertently caused harm, rather than helped them (Gawith & Abrams, 2006). Ideas of social constructionism were also influential to the anti-psychiatry movement. Social constructionists illuminated the core assumptions of medical practice and psychiatry and argued that these dominant practices were reflective of the patriarchal, capitalist society in which it emerged (Caird, 2001). Some social constructionists contend that psychiatry was created in order to play a major role in social control functions such as the eradication of behaviours that are inconsistent with expected social norms (Warelow & Holmes, 2011). The result is that psychiatry maintains its position as a gatekeeper over what is considered 'normal' behaviour and anyone who falls outside of this, risks incarceration or unwanted treatment (Caird, 2001; Warelow & Holmes, 2011).

Recovery is based on experiences that people have found helpful and is described as having a good level of wellbeing regardless of the presence or absence of mental illness (Jacobson & Curtis, 2000; Mental Health Commission, 1998). Service users are beginning to be recognized as 'partners' in their care and treatment (Mental Health Commission, 1998). New Zealand was the first country to incorporate principles of 'recovery' into the national philosophy underlying policy and the delivery of mental health services (Peters, 2010). Recovery principles have been embraced through a number of recent New Zealand mental health policy initiatives including *Looking Forward 1994*, *Moving Forward 1997*, *Blueprint for Mental Health Services in New Zealand 1998*, *Te Puawaitanga: Maori Mental Health National Strategic Framework 2002*, *Tauawhitia te Wero – Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009*, *Te Kokiri: The Mental Health and Addiction Plan 2006-2015*, *Te Tāhuhu - Improving Mental health 2005 -2015: The Second Mental Health and Addiction Plan* (Ministry of Health; Peters, 2010). Nevertheless, Gawith and Abrams (2006) contend that many issues still need to be overcome before the reality of service user participation and recovery principles are put into everyday practice in New Zealand mental health services (Jacobson & Curtis, 2000).

Inadequate funding of services and investment in the appropriate amount of resources into community mental health was never addressed. Rather,

budget restrictions and funding conflicts with other health care services “...led purchasers and providers...to think very carefully about what skills are needed by community staff and their costs” (Murray, Shepherd, Onyett, & Muijen, 1997, p. 5; Richmond & Savy, 2005). The expansion of the mental health support workforce therefore originated out of the appeal of a less expensive alternative to mental health care within a context of rigid fiscal constraints (Charlesworth & Marshall, 2011). The role of non-governmental organisations expanded as NGOs tendered for the provision of mental health services at a much lower cost than that of mainstream service providers such as district health boards (Shepherd & Meehan, 2013).

Historically, the provision of mental health services has been the domain of professional staff. However there has been a growing number of support workers introduced into mental health care workforce (Murray et al., 1997; Nancarrow, Shuttleworth, Tongue, & Brown, 2005; Pace, 2009b). The support worker role has resulted as an economic solution as well as being part of a response which challenges and reconceptualises dominant forms of mental health care delivery. In this latter sense, community mental health support work has been regarded “...as a pioneering political movement in community mental health promotion” (Caird, 2001, p. 23).

Support work is based on the principles of psychosocial rehabilitation, which has roots on the service user recovery paradigm and psychiatric rehabilitation (Shepherd & Meehan, 2013). Psychosocial rehabilitation is client-oriented and assists service users with all aspects of daily living through a personalised and tailored approach. This includes physical, social, emotional and practical support (Curtis, 1994; Nancarrow et al., 2005; Siskind, Harris, Pirkis, & Whiteford, 2012). Physical support can entail helping clients with their physical health such as monitoring their medication administration (Cowan, 2008). Emotional support concerns working with people’s feelings in a non-judgemental manner (Denton et al., 2002). Social support can assist service users with connecting with their family, friends or engaging in community activities (Cowan, 2008). Practical support could require giving budgeting advice or supporting service users with meal planning (Cowan, 2008). Moreover, psychosocial

rehabilitation can involve helping clients with symptom management, advocacy, vocational skills and challenging stigma (Caird, 2001; Siskind et al., 2012). The aim is to promote recovery by focusing on strengths, empowerment, health, interdependence, goal attainment and community integration (Cowan, 2008; Pace, 2009a; Shepherd & Meehan, 2013; Siskind et al., 2012).

Support work has been described as providing a "...refreshing ordinariness" (Murray et al., 1997, p. 16) to mental health care. An intrinsic aspect of the support worker role is developing a trusting relationship with clients. Because psychosocial rehabilitation is not based on the 'disease' or medical model of care, support workers are expected to treat service users as 'people' rather than as an 'illness' (Caird, 2001; Pace, 2009a; Siskind et al., 2012). The frequency of contact with clients is also a major strength of the position. This means support workers are more inclined to notice any changes in a service user's wellbeing. This provides an opportunity to divert a crisis through early intervention (Cowan, 2008). The support worker is particularly valuable in times of great stress for clients, because support work is flexible and visits can be increased and customised for clients as required (Curtis, 1994; McCrae, Banerjee, Murray, Prior, & Silverman, 2008; Shepherd & Meehan, 2013).

The recovery model, which guides the implementation of community support work, is believed to be more commensurate with indigenous and Maori models of health as both paradigms emphasise a holistic, strengths and wellness based approach. Moreover, there is a greater acknowledgement of power dynamics and an incorporation of the social context of health (Caird, 2001; Johnson, Hodgetts, & Nikora, 2013). This makes the community support work model more amenable towards the principles of participation, partnership, protection and self determination which are upheld by the Treaty of Waitangi (Caird, 2001).

Community support work is still a fledgling role having only been in existence in New Zealand since the 1990s. Despite the growing presence of support workers in mental health service provision, there remains a large gap in knowledge regarding the function and efficacy of their role (McCrae et al., 2008; Murray et al., 1997; Nancarrow et al., 2005; Pace,

2009b; Siskind et al., 2012). Although mental health support workers are often the most 'inexperienced' staff members, they are frequently designated a high ratio of the most severely ill clients within a mental health team (Meek, 1998; Pace, 2009a; Shepherd & Meehan, 2013; Stanners, Barton, Shakib, & Winefield, 2014). The dearth of research in the area of mental health support work is a common theme emerging from the literature. There is limited research that offers an insight of the role from support workers.

A literature review of community support work commissioned by the Ministry of Health concluded that "...whilst New Zealand has been 'doing' community support we have not been recording our outcomes" (Caird, 2001, p. iii). Caird (2001) suggests service providers have been preoccupied with expanding service delivery rather than research. Caird (2001) also states that there is no available literature on Maori and Pacific providers. The mental health support worker research that has been conducted generally has a human resource focus, with an emphasis on training needs and workforce development. The working conditions experienced by mental health support workers have been a neglected area of research.

The relationship between inadequate funding and poor working conditions of staff in the NGO social services sector is apparent in much research related to issues with the recruitment and retention of staff. Yet in spite of this, action to improve wages and conditions is seldom part of any broad policy agenda and high turnover rates of staff continue to be a major issue facing the mental health community care sector (Charlesworth & Marshall, 2011; Public Service Association, 2008). Therefore it is important that more research is conducted which highlights the type of work conditions being experienced by care workers and the need for this to be addressed (Aronson & Neysmith, 1996; Elwér et al., 2010; England et al., 2002; Stone, 2000; Tronto, 2010).

Care work theories

A number of comprehensive theories have begun emerging in the literature, which suggest the underlying causes of the low wages and

marginalising work conditions associated with care work (England, 2005; Engster, 2010; Folbre, 2006). Theories regarding the working conditions of labour that has highly personal and emotional aspects will be described in this next section. As there are limited theories that specifically relate to mental health support work, mental health support work will be positioned within the broader context of care theories generally. These theories will be discussed in more detail against the results of the research in the findings section of this report.

The devaluation of women theory

The devaluation of women theory proposes that the cultural subjugation of women in society generates cognitive errors and widely accepted hegemonic masculinity ideologies which devalue women (Charlesworth & Marshall, 2011; England, 2005). Gendered assumptions are institutionalised and particularly evident in occupational domains that are associated with quintessential female roles and functions such as 'mothering' and caring for others (Bourgeault & Khokher, 2006). This means that jobs which are predominantly carried out by women, often women of colour, and are associated with the stereotypical female roles of 'mothering' and domestic labour are undervalued and go unrecognised (England et al., 2002; Knijn & Kremer, 1997; Stone, 2000).

There is no direct scientific evidence which confirms the distinct causal mechanisms of the cultural devaluation of women that leads to the perception of care work as being unworthy of material or social recognition (England, 2005). Nevertheless, the devaluation perspective may help to elucidate the underlying reasons why it is difficult to get support for improved recognition of formal and informal care labour (England, 2005; England & Folbre, 1999).

Ideal and non-ideal workers

Despite years of equal opportunity policy, men continue to be perceived as predominately breadwinners or 'ideal' workers and women as homemakers and 'non-ideal' workers (Charlesworth & Marshall, 2011; Knijn & Kremer, 1997). Ideas regarding men and women's essential nature underpin such debates. Women are conventionally depicted as

non-ideal workers with innate skills based primarily in homemaking and domestic tasks, therefore paid domestic care jobs are also bestowed with connotations of non-work. Moreover, as women are not considered primary breadwinners they are not deemed to be in need of being paid as such (Charlesworth & Marshall, 2011; Stacey, 2005). Paid caring work has wage disadvantages akin to unpaid care work (England & Folbre, 1999; Stone, 2000). Unpaid caring roles in society incur large pecuniary penalties. This is because the primary carer often needs to give up their employment and accumulation of work experience that leads to higher pay over time (Bourgeault & Khokher, 2006; England & Folbre, 1999; Knijn & Kremer, 1997; Stacey, 2005).

Stigmatisation of care givers and receivers

Tronto (2010) proposes that the secondary status of care workers may derive from the fact that care work is often undertaken by stigmatised groups in society that face discrimination. People who are marginalised and unable to find work elsewhere in the workforce may often end up taking up care positions, as it is a socially unappealing work with high workforce shortages and thereby easy job access (Tronto, 2010). Moreover, Caird (2001) contends that the low status of community mental health support work mirrors not only the low worth historically given to workers in the caring and human services, but also the social stigma placed on people with experience of chronic mental illness. People who require care from social organisations are often economically and socially marginalised. This includes people who are ill, disabled, poor, young and elderly (Bourgeault & Khokher, 2006; Tronto, 2010).

Cultural misconceptions

People tend to need care from social services the most when they are not in position to be able to work to pay for it (England et al., 2002; England & Folbre, 1999). Paid care for people with limited resources is therefore frequently provided by a third party such as families or through the state (Denton et al., 2002; Folbre, 2006). When the government is financing care services, the availability of funding depends upon political forces. The amount of money allocated to health and social services is contingent on

and reflective of the extent voters and people in positions of power are concerned about people who require care services (Bourgeault & Khokher, 2006; Knijn & Kremer, 1997; Tronto, 2010). Citizens are influential in the availability of resources because societies determine how much tax individuals are willing to pay. Government and social policies regarding public spending in turn determine the proportion of tax money that is then distributed to care services (Engster, 2010).

Structural gender discrimination perpetuates wage penalties for care work and restricts public support for higher wages and better work conditions (Engster, 2010). Gender based cultural bias guide social decision making processes which fail to recognise the importance and significant contribution of female dominated occupations on individual, organisational, societal and economic outcomes (Bourgeault & Khokher, 2006). The emphasis on the domestic or home based aspects of care work conceals the relationship of care work to paid labour (Stacey, 2005). This in turn attaches a low value to care work relative to other jobs, which becomes fixed over time (Charlesworth & Marshall, 2011; England, 2005).

Economic policies

'Compensating differentials' theory

Neoclassical economic theories have traditionally been used to justify the wage penalty imposed on people working in the care industry. For example the key feature of the 'compensating differentials' economic theory is that care work is paid lower because of the psychological pleasure women derive from caring for others (England & Folbre, 1999). If workers gain psychic gratification from their labour, lower wages are warranted. On the other hand, work which is deemed onerous and unsatisfying will need to be compensated with higher wages in order to attract workers (Folbre, 2006). Accordingly, the intrinsically rewarding aspects of care work counterbalance low wages. If workers feel that the non-pecuniary amenities of the work do not compensate for the low pay, they will simply find another job (England, 2005).

Supply and demand theory

According to 'supply and demand' theory, if low wages lead to an undersupply of services, the demand for services will rise which will lead to increased prices for services and higher wages for workers. More attractive wages will in turn entice greater numbers of workers to the care sector. Increased prices will force consumers to make more efficient use of services and demand will thereby be lowered (England et al., 2002; Folbre, 2006).

Care as a public good theory

'Care as a public good production' theory highlights that formal and informal care work provides indirect benefits of human and social capital that are dispersed throughout society and reach far beyond the individual recipients of care (Engster, 2010; Knijn & Kremer, 1997). For example if a mental health service user learns to live independently in the community, they will not only benefit. It could enhance their relations with friends and family through their improved mental, emotional and physical capabilities. Their ability to make a living may be improved, costs to the mental health system or other social services will be reduced, which in turn releases funds to spent in other areas of public interests (Engster, 2010; Folbre, 2001). No research strategy currently exists to support the argument that care work provides public benefits and increases social capital, therefore this theory has limited empirical support (England, 2005).

Measuring care quality is also problematic because the benefits of good care are not always straightforward, tangible or able to be transformed into monetary value (Engster, 2010). Monitoring care quality is difficult as standardised outcome measures such as 'length of patient stay' do not always provide an accurate reflection of client satisfaction (Folbre, 2006; Tronto, 2010). As clients often do not directly pay for care, they have to accept the care they are given, regardless of the quality (England & Folbre, 1999; Tronto, 2010).

Technology advancement

Another explanation for low wages of care workers is that human services are unable to be substituted by productivity enhancing technological capital, unlike the manufacturing sector (England et al., 2002). The human service sector requires face-to-face, empathetic and supervised personal interaction (Folbre, 2006). In order to provide equivalent pay for care and manufacturing workers for example, as wages in the manufacturing industry increase due to productivity growth, the cost of services to care recipients has to rise. As formal care is frequently provided by a third party such as the government or required by members of society who are socially and financially marginalised, a high level of funding for care is often not accessible (England et al., 2002; Folbre, 2006).

'Love' and 'money' theory

Much of our thinking in Western societies is arranged into gendered dichotomies that lead us to make generalisation between the realms of love, selflessness, family, and femininity on the one hand, and men, rationality, greed, competitiveness and the economic labour market (Engster, 2010; Folbre, 2001, 2006). The collocation of the values underlying 'love' and values of market capitalism provide the foundation of widely accepted assumptions that truly caring motivations are antithetical to money and thereby greater extrinsic rewards of care work will diminish the capacity of care workers to remain genuine and empathetic. Moreover, it is believed that profits and decent wages corrupt true compassion and altruism (England, 2005; Engster, 2010; Folbre, 2001). Paradoxically, this sacrosanct understanding of care can be the basis of rigid dogma that perpetuates wage penalties and substandard work contexts experienced by care workers (Charlesworth & Marshall, 2011; England et al., 2002; England & Folbre, 1999; Engster, 2010).

A pervasive social concern that genuine caring motives should not be thought about in terms of exchange value is an ideological contributor of the poor wages associated with care work. The commodification of certain aspects of society is considered taboo such as prostitution or human slavery (Hochschild, 2012). England (2005) argues that viewing care as a

commodity is also socially offensive and is believed to degrade genuinely caring motivations that are expected to underlie care based activities.

The 'prisoner of love' theory

The 'prisoner of love' theory emphasises how intrinsically satisfying care work can be to the point where workers will continue to care for clients at the expense of decent wages and conditions (Denton et al., 2002; England & Folbre, 1999; Folbre, 2001). The caring bonds that develop between staff and clients can be extremely powerful (Denton et al., 2002; England & Folbre, 1999; Engster, 2010). In some cases these bonds can turn workers into 'prisoners of love' whereby workers are dissuaded from withdrawing their services in order to improve wages and working conditions. This is because carers are aware that such actions will affect clients the most (England & Folbre, 1999). Thereby the intrinsic satisfaction carers derive from their work allows organisations to take advantage of workers (England, 2005; Folbre, 2006). Moreover, in some cases carers will be prepared to make personal sacrifices in the face of budget cuts in order to sustain a high level of care for their clients, such as working longer unpaid hours (Charlesworth & Marshall, 2011; Denton et al., 2002; Engster, 2010). The non-material rewards and the dignity workers derive from care work can conceal the discrimination and structural inequality care workers are exposed to (Charlesworth & Marshall, 2011; Denton et al., 2002; Elwér et al., 2010; Stacey, 2005).

Working conditions of community mental health support work

The next section of this review will concentrate on international and New Zealand literature relating to the working conditions of support workers who provide mental health care in clients' homes. The scope of community mental health support work is wide-ranging and varied (Meek, 1998; Nancarrow et al., 2005; Siskind et al., 2012). There are numerous terms used to refer to community mental health support workers in the literature including paraprofessionals, home care or mental health nurse aids and personalised support workers (Meek, 1998; Siskind et al., 2012).

Care workers as 'unskilled'

Emotional and relational based work involving domestic labour, such as that undertaken by community care workers, has conventionally been viewed as 'unskilled' (Stone, 2000; Tronto, 2010). The Public Service Association (2008) assert that in New Zealand, community disability support work is currently funded and remunerated on the basis of it being 'unskilled' which reflects a limited acknowledgment of the expertise required to carry out this work. It is very difficult to assess the worth of skills required for mental health support work, as many of the emotional and relational skills required are not palpable (Platform, 2013).

Community mental health support workers who participated in interviews and focus groups from a large number of mental health providers across the Christchurch region, criticized the assumption that support work is 'unskilled' and insisted that their job definitely requires specific abilities and expertise (Roen, 1999). Support workers felt mental health providers often depend on support workers having a high level of competence accrued through previous life and work experience. For example support work necessitates capabilities in a multitude of areas including community development, resource acquisition, relationship building, informal counselling skills, crisis intervention, rehabilitation and mediation skills. Yet the role continues to be advertised and remunerated as though it is for an 'unskilled' worker (Caird, 2001; Roen, 1999).

This research by Roen (1999) is one of few New Zealand-based studies that reference the working conditions experienced by community mental health support workers from NGOs. The research was commissioned by the Christchurch Health funding authority and the results of the study were compiled in a report to appraise the introduction of this new workforce. The results were not published as a scientific journal article and details about the study such as sample size are unavailable. The study was not intended to provide a formal evaluation of services (Caird, 2001).

A study conducted by Murray et al. (1997) demonstrates that the perception of support work as unskilled is also upheld by professionals working within the mental health field. Interviews with mental health

support workers in the UK revealed that support workers feel professional staff disregard their skills and abilities for example their potential to utilise newly acquired information. This is despite evidence showing many support workers have strong educational backgrounds such as a range of non-mental health qualifications and degrees, and diverse skills developed through work history and hobbies (McCrae et al., 2008; Murray et al., 1997; Nancarrow et al., 2005; Shepherd & Meehan, 2013). Murray et al. (1997) found that support workers felt disparaged by the lack of recognition from professionals regarding how much time and energy went into their work with clients to achieve what may appear as small changes.

Poor remuneration and lack of training required to enter mental health community support work potentially reflects the belief that support work requires a much lower level of skills than work undertaken by professionals (Shepherd & Meehan, 2013; Tronto, 2010). However a lot of the tasks performed by support workers are synonymous with work that has typically been carried by mental health nurses and social workers in the past (Cowan, 2008; McCrae et al., 2008; Murray et al., 1997).

This role overlap with many features of professional mental health work has sparked some controversy and is believed to lead to interdisciplinary defensiveness (McCrae et al., 2008; Meek, 1998). For example professional staff have expressed concerns that mental health support workers are being used as a cheap labour substitute which puts vulnerable populations, who are recipients of the services, at risk (Meek, 1998; Murray et al., 1997). It is argued that the provision of services by less qualified, low cost workers challenges the skill level and expertise of professionals and thereby robs service users of high quality care (McCrae et al., 2008; Murray et al., 1997). Despite these concerns, international research shows that overall most staff welcomes the establishment of the support worker role (Caird, 2001; McCrae et al., 2008; Meek, 1998; Murray et al., 1997; Shepherd & Meehan, 2013).

Although support work is perceived by some as 'unskilled' research suggests that support workers deliver the forms of care which service users perceive as the most useful including emotional and day-to-day support (McCrae et al., 2008; Meek, 1998). Siskind et al. (2012) undertook

a systematic review of studies relating to the efficacy of personalised support provided by community mental health support workers. The available literature was found to be of such low quality that the researchers were unable to make any definitive judgements from the results of their analysis. Nevertheless, Siskind et al. (2012) concluded that mental health support work may have a positive impact on service users and provide a unique service compared to that offered by professionals (McCrae et al., 2008; Meek, 1998; Shepherd & Meehan, 2013; Siskind et al., 2012).

Many of the clients mental health support workers work with have experienced various forms of violence including sexual, emotional and physical abuse (Caird, 2001; Pace, 2009a; Reid, van Os, Morrison, & Ross, 2005). There is a strong correlation between child trauma and later mental health problems with a dose effect. This relationship exists even though there is evidence of significant underreporting of abuse by mental health patients (Reid et al., 2005). Support workers are therefore working with a very complex, challenging and vulnerable client base. This has led some researchers to describe the absence of mandatory entry requirements for mental health support work as disconcerting (Pace, 2009b). Denton et al. (2002) argue that the typical care industry practice of hiring a large number of staff with limited qualifications, competencies or background in care work, undermines the abilities of other non-professional care staff who do possess high levels of skill and expertise in their field of work.

The subordinate status of support workers

Literature regarding caring and domestic based labour indicates the presence of stigma that accompanies this work (Aronson & Neysmith, 1996; Caird, 2001; Charlesworth & Marshall, 2011; England et al., 2002; Stacey, 2005; Stone, 2000; Tronto, 2010).

Qualitative studies involving focus groups and interviews with home care workers in the USA have illustrated that some carers gain a great sense of honour and fulfilment out of their ability to carry out work that is socially unappealing, yet makes a positive impact on the lives of others (Aronson

& Neysmith, 1996; Denton et al., 2002; Elwér et al., 2010; Stacey, 2005). Whilst care workers have an awareness of care work being perceived as 'dirty', in the sense that it involves taking care of others' personal hygiene and domestic tasks, the stigma attached to caring labour is often not internalised and instead is transformed into pride (Aronson & Neysmith, 1996; Elwér et al., 2010; Stacey, 2005). This work pride is also upheld by distinguishing their care service from that provided by other health professionals. Community home care is perceived by care workers as more in touch with the day-to-day needs of clients (Elwér et al., 2010). Stacey (2005) therefore contends that one of main job incentives of home care workers is "...finding dignity in dirty work" (Stacey, 2005, p. 845). However, although the low status of care work may not be internalised, home care workers claim that stigma is a daily chronic stressor that impacts on their job satisfaction and interactions with other staff (Elwér et al., 2010).

The social stigma attached to care work also reveals itself within the relationships between workers from different mental health specialities. Research has highlighted that many community mental health support workers feel health professionals and their employers do not hold them in high regard (Caird, 2001; Elwér et al., 2010; McCrae et al., 2008; Murray et al., 1997; Te Pou, 2010). Support workers are often disregarded or ignored by other health professionals due to their low status in the health care system (Hare & Pratt, 1988; Murray et al., 1997). The presence of stigma towards support work within the mental health profession is not an unfounded observation. The introduction of non-professionals working in mental health was carried out in an atmosphere of caution from senior staff about the limitations of this new workforce (Murray et al., 1997). Moreover, research shows that many staff in senior positions do convey concerns about the competence and liability of support workers in key areas (Meek, 1998). McCrae et al. (2008) found that there is a strong proclivity amongst nursing staff to work from a medico-hierarchical perspective and thereby to treat support workers as subordinate.

A UK based report compiled by Murray et al. (1997) provides the most exhaustive and in-depth representation of community mental health

support work available. This study incorporated the views of both professional mental health staff and community mental health support workers from the same teams about the introduction of this new role. A large sample of 152 senior staff and 62 support workers were consulted in the research. Murray et al. (1997) believe the sample was broadly representative of the views of staff involved in the provision of community mental health services in the UK.

The majority of professional and senior mental health staff interviewed by Murray et al. (1997) thought that support workers may not be able to maintain appropriate boundaries, would get too emotionally involved with clients or would not have the competence to deal with staff from other social service agencies. There were many aspects of mental health work that were considered professional territory and there was a fear support workers would try and take on tasks above their capacity. When support workers from the same teams were interviewed it was found that professional staff significantly underestimated the breadth of duties being performed by support workers in reality. Alongside practical support, such as helping service users find accommodation, emotional, physical and networking support are often provided, as well as helping service users connect with their families (Cowan, 2008; Meek, 1998; Murray et al., 1997; Siskind et al., 2012). Furthermore, some senior staff interviewed by Murray et al. (1997) commented that encouraging and assisting mental health support workers could be laborious at times, implying that support workers have difficulty performing job tasks independently. It was strongly endorsed by health professionals that support workers should be working under strict clinical supervision (Murray et al., 1997). Analysis of social service workforce data in the UK by Nancarrow et al. (2005) indicates however, that most support workers function in isolation with limited guidance from professional staff due to a shortage of available health professionals.

The findings from international literature regarding the subordinate status of community care work is consistent with feedback from workshops with New Zealand based mental health support workers, suggesting that stigma may also be a significant issue here. A large sample of two

hundred and thirty six support workers from one hundred and thirty one mental health NGOs across New Zealand participated in workshops which intended to identify themes regarding the most pertinent workforce development needs facing mental health and addiction community workers (Te Pou, 2010). Addressing hierarchy between the different mental health occupations and a need to value all of the different specialities within mental health equally, were issues raised by support workers across New Zealand (Te Pou, 2010).

The feedback from these workshops provides the most recent evidence about New Zealand NGO mental health support workers' perception of their work and involved a large number of workers from diverse locations. The information was compiled into a report without any scientific or in-depth examination of support workers experiences. Nevertheless the findings from these workshops and international literature do provide a good rationale for further exploring the discrimination community mental health support workers' experience in their work.

Low wages

Support workers from NGOs around New Zealand have identified low pay as a major issue facing the community mental health workforce (Te Pou, 2010). Overall a common theme to arise in workshops with support workers across New Zealand was that more funding and better wages are required in mental health in order to value the workforce. Moreover, it was proposed that pay scales should reflect the increasing complexity of the support worker role. Incentives built into funding contracts to retain experienced and qualified staff are also needed (Te Pou, 2010).

Available evidence offers empirical support for the premise that care work is not rewarded comparative to its job characteristics and demands and is thereby undervalued in society (Bourgeault & Khokher, 2006; Elwér et al., 2010; Knijn & Kremer, 1997). England et al. (2002) formally investigated the relative pay of care labour. Care work was defined in general terms in their study as providing a face-to-face service that enhances the competencies of the care recipient. A quantitative statistical analysis was applied to within subjects, longitudinal data. England et al. (2002) found

that people working in care industries are paid less than what would be expected of the skill level requirements and job demands. This research also demonstrated that when people enter a care profession they experience a drop in wages and an increase when they move into non-care fields of work (England et al., 2002).

Some limitations of this research are that it was based on a young sample, with all participants being under 30 years of age. This means that the full extent of the pay penalty accompanying care work may not have been illustrated by the research. Nevertheless, the researchers claim that a young sample was most likely to lead to an underestimation rather than over estimation of the care penalty (England et al., 2002). This study also included American participants, job and pay structure data, so the findings may not be entirely applicable to a New Zealand context. However the findings by England et al. (2002) are consistent with other job analysis research which has validated gender based pay discrepancies (Bourgeault & Khokher, 2006). After controlling for variables such as skill demand, education, entry level requirements and sex composition, evidence suggests that jobs with high proportions of female workers pay significantly lower than commensurate work occupied by primarily male workers (Bourgeault & Khokher, 2006; England, 2005).

A job evaluation exercise commissioned by the Public Service Association (2008) also highlights comparable gender discrimination evident in the New Zealand community disability workforce. Remuneration levels of community disability support workers were compared to those of prison guards in a New Zealand-based job evaluation exercise (Public Service Association, 2008). Prison officer work was chosen because the jobs were formally evaluated as possessing similar levels of expertise, entry-level requirements and on-going training opportunities. The gender makeup of the job occupancies were almost exactly opposite, with men comprising 77% of the prison officer workforce and women 76% of the disability community support workforce (Public Service Association, 2008). Prison officers were analysed as having a 51% higher starting rate pay (\$27,518 is the annual starting salary for community support workers compared to \$41,615 for corrections officers). Moreover there is a 52% pay disparity between

community support workers and prison officers top pay rates (Public Service Association, 2008). The disadvantages experienced by workers affects both men and women working in female dominated occupations (Folbre, 2006). However, as women represent the majority of the workers in these jobs, the wage penalties help to sustain the gender pay gap (Aronson & Neysmith, 1996; Elwér et al., 2010; England et al., 2002; Stacey, 2005).

Frequency and flexibility of client contact is believed to be a significant advantage and key aspect of the support worker role (Caird, 2001; Murray et al., 1997). If support workers were to receive improved pay it is questionable whether this valuable and unique service would still be affordable through funding. Furthermore, as a result of the introduction of the support worker role, it appears that Kaupapa Māori and Pacific services and staff numbers have expanded (Caird, 2001). Kaupapa Māori NGO services have a broad and inclusive approach to wellbeing and aim to improve the health of service users and their families as a whole, by strengthening service users resilience and sense of whanaungatanga or connectedness (Platform, 2013). It could be argued that the growth of Kaupapa Māori and Pacific services would not have been possible without a reduction in staff costs, which have resulted from the development of the community mental health support worker role.

Funding systems

NGOs must tender for contracts to provide community services (Cowan, 2008; Kearns & Joseph, 2000). Competition defines the tendering process, which means that there is an overarching emphasis on the efficient and economic management of fiscal and human resources. This leads to a focus on short-term cost effectiveness at the expense of consideration about the quality of care and the wellbeing of staff and clients (Acker, 2012; Charlesworth & Marshall, 2011; Tronto, 2010). Furthermore the essentially competitive nature of funding arrangements constricts the ability of care organisations to offer viable staff wages, which reinforces the low worth associated with caring labour (Charlesworth & Marshall, 2011).

Support workers from NGOs around New Zealand identified funding issues as a major barrier for mental health support work development (Te Pou, 2010). New Zealand based support workers stated that services are underfunded and increasingly unable to meet the large demands placed on community care organisations. Moreover, the unique needs of services and the costs and time involved to support clients are not taken into consideration (Te Pou, 2010).

A report undertaken by Platform (2009) provides an in-depth depiction of the current contracting environment that New Zealand mental health NGOs operate in. Platform Trust is an organisation that enhances the national networking of community mental health and addiction organisations and drives change within the sector. Platform Trust advocates for the interests of its members, advises on policy and provides information and evaluation of the Non-Government sector from a community perspective (Platform, 2013). Platform (2009) argue that a large proportion of resources are being diverted away from the frontline into a contracting system that has been described as cumbersome, rigid, and inefficient (Peters, 2010; Platform, 2009).

The majority of NGOs are funded through government contracts. Purchasing of contracts is predominately delegated to twenty one DHBs across the country and occurs through the DHB provider arm (Peters, 2010). Platform (2009) found that NGOs are extremely dissatisfied with the present contracting context and contracting relationship between NGOs and DHBs (Peters, 2010; Platform, 2009). A disconcerting lack of transparency characterises much of the current tendering processes. For example in most regions there is no longer a distinction between the purchaser and provider arm with DHB clinical staff and managers having a significant influence on the planning and funding contracting process of mental health services (Peters, 2010; Platform, 2009). In numerous instances DHBs are not handing over Government price adjustment increases to NGOs which means NGOs are having to operate without the appropriate funding that accommodates for increasing service delivery costs (Platform, 2009, 2015). DHBs also do not fund NGOs equally, which means NGOs struggle to compete with DHBs for example to attract the

same calibre of staff (Platform, 2009). It has been reported that there are wide discrepancies in contract price and pay rates for support workers as there is no benchmarking pricing system which ensures equitable wages for support workers nationally (Platform, 2009, 2015).

NGOs have had to survive in an environment that offers no certainty of contract renewal, a lack of price adjustments that mirror increasing service costs and unequal funding practises that disadvantage NGOs (Platform, 2009, 2015). Moreover, NGOs tendering for new contracts are subjected to immense costs. Long delays are often experienced in the contracting process, which occur alongside inappropriate and obscure documentation and reporting procedures (Peters, 2010; Platform, 2009).

The funding and planning manager role is critical to the contracting process but the hiring of planning managers who do not possess experience and knowledge of the mental health sector and high levels of staff turnover within this role has also contributed to issues with contracting environment which negatively impact NGOs (Peters, 2010; Platform, 2009). More mutually respectful relationships and a better insight into what the social and health sectors are able to offer the mental health sector are needed between funding planning managers and NGOs (Platform, 2009).

Staff in the NGO sector believe that the current contracting environment suppresses growth, ingenuity and development in the mental health and addiction sector (Platform, 2009, 2015). Platform Trust have recently spearheaded a campaign which has a website called Fairfunding.org.nz. The aim of the campaign is to address the inequality of funding between DHBs and NGOs and other issues identified with the contracting system (Platform, 2015). An alternative 'high trust' contracting model has been espoused by community organisations (Platform, 2009). The high trust model would focus on service collaboration, providers determining the results they are aiming to achieve, flexibility, streamlined contracting procedures, less reporting and advanced payment for services (Platform, 2009)

Caird (2001) asserts that the current funding system establishes the framework for a mental health system that is not client-centred. Enhancing the lives of people with mental illness is not central to the contracting process (Platform, 2008). Rather, service users and their carers are expected to fit into the system and navigate their way around the complex web of services. Many mental health service users with multiple needs are unable to access the treatment they require because of rigid funding access criteria (Cowan, 2008; Kearns & Joseph, 2000).

The competitive funding environment also creates a sense of rivalry instead of collaboration between social service organisations (Charlesworth & Marshall, 2011; Cowan, 2008; Kearns & Joseph, 2000). There is a widespread perception amongst New Zealand based NGO support workers that mental health services are suffering from fragmentation and limited coordination (Caird, 2001; Te Pou, 2010). Support workers have suggested that genuine collaboration between clinical staff and the NGO sector is necessary, in order to reduce barriers for effective health care delivery (Te Pou, 2010). Caird (2001) also contends that a greater interagency, community-wide response is required to facilitate community support outcomes. The lack of coordination between services makes support workers job more difficult, as there is very little pooling of resources and therefore less for support workers to access and utilise. Addressing service fracture and the lack of communication between services would help reduce duplication of effort, costs and would support smaller mental health agencies (Te Pou, 2010).

Another root cause of service fragmentation is the tension amongst service providers about the correct philosophy that should underlie effective mental health treatment. Research has found that differences in core values and rigid stances between social and health institutions are a major barrier for the collaboration of services (Johnson et al., 2013; Mitchell, 2009). Social and community services function from a holistic and strengths paradigm, whereas health institutions are based on the bio-medical model, which has traditionally been the dominant paradigm for mental health care (Cowan, 2008; Jacobson & Curtis, 2000; Mitchell, 2009). The medical model focuses on treating the illness as a separate

entity to the person and has a deficit focus, the antithesis of the social model. Furthermore, the medical model emphasises risk reduction, which is believed to alleviate societal concerns about the unpredictable nature of mental illness (Cowan, 2008; Johnson et al., 2013).

Since the inception of the community mental health support workforce in the mid 1990s, NGO social services struggled to be recognised by conventional professional mental health providers. Despite having distinct philosophical approaches to service delivery, NGOs have attempted to maintain efficacious relationships with mainstream organisations (Caird, 2001). Peters (2010) states that community organisations have forged some solid partnerships with other care providers, government, voluntary and private sector organisations. These collaborations have led to more efficient and effective service planning and delivery, communication across agencies and input by NGOs into policy development and administration (Peters, 2010). However tension still exists between service providers due to a lack of shared vision and values (McCrae et al., 2008; Mitchell, 2009).

Role ambiguity

Research indicates that there is widespread confusion surrounding the exact nature of support work, which arises from the debate about whether community support work falls under the category of 'health' or 'social' care. This has meant that mental health support work has been delivered by a range of different organisations, which has contributed to a lack of clarity about the scope and expectations of the support worker role (McCrae et al., 2008; Murray et al., 1997; Nancarrow et al., 2005; Pace, 2009b).

A lack of clarity around job role can lead to workers feeling frustrated, stifled and dissatisfied (McCrae et al., 2008). This can contribute to problems retaining staff, with their role being perceived as dead end and as a stepping-stone to more enticing careers (Paris & Hoge, 2010). Job ambiguity can also produce role conflict amongst non-professional and professional staff (McCrae et al., 2008; Meek, 1998).

In research with support workers who had recently been introduced to a community mental health team supporting older adults, role ambiguity was

a common theme to emerge (McCrae et al., 2008). Support workers expressed frustration about the apparent absence of knowledge amongst professional staff around the scope and function of support work. Despite working in a multidisciplinary team, support workers felt their role was dominated by a medical hierarchical approach, whereby they were delegated work by nurses, who were in turn led by psychiatrists. In contrast, it was believed by support workers that their work should have more of a psychosocial approach, in line with the work assigned to them by other allied health professionals (McCrae et al., 2008). In workshops with New Zealand based support workers, a need for an increased understanding of their role and expectations for all workers was also conveyed. Support workers also called for clearer guidelines about clinical versus non-clinical definitions of mental health work (Te Pou, 2010).

Murray et al. (1997) asked professional staff and senior managers about their interpretations of the support worker job description. There was an overall agreement that support workers had an important role to play in the practical day-to-day support of clients. Although opinions differed as to what daily work actually entailed, with some envisaging a restricted function, while others believed the support worker role was more elaborate and that there is potential for their work to overlap with that of professionals (Murray et al., 1997).

There has been a strong commitment in New Zealand towards achieving a consistent national standard of training to serve as foundation for support work practice (Caird, 2001; Cowan, 2008). In 1988 the National Certificate in Mental Health Support work became the core requirement qualification for support staff working in the mental health field. The National Diploma in Mental Health support work was also later created but there has been very little uptake of this qualification (Platform, 2013). A high degree of role clarity within the working context is important so that support work does not simply become moulded and subjugated by other professional staff approaches (McCrae et al., 2008).

Much of the support work service delivery takes place with clients in the community, with a strong service user focused ethos. This can put staff in a precarious position, not knowing what activities they can and can't

engage in with clients (Curtis, 1994). There are no clear guidelines for support workers, regarding the extent and limits of their relationships with service users, because of the individualised and flexible nature of this role (Cowan, 2008; Curtis, 1994). This makes ethical and boundary decision-making even more ambiguous. Curtis (1994) states that the negotiation of professional distance on a daily basis is an intrinsic aspect of the support worker role.

Research has found that putting the principles of recovery into practice is not always an easy or straightforward task for mental health support workers (Shepherd & Meehan, 2013). Caird (2001) claims that de-institutionalisation policy has been written without a firm understanding of how many of the key concepts can be put into action. Therefore health strategy needs to be firmly grounded in reality and written with the active participation of all stakeholders in order for best practice community support to be implemented. Otherwise there is a strong likelihood that the values of community support work will be promulgated, without any true realisation of that vision. For example it has been noted that many organisations use recovery discourse, yet have made a limited attempt towards changing power dynamics and aligning their services towards a service user-oriented approach (Caird, 2001; Jacobson & Curtis, 2000).

In workshops with NGO support workers in New Zealand, there was a desire for more effective feedback from leaders and more supportive management. There was a strong recognition of the importance of access to appropriate supervision, such as the incorporation of staff's cultural values (Te Pou, 2010). In interviews with support workers in the UK, Murray et al. (1997) found general staff satisfaction with the frequency and content of the supervision they were receiving, which occurred almost daily. Nonetheless, support workers stated that they needed further training and more feedback about their individual performance, as they often had minimal guidance with this. In contrast, an Australian sample of NGO community support worker managers claimed that they were not able to provide an appropriate amount of supervision to staff, as funding allocations did not allow for this (Shepherd & Meehan, 2013).

Sufficient orientation, training and support structures are deemed vital in terms of protecting client and staff safety (Curtis, 1994; Denton et al., 2002). Nevertheless, organisations may be reluctant to provide staff with appropriate and robust training as 'up-skilling' could augment remuneration expectations (Shepherd & Meehan, 2013).

Unsafe work environments

New Zealand and international based literature demonstrates that workplace safety is of notable concern for community mental health workers (Hughes & Gilmour, 2010; Roen, 1999). Research shows that mental health workers are at a greater risk of client violence against staff as workers are increasingly delivering mental health care in isolation, to clients in their homes (Denton et al., 2002; Spencer & Munch, 2003). Client violence is believed to be a common but underreported phenomenon (Hutchings, Lundrigan, Mathews, Lynch, & Goosney, 2011; Spencer & Munch, 2003). Verbal threats against staff occur most frequently followed by physical assaults. Other significant forms of client aggression include psychological violence, harassment, threats and property theft (Denton et al., 2002; Hutchings et al., 2011; Spencer & Munch, 2003).

There is no firm consensus about what defines an act of client violence and perceptions of what constitutes violence against staff may vary between individual workers. This makes the development of standardised reporting procedures difficult and has hampered efforts to research and measure the extent of client violence (Lundrigan, Hutchings, Mathews, Lynch, & Goosney, 2010; Spencer & Munch, 2003). Reasons why client violence against staff is believed to be significantly underreported includes workers thinking it is an inherent part of their job, wanting to protect clients or staff or do not want to appear as incompetent (Hutchings et al., 2011; Spencer & Munch, 2003).

Although most people with mental health problems do not pose any risk to others, the potential for danger is elevated when working with a minority of service users with chronic mental health issues due to the unstable nature of the illness (Cowin, 2003; Spencer & Munch, 2003). Service users who

had been considered too unwell to ever be released from psychiatric hospitals in the past are now residing in the community (Spencer & Munch, 2003). Community support workers and other health professionals are now at greater risk because they are increasingly providing treatment in clients' neighbourhoods and homes, which are an unpredictable and potentially unsafe work context. Research in the area of client violence is minimal, however the literature suggests that mental health workers are at more danger in the client's own home than in any other environment (Denton et al., 2002; Spencer & Munch, 2003). Mental health workers are unable to access immediate help if a dangerous situation should arise (Cowin, 2003; Denton et al., 2002; Hutchings et al., 2011; Spencer & Munch, 2003).

Research by Roen (1999) with Southern based support workers in New Zealand found that security in clients home is considered a major priority for staff, even more so than receiving higher wages. Some staff were not provided with the appropriate resources to conduct their work safely such as a cell phone, even though a mobile phone is considered an intrinsic element of a safety when conducting home visits (Roen, 1999). Furthermore, mental health workers are often not given accurate or in-depth information about a service user's past aggressive or threatening behaviour (Denton et al., 2002; Hutchings et al., 2011). In New Zealand based research, mental health support workers stated that the safety of staff and clients could be put at risk if staff are hired without appropriate backgrounds or provided with adequate training (Caird, 2001). Characteristics of mental health work environments have an effect on both the safety of staff and service users (Denton et al., 2002; Salyers et al., 2013).

Spencer and Munch (2003) state that despite the perilous conditions community mental health workers continue to be faced with, safety is often not a prime concern in training programmes and few thorough safety policies exist in mental health organisations. Research indicates that management do not give client violence or victims of client violence a high priority and this contributes to a culture of silence about the issue (Spencer & Munch, 2003). Ignoring such incidents can lead to much

greater feelings of trauma, stress, demoralisation and burnout (Hughes & Gilmour, 2010; Lundrigan et al., 2010). Symptoms of burnout can manifest as cynicism, hopelessness and despair about the workers ability to perform their job. Furthermore, burnout can lead to an erosion of self-protective strategies and beliefs about their ability to predict, control and remain safe in potentially dangerous situations (Hughes & Gilmour, 2010; Spencer & Munch, 2003).

Staff and client interactions are influenced by mental health workers views of service users (Hughes & Gilmour, 2010). The negative effects of client violence if left unresolved can make workers less effective at their jobs if they are afraid, and put workers at a higher risk of future incident if they do not have any knowledge of what to do in a recurrent situation (Spencer & Munch, 2003). The financial repercussions of unresolved violent incident are also high as it is related to low staff retention, absenteeism and health expenses (Acker, 2012; Hughes & Gilmour, 2010; Spencer & Munch, 2003).

Relationships between carers and care recipients

Gaining fulfilment and meaning from work, developing interpersonal skills and having autonomy over labour are some of the unique aspects of care work that compel workers to accept conditions which appear unfavourable on the surface (Denton et al., 2002; Stacey, 2005). Intrinsic rewards that derive from care labour are primarily related to the interactions with service users and having the opportunity to work independently with clients without bureaucratic constraints (Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011; Denton et al., 2002; Elwér et al., 2010; Folbre, 2001; Stacey, 2005). Supporting service users on their recovery journey is also a source of fulfilment (Kristiansen, Hellzén, & Asplund, 2010; McCrae et al., 2008; Murray et al., 1997; Salyers et al., 2013).

Research shows that the boundaries between formal and informal care can easily become blurred through the strong bonds that naturally form between staff and clients and because of the personal settings in which community based care work takes place (Denton et al., 2002; England, 2005; England & Folbre, 1999; Stacey, 2005). Moreover, Curtis (1994)

argues that the values and recovery philosophy underlying mental health support work challenge the traditional 'professional' boundaries between staff and clients.

Findings from a study conducted on informal caregiving within Māori families has illustrated that caregiving obligations are often a responsibility of the entire whanau and this perception may extend into formal care work (Collins & Wilson, 2008). According to Goodhead and McDonald (2007), relationships, whanau (family), manaakitanga (caring for others or hospitality), whanaungatanga (kinship relationships), aroha-ki-te-tangata (respect for others), wairua (spirituality) awhinatanga (assisting people) are central aspects of Māori worldview that may influence preconceptions about care work. These values are also common to and interrelated with Māori models of health and wellbeing and are incorporated into the process of building relationships (Collins & Wilson, 2008; Goodhead & McDonald, 2007). Research with Māori health professionals working with homeless Māori mental health clients also found some Māori staff prefer to perceive their clients as whanau, and incorporate this concept when developing relationships with clients (Johnson et al., 2013).

The relationships forged through care work can lead workers to absorb and accept the responsibilities and costs for the client that are not met by other forms of assistance (Denton et al., 2002; England, 2005). For example care staff may feel coerced into taking on moral demands posed by clients (Aronson & Neysmith, 1996; Denton et al., 2002; England, 2005; Stacey, 2005). Research shows home care workers are often put in ethically compromising situations which lead staff to take on responsibilities that are beyond the scope of their job requirements (Aronson & Neysmith, 1996; Denton et al., 2002; Elwér et al., 2010; Stacey, 2005). This puts the client at risk and forces the worker to carry the liability for the client's wellbeing (Aronson & Neysmith, 1996; Stacey, 2005). The moral demands experienced by workers include feeling pressured to give money to clients when the client would otherwise have to go without, being asked to spend time with clients after hours and monitoring physical health conditions when no nursing staff are available

(Aronson & Neysmith, 1996; Denton et al., 2002; England, 2005; Stacey, 2005).

Research regarding the moral demands faced by formal carers is based on American samples and with home care workers as a general category, rather than with mental health care workers specifically. Therefore it is uncertain whether New Zealand community mental health support workers are facing the same situation. More research is needed to further explore the relational aspects of community mental health support work and to determine whether these findings are generalizable to home care workers in other fields such as community mental health support work (Aronson & Neysmith, 1996; Elwér et al., 2010).

Job strain

While care work has been found to be intrinsically rewarding, there is much evidence indicating a widespread prevalence of burnout and turnover among mental health care staff (Paris & Hoge, 2010; Rössler, 2012; Salyers et al., 2013). This is major cause for concern as it signals substantive distress being experienced by staff involved in the delivery of mental health services (Paris & Hoge, 2010). Low staff retention and elevated rates of burnout amongst staff working in mental health counters the notion that caring for others entails skills that are innate to women, 'natural' or 'unskilled'.

Investing large amounts of energy into other people's wellbeing can take an emotional toll on workers (Acker, 2012; Denton et al., 2002; Rössler, 2012; Stacey, 2005). Emotional exhaustion has been described as a form of subjective psychological distress that consumes energy and enthusiasm for work and results from being emotionally overextended (Acker, 2012). Emotional exhaustion is related to poor job performance, desire to leave, turnover and job dissatisfaction. These experiences are frequently associated with emotional labour and result in symptoms of burnout (Elwér et al., 2010; Spencer & Munch, 2003; Stacey, 2005). Emotional exhaustion poses a significant problem at a time when organisations are overburdened with high need case loads, are financially restricted and

frustrated by unsuccessful attempts at meeting the needs of service users (Acker, 2012).

Burnout is a construct that originated in the 1970s and was developed in relation to front line care workers especially in the mental health and social service field (Paris & Hoge, 2010). Since this time, the concept of burnout has received growing research interest because of the strong correlation between burnout, staff turnover, employee wellbeing and work absence (Hare & Pratt, 1988; Paris & Hoge, 2010; Rössler, 2012). Burnout is widely accepted in the literature as comprising three main dimensions including emotional exhaustion from work, depersonalisation towards the recipients of care and a reduced sense of personal achievement in work (Paris & Hoge, 2010; Salyers et al., 2013). In general, the construct of burnout describes how a worker's emotional and physical resources are exhausted through the attempt to cope with work related issues (Rössler, 2012).

Symptoms of burnout can also lead to negative staff attitudes (Charlesworth & Marshall, 2011). For example mental health workers from a supported accommodation setting in research by Kristiansen et al. (2010) reported feeling as though they were household drudges working in a 'strangled' environment. Over time, staff developed an ambiguous and negative perception of clients and described the nature of their work as leading to "...overwhelming frustration" (Kristiansen et al., 2010, p. 429). A discouraging approach towards clients is linked to poorer outcomes for mental health service users (Charlesworth & Marshall, 2011). Kristiansen et al. (2010) concluded that mental health workers ability to provide effective care is influenced by individual, organisational and structural factors. Individual level factors include characteristics of staff and clients such as attitudes and behaviour. Organisational factors are the work environment, institutional values and philosophies, economic constraints and resource availability. Structural factors include legislation, policy and social attitudes (Kristiansen et al., 2010).

Burnout is problematic as it contributes to staff turnover rates that in turn interrupt continuity of care, productivity levels and organisational stability (Charlesworth & Marshall, 2011; Paris & Hoge, 2010). The Public Service Association (2008) maintain that high turnover and substandard working

conditions lead to a low quality of life for workers and the people they support. Furthermore, scarce resources are drained into recruitment, training and staff replacement (Paris & Hoge, 2010). In principle, similar levels of work related stressors should be experienced by mental health workers, however in reality the potential for burnout, stress and job dissatisfaction is much greater for mental health care workers than in other occupations (Rössler, 2012). Low levels of staff retention are characteristic of community disability support workers in New Zealand with 50% of hired staff leaving in the first year of work (Public Service Association, 2008).

Sources of job strain in community support work include extensive and demanding caseloads, long working hours, no overtime pay, irregular and antisocial shift schedules and occupational stigma. Moreover, support work involves chronic interpersonal stresses such as through challenging interactions with staff from other professions, patients and patient families, limited positive feedback, poor pay, unpleasant work environments and legalistic obligations (Caird, 2001; Cowan, 2008; Denton et al., 2002; Murray et al., 1997; Rössler, 2012; Te Pou, 2010). Other notable stressors include unsuitable and uninformative referrals, role ambiguity and conflict, absence of supervision and adequate support, risk of client violence and patient suicide (Charlesworth & Marshall, 2011; McCrae et al., 2008; Rössler, 2012; Shepherd & Meehan, 2013; Spencer & Munch, 2003; Ting, Jacobson, & Sanders, 2011). High work stress has been found to be associated with roles that involve a lot of exposure to complex service users who are dependent on staff for social interaction and have a poor prognosis - traits which are characteristic of many mental health service users (Denton et al., 2002; Hare & Pratt, 1988). Most service users that mental health support workers work with have multiple and severe health care needs (Beebe, 2010; Caird, 2001; Cowan, 2008).

Hare and Pratt (1988) demonstrated that paraprofessional care staff in health settings are more vulnerable to the effects of burnout than professional staff. Hare and Pratt (1988) surveyed 312 professional and non-professional mental health nurses. Paraprofessional care staff had significantly higher rates of emotional exhaustion and depersonalisation than professional staff. Furthermore paraprofessional staff were found to

experience less supportive work contexts. Perceptions of support from organisations, managers and co-workers is important as research has demonstrated that this can affect levels of staff turnover (Lundrigan et al., 2010).

Paris and Hoge (2010) concluded from their analysis of related literature that although emotional burnout is commonly purported by staff providing mental health services, a strong sense of achievement and engagement with clients is maintained in their work. The rewards obtained from the non-material and emotional features of care labour are often strong enough to buffer the effects of external constraints in the short term (Paris & Hoge, 2010). Hare and Pratt (1988) concluded that higher levels of burnout and emotional exhaustion experienced by paraprofessional staff in their research were evidence of oppressive organisational environments. Care workers have some of the highest and demanding workloads yet are often disregarded by health professionals, receive little training, low wages and support (Aronson & Neysmith, 1996; Denton et al., 2002; Hare & Pratt, 1988; Stacey, 2005).

Research by Hare and Pratt (1988) was one of the earliest studies which highlighted the need for more investigation into the potential effects of organisational contributors of paraprofessional staff burnout and job dissatisfaction. The impact of structural and organisational workplace stressors on home care workers has been further substantiated by research (Aronson & Neysmith, 1996; Denton et al., 2002; Elwér et al., 2010). For example mental health staff in positive work environments report lower levels of burnout and intention to leave their job, a stronger sense of personal accomplishment and work satisfaction (Salyers et al., 2013). Healthy work environments are comprised of higher levels of organisational support for emotional and relational labour, egalitarianism, stable work hours, autonomy and control over work and higher institutional resources such as better pay and benefits (Denton et al., 2002; Salyers et al., 2013; Stacey, 2005; Tronto, 2010).

Addressing work conditions

Some of the main approaches that have been conducive toward enhancing the working conditions and wages of female dominated occupations in the past include increasing entry requirement credentials and professionalization of the sector, collective organisation and unionisation, pursuing pay equity through litigation and seeking more public assistance for care based labour services (Bourgeault & Khokher, 2006; Stone, 2000). Proponents of unionisation have advocated for higher wages and better work conditions on the basis that improved productivity subsidises the associated costs (Folbre, 2006; Public Service Association, 2008). Folbre (2006) suggests that the relationship between increased unionisation and quality of care needs to be studied further. A combination of these strategies have been found to be an effective way to successfully advocate more public funding of care related work to ensure greater pay equity (Bourgeault & Khokher, 2006; Stone, 2000).

Some support workers have stated that there should be more value placed on the qualifications required to enter the job (Te Pou, 2010). Support workers have also maintained that more university training for support work, better career pathways and succession opportunities are necessary. It has also been reported that basic competence training needs to be implemented across the workforce, such as how to use computers (Te Pou, 2010). Many support workers from New Zealand NGOs are proponents of professionalization of the support worker role and contend that a professional national body for support work is needed (Te Pou, 2010).

Raising the educational credentials of workers and professionalization as a strategy for improving wages and conditions of care workers has however been criticized. It is believed that whilst improving the educational standards of workers does enhance the status of occupations it does not necessarily add any value in terms of the skill levels or practices of staff (Caird, 2001; Meek, 1998). Improved wages and conditions may only impact a small minority of the higher educated group of workers, rather than enhance the welfare of the group as a whole (Bourgeault & Khokher, 2006).

There is continuing debate in the literature regarding whether further training or the personal attributes of workers in caring occupations provide greater benefits for patient care (Shepherd & Meehan, 2013). Some research shows that professionalization and increased training of staff does not necessarily have any influence on the effectiveness and ability of workers (Faust, 1995; Hattie, Sharpley, & Rogers, 1984; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). Meek (1998) contends that in terms of service user wellbeing, personal characteristics are just as, if not more important than professional expertise. Evans (2000) concluded from a literature review that the most important qualities of community support workers are a non-judgemental attitude, being able to instil a sense of hope in service users and providing a positive environment where learning opportunities are available.

Caird (2001) claims that professionalization of the support worker role could impact negatively on workers' attitudes towards clients. In conventional health care relationships staff are primarily perceived as the givers and clients as receivers. By implementing professional boundaries, for example, by declining offers of reciprocity, service users may be led to believe that they have nothing to offer (Curtis, 1994). Research shows that caring relationships are not uni-directional but rather interdependent, whereby both client and worker obtain value and meaning from the interpersonal bonds that develop (Stacey, 2005). Strict enforcement of professional distance has also been found to be detrimental to the therapeutic relationship (Curtis, 1994; Shepherd & Meehan, 2013).

Workforce shortages in mental health are already a major challenge and increasing entry-level requirements could add to further recruitment problems (Shepherd & Meehan, 2013). Some support workers have expressed fears of job uncertainty as they are concerned that more qualified support workers are going to take over their jobs in the future (Roan, 1999). Nevertheless, increased professionalization of support work does have the potential to make the occupation more credible, improve work conditions and provide a greater assurance of the quality of care provided to clients (Caird, 2001; Cowan, 2008).

In the past care work has been perceived as mainly consisting of the provision of an individualised, personal and interactive service that responds to a direct need of the care recipient such as teaching, nursing or caregiving. However there is a greater understanding of the 'public good' and indirect social benefits that result from the work of carers (England & Folbre, 1999; Stone, 2000; Tronto, 2010). The grossly unrecognised and unrewarded labour undertaken by care workers has become more salient (England et al., 2002; Stone, 2000).

Feminist academics and care movement activists have begun to challenge traditional ethics, ideologies and policies around care work and argue that notions of care and care related activities need to be redefined as political and social issues (England, 2005; Engster, 2010; Folbre, 2001; Stone, 2000). This has provided the foundation for the political and social goals of care theorists and activists that are part of a broader care movement, which aims to address the inequality experienced by care workers, increase public awareness and mobilise greater public support for care work. Moreover, the care movement aims to attain progressive policy outcomes across the continuum of care policies of various care domains (Engster, 2010; Folbre, 2001; Stone, 2000; Tronto, 2010). Caring public policies fulfil the basic human right to give and receive adequate care and ensure quality care for others (Knijn & Kremer, 1997; Stone, 2000). Progressive care policies also acknowledge the essential interdependence of all human beings and are a form of social investment in the capabilities of future generations (Folbre, 2006; Tronto, 2010).

Changes in care policies are needed to improve wages, work conditions and public oversight of care provision, and achieve more effective regulatory standards (Denton et al., 2002; Engster, 2010; Tronto, 2010). Care policies often disregard the significance of emotional labour and instead there is a greater focus on tangible job tasks (Denton et al., 2002). This is despite growing research which recognises that emotional and relational labour are the most favourable and beneficial aspects of support for both care givers and receivers (Aronson & Neysmith, 1996; Denton et al., 2002).

Care advocates have argued that a generalised care movement is needed that is based on an inclusive definition of care work, which unifies the many common interests of care providers (Engster, 2010; Stone, 2000). In order to build and foster a successful care movement it has been suggested that activists, organisations and advocacy groups from different care constituents need to put a greater emphasis on their support for care policies and activities in general, rather than only focusing on discrete concerns from their particular occupation (Engster, 2010; Folbre, 2006; Stone, 2000).

Folbre (2006) argues that care occupations that have achieved good levels of organisation need to form stronger partnerships with less empowered groups of workers and incorporate them into a more expansive coalition consisting of all workers in the care sector. Successful campaign outcomes in any one field of care work should be perceived as a triumph for all care activists, as the implementation of effective strategies in one domain can illustrate potentially useful initiatives for other care occupations (Bourgeault & Khokher, 2006; Engster, 2010).

Unique methods of organising may need to be used to unify care workers. As care workers often draw non-monetary rewards from their work, the unionisation and organising of workers can be very difficult (England & Folbre, 1999). For example the latest workforce survey data shows that only 23% of staff working in New Zealand NGO mental health and addiction service are union members (Platform, 2008). Stacey (2005) argues that traditional approaches, such as organising workers in relation to monetary interests, are not sufficient when workers derive non-material satisfaction from their work. Care workers may also be opposed to using controversial methods such as strikes to get their needs met as workforce stoppages can put their clients' wellbeing at risk (England & Folbre, 1999; Engster, 2010). Therefore organising campaigns with care workers need to focus on both improving the material conditions of workers whilst also acknowledging the relational and intrinsically rewarding nature of caring for others (Elwér et al., 2010; Stacey, 2005).

Other impediments to successful mobilisation are the lack of time and resources available to care workers due to their minimal remuneration

levels, heavy workloads and external commitments (England, 2005; Engster, 2010; Stone, 2000). Many recipients of social care services may be too young, old or unwell to participate in conventional forms of political protest such as rallies and marches. Moreover, care workers do not have a shared identity or site to facilitate political activism and the mobilisation of workers (Engster, 2010; Stone, 2000; Tronto, 2010).

Engster (2010) argues that the Internet is a potentially valuable tool to use for the political organisation of care workers. Engster (2010) suggest that an umbrella website could be set up that provides a general philosophy of a care movement and links carers to distinct constituents and care organisations. The creation of an umbrella organisation that encompasses all care advocacy groups could make the unified goals of different care providers more salient and less counterproductive. This could help to garner greater public support for caring work overall and help prevent competing interests to override potential gains in other care sectors (Engster, 2010; Stone, 2000). The internet could also enable a space for consciousness raising, discussion, relating to other workers, developing solidarity and supporting political projects, according to workers own schedules and without the need to travel (Engster, 2010). However not everyone has Internet access and even people that do may not be aware of mobilisation activities. Therefore public outreach is also necessary to raise consciousness about the aims and activities of the care movement (Charlesworth & Marshall, 2011; Engster, 2010; Stone, 2000; Tronto, 2010).

Chapter Three: Methods

Recruitment

Target population and sample

The target population was men and woman over the age of 18 who currently or previously have worked in an NGO mental health service as a community mental health support worker, for any period of time. Mental health support workers who currently work in NGOs, or have in the past, were chosen as participants in this study because the literature review has highlighted that community support workers from these organisations

experience poorer work conditions than those who work for DHBs. Male and female workers were invited to participate in this study as the structural sexism and discrimination faced by workers in female dominated professions affects both men and women (England et al., 2002; Folbre, 2006).

The total sample size was 14 participants. The sample was not intended to be too large because of the limited time available for the project and the lengthy process required for data collection and analysis. All of the participants were non-Māori. Seven males and seven females agreed to participate in the study. The equal gender distribution of participants was purely coincidental. One community mental health support worker from a DHB provider who expressed interest in the study also participated in order to boost the sample size that was initially very low. The rest of the participants had in the past or currently work for an NGO for a period of between one month and up to 10 years. Specific details about support workers will not be presented in order to protect the anonymity of the participants.

The sample was comprised of mental health support workers across New Zealand. Participants were offered the option of a face-to-face, phone or Skype interview to allow participants from anywhere around the country to participate, without any need to travel.

Recruitment strategies

Ethical approval was sought to recruit participants through a number of different means to ensure an adequate sample size and to provide a back up plan in case any of the different recruitment strategies were unsuccessful.

Unions

Unions such as the PSA continue to actively fight for the rights and working conditions of disability community workers (Public Service Association, 2008). Therefore, I thought the PSA union would be an appropriate organisation to approach to source potential participants. Mental health support worker union members are likely to have an interest and concern about the working conditions of mental health support work.

Stacey (2005) found that speaking to home care workers through union meetings was an effective recruitment strategy. Stacey (2005) gained permission from the union meeting organiser, presented information about her research and requested participants at a union meeting. A sign up sheet was sent around the union meeting. Although a large number of care workers would sign up initially for interviews many did not want to participate at follow up, even though they were offered a \$20 voucher for participation (Stacey, 2005).

I contacted the PSA union by email through contact information made available on their website. I introduced myself, provided details to the contact person about the research and asked if it would be possible to briefly attend a mental health support worker union members meeting or whether the PSA would be able to assist with recruiting participants for this research. I was not granted access to a union meeting. However the PSA policy and research unit contacted me and asked for more details about my research. They agreed to email a recruitment poster to their union members across New Zealand and I wrote a recruitment email encouraging support workers to participate to go along with the poster. Around five weeks after I made contact with the PSA there was a surge of support workers who emailed me expressing interest in participating. I emailed potential participants back with an information sheet and arranged an interview time with them. A number of support workers did not reply after being sent an information sheet.

Snowball sampling

I also used snowball sampling as a recruitment strategy. Snowball sampling involves using research participants and their contacts as a potential source of recruitment. For example once an interview had been conducted I asked the participant if they were aware of any other mental health support workers who would be interested in participating in the study. I emailed the participant a recruitment poster to email or hand out to other support workers they knew who may have been willing to participate (Dahlberg & McCaig, 2010).

Advertising research around the community

I put up posters about the research on notice boards around the community in different urban regions around the North Island. Recruitment posters had details about the study along with my contact information. Recruitment in a number of urban areas ensured that support workers were recruited across diverse regions and that the study was advertised to a large pool of potential participants.

A key aspect of community support work is supporting service users with community living, therefore recruitment posters were placed on notice boards in areas that support workers were likely to frequent through their work with clients such as libraries, supermarkets, drop in centres and health and community service agencies.

I also approached Platform Trust to ask for assistance with recruiting participants. Platform Trust is an organisation that promotes the national networking of NGO community mental health and addiction services. Therefore I thought Platform Trust would be a relevant organisation to get in contact with.

I emailed the administrator of Platform Trust, informed them about my research and inquired as to whether they would be willing or able to assist me in anyway with recruiting participants for this research. Moreover I asked if they were aware of any other contacts or sources of participants for this research. I also emailed an information sheet and recruitment poster. They were more than happy to help and placed my recruitment poster on their social networking page. They also said the Blueprint training centre which runs the National Certificate in Mental health and Addictions was in the office next door to them and that they would pass on recruitment posters to them also.

Training institutions

The Certificate in Mental Health Support work is usually the minimum educational requirement for support work and mental health organisations often pay for staff to attend this one year training course (Cowan, 2008). A number of educational institutes across New Zealand offer qualifications in Community Mental Health Support work such as UCOL, AUT and

Blueprint. Minimum qualifications are normally provided to support workers while they are working full time and they receive time off work to attend training. I emailed the course administrators from training institutes that offer qualifications in mental health support work, introduced the research and myself and asked if they were able to inform their students about my research or whether I could attend a class to make a brief presentation about my research. I was not allowed access to a class but was told by one course instructor that they would inform their class about the research and give out a recruitment poster with my contact details. However I did not get any response from some of the training institutes and did not recruit any participants in this manner.

I placed recruitment posters on the University of Waikato notice boards and my recruitment poster got sent out to students on the University of Waikato Psychology Research Database. Students may be likely to have done community mental health support work as it offers part time and casual hours that fit around students' schedules and can compliment their field of study. Therefore I thought Universities would be a useful recruitment site (McCrae et al., 2008; Murray et al., 1997). As the University of Waikato logo was on the recruitment poster I was not granted permission by other universities to place recruitment posters on their campuses.

Mental health organisations

I did not feel it was appropriate to approach NGO mental health organisations directly to seek assistance with recruiting support workers for this study. I wanted this research to be independent from any affiliation with mental health organisations so that support workers felt able to speak as openly and honestly as possible about the working conditions they experience.

Data collection

Methodological considerations

I incorporated principles of feminist research into the data gathering techniques used in this study. The main rationale for using a feminist

approach is my interest in the gendered nature of care work, a desire to privilege participants' voices and the activist orientation of this research, which was conducted with a social justice agenda.

Feminist scholars assert that conventional research paradigms have prejudiced women. Therefore an alternative feminist approach to research has been devised, which is more appropriate for the research of and for women (Cosgrove & McHugh, 2000; Harding, 1987; Riger, 1992). A number of principles for feminist research have been developed in order to explicate what feminist research means and how it can guide feminist research. Some of the main features of feminist research are that it highlights gender inequality and investigates the ways in which gender affects the context of people's lives. Moreover, feminist research privileges women's lived experience and aims to avoid dualistic thinking about gender related issues. The overall goal of feminist research is to enhance social justice for women, through a focus on structural rather than individual level change (Cosgrove & McHugh, 2000; Riger, 1992). Feminist research involves the use of methodologies that give voice to the experiences of women, are participatory, empowering and reflexive (Cosgrove & McHugh, 2000; Riger, 1992).

Feminist research deviates from traditional psychological research in that the researcher's subjective reality and inherent biases are embraced (Cosgrove & McHugh, 2000; Dahlberg & McCaig, 2010; Harding, 1987). A feminist approach is therefore fitting for this project as I have personal experience working as an NGO community mental health support worker and have had exposure to the topic under investigation. In feminist research it is important to make explicit that my values, bias and personal experiences have shaped and framed the implementation of this research project (Dahlberg & McCaig, 2010).

Feminist researchers argue that intrinsic researcher biases have an unavoidable influence on all scientific research. It is impossible to make decisions regarding which research method to use without the guidance of one's own methodological, ontological and epistemological beliefs about social reality (Campbell & Wasco, 2000). In contrast, a key tenet of

traditional, positivist research is 'scientific neutrality' which aims to reveal objective and observable truths about the social world (Neuman, 2011). The positivist paradigm in psychology is assumed to be 'value free' which conceals the value-laden nature of all research (Campbell & Wasco, 2000; Riger, 1992). Cosgrove and McHugh (2000) contend that the illusion of objective, 'value free', decontextualized, empirical research has led to an unacknowledged androcentric bias that pervades traditional research at all levels and has contributed to the oppression and pathologisation of women (Campbell & Wasco, 2000; Harding, 1987; Riger, 1992).

Feminist research has been criticized as being too subjective in comparison to traditional research, which idealises impartiality and objectivity (Barker & Pistrang, 2005; Dahlberg & McCaig, 2010; Neuman, 2011). Feminist literature and research is political and value laden with the results of research often being threatening to the status quo (Coghlan & Brannick, 2010; Dahlberg & McCaig, 2010). It has been argued that the researcher's personal experience and values contaminate the research process and is thereby perceived by some as subordinate to research conducted within a traditional research paradigm (Coghlan & Brannick, 2010).

Although researchers who adhere to the traditional scientific paradigm may argue that personal experience with the phenomena under investigation will bias the research, others contend that first-hand experience of the research topic is an advantage as this could provide a more in depth insight into the issue and facilitate rapport building with research participants (Barker & Pistrang, 2005; Coghlan & Brannick, 2010; Dahlberg & McCaig, 2010). Personal experience of the topic under investigation could also enhance the ability of the researcher to gain access to participants and it may help with developing trusting relationships. If there is a sense of trust between the participants and researcher, participants may be more willing to share information and experiences (Barker & Pistrang, 2005).

In feminist research, the identification of the researcher's values, social background and position are important as the researcher must engage in

scrutinising and deconstructing their role in the production of knowledge (Barker & Pistrang, 2005; Campbell & Wasco, 2000; Riger, 1992). It is imperative that the researcher explicitly reflects upon their personal characteristics, values, life experiences and socio-political agenda and the way these biases underpin and influence decision making at every stage of the research process (Cosgrove & McHugh, 2000; Dahlberg & McCaig, 2010). Moreover, it is essential that the researcher consider any inadvertent consequences that may result from their research. The results of research can lead to unexpected outcomes that may be irreversible and/or damaging (Dahlberg & McCaig, 2010).

A reflexive approach that has been suggested involves the researcher disclosing biographical information about themselves (Barker & Pistrang, 2005). This helps to elucidate the context of the researcher's decision-making throughout the research process such as the researcher's choice of topic, research questions and conclusions drawn from the findings (Barker & Pistrang, 2005; Cosgrove & McHugh, 2000). Whilst it is important that the researcher identifies their positionality regarding the research topic, the research should not be conducted with a narrow, preconceived outcome in mind (Dahlberg & McCaig, 2010). Moreover, it should be acknowledged that certain values and biases are harmful and ethically and morally unacceptable such as any form of discrimination (Dahlberg & McCaig, 2010)

Through the examination of researcher bias, it is recognised that all knowledge is produced within a specific socio-political and historical context (Barker & Pistrang, 2005; Campbell & Wasco, 2000; Cosgrove & McHugh, 2000; Harding, 1987). The idea that all knowledge is constructed within a given social context is consistent with a constructionist epistemological perspective. Social constructionists argue that reality is constructed through the use of language and by individual's drawing on existing dominant discourses and ideologies (Campbell & Wasco, 2000; Cosgrove & McHugh, 2000; Harding, 1987; Neuman, 2011; Riger, 1992; Stanners et al., 2014). It is maintained that the world essentially consists of infinite discourses and texts, most of which serve the interests of those

in positions of power in society who function to uphold these unequal power relations (Cosgrove & McHugh, 2000; Riger, 1992).

Social constructionists challenge the notion that there is a single objective reality or truth, as interpreted by the 'expert' and instead argue that this is a harmful misconception (Campbell & Wasco, 2000; Cosgrove & McHugh, 2000). The belief that a single observable truth exists, can potentially assign to the researcher the power to determine what constitutes reality or truth, without acknowledging how their own position and values are dictating their perspective (Campbell & Wasco, 2000; Cosgrove & McHugh, 2000; Riger, 1992). This research will be conducted within a constructionist epistemological stance, as the ideas underlying this paradigm are compatible with a qualitative feminist perspective and my own beliefs regarding the context specific nature of reality and knowledge.

Qualitative research has been recognised as a preferable and suitable method for feminist research (Cosgrove & McHugh, 2000; Riger, 1992). Data collection will involve a qualitative semi-structured interview. Interviews are a fitting data collection method to use in this study because this research is exploratory and aims to listen to the experiences of mental health support workers rather than pre-categorise responses through closed-ended questions. Interviews are an excellent method to use to derive context specific, authentic responses and for understanding how people find meaning and coherence about complex problems (Barker & Pistrang, 2005; McCrae et al., 2008). Qualitative methods such as semi-structured interviews are collaborative and match the support work role, which frequently involves informal and formal dialogue of work related issues with co-workers (Barker & Pistrang, 2005; Kristiansen et al., 2010). Furthermore, semi-structured interviews are an appropriate data collection method because they allow the researcher the opportunity to inform the participants about what the interview will entail at the outset, but also the flexibility to adapt questions and prompts throughout the interview as required (Dahlberg & McCaig, 2010).

A disadvantage of an individual interview is that participants are not able to discuss issues facing community support workers as a group, which

could build solidarity between participants. Moreover, I was not able to facilitate the development of a consensus view of the issues under investigation in this study (Dahlberg & McCaig, 2010; Morgan, 1996). However individual interviews are a lot more flexible and more easily managed. For example it can be difficult to arrange a time when all participants are available to attend a focus group (Dahlberg & McCaig, 2010; Thomas & Hodges, 2010). Individual interviews allowed me to obtain a broad range of responses from across a large number of regions.

Interview procedure.

Interviews were carried out either by phone, Skype or face-to-face. As participants were recruited from different locations across the country, Skype and phone interviews were generally the most convenient and commonly used method. Up to one hour was designated for each interview. A suitable time for the interview to take place (and venue for the face-to-face interview) was negotiated beforehand by email. A participant information sheet was also emailed to participants when initial contact was made.

Skype, phone and face-to-face interviews were conducted in a similar fashion. Interviews were conducted in an environment that was as free from distractions as possible. The first few minutes of the interview session was used to explain the research further and for developing a rapport between researcher and participant. Principles of informed consent and confidentiality were discussed and participants had the opportunity to ask any further questions they had about the study. Participants were advised that they could withdraw from the study at any stage or did not have to answer any questions they did not feel comfortable responding to. For the phone and Skype interview the participant information sheet was read aloud if they had not already read it and verbal informed consent was given which was audio-recorded. For the face-to-face interview, participants were given the information sheet to read if they had not read it and were asked to sign to a written consent form.

After the introductions I began the interview using the interview questions as a guide, which had a number of prompting questions. The interview was carried out in an informal, interactive, conversational style. As the interviewer, I led the discussion to ensure that relevant issues were canvassed whilst also maintaining my position as a listener. I improvised questions during the interview, according to the direction and information being disclosed by the participant.

I continued to prompt and probe discussion with open-ended questions for up to fifty minutes. During the interview I took notes. Once the discussion had been going for between fifty and fifty-five minutes I began to wrap up the interview. After the interview I thanked participants for their time and asked for their email address so that I could send them a summary of their interview. I emailed the participants a summary of their interview to allow them to verify that I accurately captured their responses. Moreover, sending participants a summary of their interview gave them an opportunity to make any changes to their responses before it underwent data analysis. I told the participant they had up to two weeks to make changes and that if I do not hear from them I will assume that they are happy with it. I also asked if they would like to receive a copy of the summary of the final results.

The interviews were recorded with two digital-recorders. Two recorders were used to ensure there was backup in case one of the recorders malfunctioned.

Interview questions

The interview questions are a replication of those used in research conducted by Aronson and Neysmith (1996) with elder home care workers. The interview was structured around the following seven open-ended questions.

1. Please describe your job as a community mental health support worker as if you were trying to explain it to someone who was thinking of becoming a support worker and wanted to know what community mental health support work involved on a day to day basis?

2. Can you describe factors and/or aspects of your work environment that you find supportive?
3. What factors and/or elements of your work environment make your work challenging?
4. What factors and/or elements of your work environment make your job rewarding?
5. What factors and/or elements of work environment make your work unrewarding?
6. What do you think could be done to enhance the rewarding and enjoyable aspects of your work?
7. What do you think could be done to improve the unrewarding and negative aspects of your work?

These questions intended to elicit responses from support workers that described their experiences and perceptions of their work, in terms what makes it easy, difficult, rewarding and unrewarding. Moreover, how the positive aspects of their work could be enhanced and the negative aspects addressed through gaining an insight into some of the sources of the issues facing support workers (Aronson & Neysmith, 1996). Participants were asked to give examples to support their responses. I asked participants to elaborate on their responses relating to their working conditions, supervision, work organisation, job tasks, relationships with co-workers, workload, their work history or any other issues that were of particular significance to them (Aronson & Neysmith, 1996).

Data analysis procedure.

A thematic data analysis was carried out on the data obtained from the individual interviews. Thematic data analysis has been identified as a good foundational tool for inexperienced researchers, which can be used in conjunction with most theoretical and epistemological approaches (Boyatzis, 1998; Braun & Clarke, 2006; Marshall & Rossman, 2006). Braun and Clarke (2006) have produced a comprehensive description of the thematic analysis process which predominately guided the

implementation of data analysis in this project. I was the only researcher available for the analysis of data in this study.

As soon as possible after an interview took place, I replayed the recording and wrote up a written record of the interview. I checked the written record against the audio-recording at least twice to ensure it was accurate (Braun & Clarke, 2006). Braun and Clarke (2006) state that a thematic analysis does not necessitate a verbatim transcript of the data. However a vigorous and authentic account of the interview is required in order that significant amounts of information and detail are not lost in the conversion of the data from verbal to written form (Braun & Clarke, 2006).

After the written record had been typed up, I wrote a summary of the interview and emailed this back to the participant to confirm I had accurately understood what they had said in the interview. All of the participants were satisfied with their interview summaries.

Participant checks were limited to reviewing their individual record. This was because my analysis is based on the interviews as a whole and any participant with a dissenting view could not veto aspects of the overall analysis. Moreover, as I am operating under a critical feminist paradigm there were likely to be instances where I needed to read interview responses critically – that is I needed to go beyond or behind what a participant said to reveal unstated or unexamined assumptions.

The next stage of data analysis involved familiarising myself with the data by reading over the transcript numerous times (Braun & Clarke, 2006). After the first read through of the transcript, I started actively reading the data by looking for recurring themes and patterns and making notes about my initial observations. I began coding the data and all sections of the text, searching for patterns and aspects of the data that were interesting, unique, related to the research questions or previous literature (Boyatzis, 1998; Braun & Clarke, 2006).

In the coding stage, data extracts get arranged into categories and chunks that have meaning and significance for the aim of the research. The codes need to be examined from within the particular context in which they are created, so the data extracts needed to retain enough text for the extract

to be interpreted correctly (Boyatzis, 1998; Braun & Clarke, 2006). Codes are different from themes in that codes are more numerous and narrowly defined. Codes eventually become grouped together and refined further to produce a broad set of themes that reflect the overall patterns that have emerged across the entire data set (Boyatzis, 1998; Braun & Clarke, 2006).

I coded the data manually by taking notes on the transcripts and used highlighter pens to identify and categorise the data extracts. I coded each individual transcript and found as many different codes as possible. I began the coding process before all the interviews were complete and therefore I wanted to have many coding options available for the development of themes (Boyatzis, 1998; Braun & Clarke, 2006).

The next phase of analysis began once all the codes had been established across the data set. There were now a large amount of codes that were ready to be sorted into broader clusters, which constituted the overarching themes of the data set (Boyatzis, 1998; Braun & Clarke, 2006). I drew a mind map, which was useful for helping to categorise the codes into broader themes.

Once all the codes had been organised into themes I found that some of the codes did not fit anywhere and were therefore discarded. By this stage of the data analysis all the codes were sorted into groupings of either sub themes, main themes or abandoned (Boyatzis, 1998; Braun & Clarke, 2006).

How were themes defined?

There are no fixed rules for determining what constitutes a theme in a thematic data analysis. However a systematic method needs to be used for determining the key themes and this should be made explicit (Braun & Clarke, 2006; Dahlberg & McCaig, 2010). In this study, the significance of a particular theme did not depend entirely on the prevalence of codes that made up the theme. Each theme had to be relevant to some aspect of the aim of this research. If a code had been identified numerous times in one interview, its inclusion as a key theme depended on how many other different themes were found overall and it's relevance to the research aim

and questions. Codes were of particular interest and evolved into a theme if it had been stated frequently across participants, was a novel idea, contradicted expected findings or was of particular relevance to the research questions and aim (Boyatzis, 1998; Braun & Clarke, 2006). Themes were counted across interviews rather than within interviews. For example if a theme appeared multiple times within a participant's interview, it was counted as occurring once as a theme across the dataset.

Qualitative research tends to be inductive whereby concepts and theories relating to the data emerge through the process of data analysis. This is in contrast to a deductive approach whereby the researcher attempts to organise the data into themes that are congruent with pre-existing theoretical frameworks (Boyatzis, 1998; Braun & Clarke, 2006; Dahlberg & McCaig, 2010; Marshall & Rossman, 2006). However it has been recognised that good quality research uses an amalgam of both induction and deduction (Braun & Clarke, 2006; Dahlberg & McCaig, 2010). This research predominately took an inductive approach with the themes being developed from the data but analysed in light of the related theory and literature on the research topic (Dahlberg & McCaig, 2010)

The next phase of data analysis involved reviewing and further refining of the themes (Braun & Clarke, 2006). The researcher can employ their tacit knowledge skills to get a sense of the meaningfulness of each theme (Braun & Clarke, 2006). The robustness of each theme becomes more obvious as the analysis progresses. It may become apparent that some themes need to be combined with other themes, separated into two or more new themes or discarded completely (Boyatzis, 1998; Braun & Clarke, 2006).

Next, all the data extracts that constitute each theme were read through in order to determine whether they followed a logical pattern (Boyatzis, 1998; Braun & Clarke, 2006). If the data extracts from a particular theme did not have a coherent structure, decisions were made about whether the data extracts were better suited elsewhere, or whether the theme itself was actually valid. In this case I had to revise the theme or codes until I was satisfied that the data extracts within a theme formed a coherent pattern. I then needed to determine whether the key themes complimented each

other and were a good representation of the data set as a whole. I then needed to again make any amendments to the themes and codes as required (Braun & Clarke, 2006). Researchers should be able to connect the themes in such a way that a fluid narrative or story runs through the collection of themes (Boyatzis, 1998; Braun & Clarke, 2006).

Once the key themes had been finalised I also needed to go back over the data set to ensure that I had not missed out any of the data that could have been coded into one of the key themes (Braun & Clarke, 2006). I needed to move back and forth between the data set and codes revising and refining the themes until I was satisfied that the themes represented an accurate reflection of the data set. When the reviewing of the themes did not appear to be adding any substance to the analysis then it was time to bring the analysis to a close, as revising can potentially be a never-ending process (Braun & Clarke, 2006).

Whilst the titles for each of the themes had most likely been considered throughout the process, the titles that were going to be used in the final report needed to be decided upon. The titles should be succinct and capture the essential nature of each theme (Braun & Clarke, 2006; Marshall & Rossman, 2006).

Once all the concrete decisions had been made regarding the interpretation of data, the results of the thematic data analysis were disseminated in my thesis research report. Writing of the report is part of the process of tying up loose ends and finalising the thematic analysis (Braun & Clarke, 2006). The aim of the final report is to portray the cogency and significance of the research and to articulate the underlying narrative of the data by presenting the key findings in an interesting and vibrant manner. The write-up should be articulate, with numerous vivid examples from data extracts threaded throughout the analysis, which clearly support the validity of the themes and illuminate the main argument of the research (Braun & Clarke, 2006). The findings of the thematic analysis were then discussed against previous literature and theories and research questions. The implications of the findings and future directions

were also suggested from the results of the research (Boyatzis, 1998; Braun & Clarke, 2006; Marshall & Rossman, 2006)

Ethical considerations and responsiveness to Maori

The University of Waikato Psychology Research and Ethics Committee granted ethical approval for this research. This study complied with the criteria laid out in the University of Waikato School of Psychology Ethics Review for Human Research Guidelines. Harm minimisation and regard for the welfare of the participants was a priority throughout the research process. Participants were treated with dignity and respect and kept informed about aspects of the research process once they had agreed to take part in the study, including the interpretation of the results and use of the data.

Informed consent

I gave a written information sheet to participants I interviewed face-to-face and emailed this beforehand to participants I interviewed by phone or by Skype. The information sheet included details about what participation would involve, the aim of the research, the interview questions and what will happen to the information they provide.

The participants needed to give informed consent to participate, either verbal or written. Before the interview began, participants signed a consent form to give consent to participate. If a phone interview took place participants gave verbal consent over the phone, which was audio-recorded. Participants needed to agree to have their interview audio-recorded and to provide their email address so I could email the participants a summary of their interview. I restated that their responses would be confidential but I asked for consent to use their verbatim quotes in my report. I reminded participants that the quotations would not be attributed to them (i.e. the source will be unidentifiable) in my final report.

The participants were informed about their right to withdraw from the research at any stage without any explanation or penalty, through the information sheet, on the consent form and were also told verbally before the interview began. Participants did not receive any form of monetary or

material incentive or compensation for participation in this research. Participation was entirely voluntary.

Privacy, confidentiality and anonymity

Every effort was made to protect the identity and confidentiality of the participants of this research. The only personal information obtained during this research was the participants' first names and email addresses so I could send participants a summary of their interview and final results of the study. Participants were told that they did not need to use their real names. The information collected in the interviews was anonymised. Any identifying information regarding places, the names of service users, staff, mental health organisation or any other individuals, was removed as soon as the interviews were typed up. The audio-recordings were stored on my laptop, which had a password to keep it secure. The recordings were deleted as soon as they were typed onto my computer.

Responsiveness to Māori

I am of Pākehā origin and do not have a lot of knowledge about Māori culture and Māori worldview. In order to be responsive to Māori, I consulted with Māori staff members at the University of Waikato about the research topic when in the early stages of this project.

This research has the potential to affect Māori as approximately 19% of community mental health support workers identify as Maori (Peters, 2010). This research could also impact Māori as Māori comprise approximately 33% of NGO mental health service users (Peters, 2010). Māori service users could be affected by this research by any potential changes made regarding the staff caring for them (Acker, 2012; Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011). It was important to have Māori participants in this study to represent the different cultural perspectives of community support workers. I did have access to Māori participants through the different recruitment methods that I used. However no Māori participated in this research.

If any participants were Māori I would have incorporated Māori tikanga into the interview procedure such as offering refreshments, asking if

participants would like to do a karakia and introduce ourselves through Whanaugantanga before the interview, to ensure that Māori participants felt more comfortable with the research process (Hudson, Milne, Reynolds, Russel, & Smith).

I also intended to identify the responses by participants as coming from either Māori or Pākehā participants so that the different cultural perspectives are clear and the views of Pākehā participants were not assumed to be representative of Māori support workers. The results of this research could potentially be generalized to Māori mental health support workers, which would not necessarily accurately reflect Māori experiences. I have attempted to make my cultural background as explicit as possible in my final report in order to elucidate the context of my decision-making and the interpretations I have made throughout the research process. I have made it clear that my interpretations have come from a Pākehā cultural lens.

Social responsiveness

Participation was open to all NGO community support workers, regardless of gender, ethnicity, sexuality or culture. I have chosen research methods that are exploratory, inductive and enable the researcher to listen to the voice of the participant as much as possible. I have intended to make participants feel comfortable and welcomed by offering refreshments and using a research method that resembles a one-on-one discussion about topics of interest to the participant and allows participants to speak their minds. The option of a phone or Skype interview was available for participants who were unable to spend money or time travelling to do the interview.

I have written and based my research procedure and questions in light of the ethical guidelines for psychologists and the relevant literature. I have also consulted with my supervisor about the ethical appropriateness of my research.

Dissemination of findings

A summary of the findings of this research will be emailed to the participants. A presentation of key findings will also be delivered to the Public Service Association in return for their assistance with recruitment.

The findings will be disseminated in a thesis document, as part of the requirements for fulfilment of the Masters of Applied (Community Psychology) degree. The thesis will be made available online through the University of Waikato Library.

Chapter Four: Findings

Job tasks associated with mental health support work

Participants were asked to describe their day-to-day work as a mental support worker in order to determine whether the job tasks are synonymous with the unpaid domestic labour that has traditionally been undertaken by women. In general the participants' responses were homogenous and therefore were combined to create an overall summary of the job.

Mental health support workers work with people in the community experiencing mental illness. Support workers often work with long term mental health service users or forensic clients who experience a range of different mental illness across the spectrum. All of the participants worked with clients in either supported accommodation, residential settings or visited clients in their own homes. Support workers sometimes work with clients indefinitely and with other clients there is a set timeframe. Some mental health support workers create recovery plans with clients and all support workers support service users to carry out their recovery plans, which involves helping service users to achieve their 'wishes', 'goals' and 'aspirations'. Support workers cater their support for each person in a unique way that suits the client. The goal plans are collaborative and usually involve the input of different agencies, clinical teams and families. Support workers described their work as unpredictable in that they never know what they were going to get each time they go to work. Participants emphasised that they were not supposed to do anything for service users but instead work alongside them. However some participants commented that they would often pitch in with housework in order to help with rapport building. Participants spoke of taking on many roles as a support worker. Support work involves a range of duties that generally fell into four categories that included support with day-to-day tasks, social support, emotional and relational support and practical tasks.

The goals service users work on predominately revolves around supporting service users to meet to their basic needs. This includes supporting or motivating a client with getting out of bed, personal hygiene, developing routines, cleaning, doing washing and prompting to do chores.

Support workers also take service users grocery shopping, teach them how to budget, cook and develop healthy eating habits. Moreover the job is often focused on medication support such as administration, ensuring compliance and driving people to medical appointments or blood tests. Some support workers in residential setting also have to oversee visitors coming on site and issue trespass notices, monitor clients drug and alcohol use and observe clients if they come home drunk.

Support workers also assist service users with social activities which can include taking people on social outings, providing company, supervision in public, supporting people at psychiatrist appointments or attending meetings with clients. Moreover social support can include making referrals to employment and housing agencies, liaising with health professionals and other community agencies and planning day activities for clients.

The emotional and relational aspects of the role involve using relationship counselling skills such as developing therapeutic, professional relationships with clients, helping people deal with stigma, listening, advocating on service users behalf and helping people find their interests. Support workers also must utilise distraction techniques and assist people having psychotic episodes, seeing visions, hearing voices especially at night time, or people experiencing a lot of anxiety, such as if they are homebound. Moreover, support workers help people get through a rough day, work with suicidal and self-harming clients, deal with aggressive or violent behaviour and verbal abuse. The job also involves helping people with behaviour management through behaviour expectations and also must de-escalate threatening behaviour.

The practical aspects of support work entail monitoring clients behaviour, writing daily notes and long distance driving across regions to visit clients. Support work requires lots of paper work such as through writing service reviews, documentation, signing forms, having knowledge of and following legislation, policies and procedures.

The results demonstrate that many of the job tasks required in mental health support work such as supporting service users to meet their basic personal and social needs are analogous with the work involved in caring

for dependents and domestic labour that has traditionally been undertaken by women (England, 2005; Folbre, 2006; Stacey, 2005). Women have historically carried out housework and domestic tasks in the home such as washing, cooking, cleaning, personal cares, and emotional and relational support whilst men are considered the primary breadwinners out of the home (Charlesworth & Marshall, 2011; England, 2005; Folbre, 2006; Stone, 2000). Arguments regarding women's biological or essential nature underlie assumptions that domestic labour is naturally 'women's work' through which women are believed to derive great satisfaction and pleasure (Charlesworth & Marshall, 2011; England, 2005; England & Folbre, 1999).

Many of the job tasks involved in the relational and emotional, practical and even day-to-day aspects of support work are more aligned with the work that has traditionally been the realm of trained, professional, regulated workers. For example dealing with psychotic patients, using counselling skills, administering medication, implementing distraction techniques, knowledge of policy and documentation, employment and housing referrals has previously required training in mental health nursing and social work (McCrae et al., 2008; Murray et al., 1997). This finding is corroborated in the literature which states that there is interdisciplinary overlap of the job tasks involved in mental health support work with that of mental health professionals (Cowan, 2008; McCrae et al., 2008; Meek, 1998; Murray et al., 1997).

Overall these results indicate that while many of the job tasks are associated with domestic labour, mental health support workers are also expected to do tasks that have been carried out by professionals in the past. The invisible nature of relational and emotional labour could explain why the depth of work being performed by support workers is not being recognised (Aronson & Neysmith, 1996; Stacey, 2005; Stone, 2000).

Themes regarding the working conditions of support work

In order to gain a vivid picture of the working conditions mental health workers experience, a thematic analysis was conducted on the data obtained from the interviews. The most common responses were developed into main themes and subthemes. The findings are reported in

the order of the response frequency of the main themes. The nine main themes which emerged were wages, clients, colleagues, the system, staff turnover, guidance, safety, hierarchy and funding.

Wages

The low wages received by support workers was one of the most common themes to arise across the entire data set. Thirteen participants did not believe support work was fairly remunerated;

“The pay is pretty dismal... rather ironically actually because the mental health certificate I am doing talks about the factors that contribute to wellbeing or conversely, or what contributes to poor wellbeing and one was of course people’s economic situation, you know people who live in poverty are more likely to struggle with many things, and Charles Waldegrave has written about the Living Wage, and it’s beneath! The pay is \$15 an hour its ridiculous you know, I cant believe it.”

“One on the pay scale would be about \$15, for caring for people who have acute chronic mental illness. It requires a particular sort of temperament to deal with service users, at one point previously we had a woman in the house who would self-harm, there would be a knock on the office door and she’d say I just cut myself. I’m not a nurse you know, and here I am having to deal with this person who has blood pouring out of their arms with deep cuts”.

For eight support workers, low pay was a significant issue and reason why they had already left support work, did not see it as long term career option or were currently dissatisfied and looking for other work;

“My dissatisfaction with pay and the conditions, things like not getting breaks, high staff turnover and the amount of work, mean that I look for other work and am currently considering other options, furthering my qualifications and those sorts of things. But in the first instance it is the income, I would like a better wage, that would be the first thing.”

For six participants dissatisfied with pay, the low wages did not detract from the overall satisfaction they derived from the work. All thirteen of the participants stated they were not doing the job for money but they still thought it would be gratifying to be paid more. Three staff believed that while they personally were able to manage on the low pay, it was recognised that staff who have dependents or other high living costs would struggle to get by;

“I’m a single person without dependents so...my salary total... is fine for me but... if I had to travel to work or if I had family then I think it would be a different kettle of fish”.

“I basically had three jobs, so because I was doing that, I could afford to live but otherwise it was unaffordable”

All of the participants commented that they received other benefits to doing support work such as finding the work very rewarding, got excellent work experience, they learnt about themselves and felt privileged being a part of other people’s lives;

“...mostly I feel this kind of work, and what I like about it, it is that simple things can make a difference to people’s lives, it’s people helping people”.

All thirteen participants dissatisfied with pay believed that support work warrants higher wages with regards to the skills required to carry out the work and the complexities staff have to deal with on a day-to-day basis;

“For the knowledge that is required to do the job effectively, you will not find anyone fully qualified with that knowledge who would also be prepared to accept the rate of pay that is offered. And it is not because the organisation doing anything wrong, it is simply because of funding”.

Moreover, nine participants believed support work was not paid high enough in relation to the responsibility staff have for the others’ lives, job risks, challenges and relative to other professions or jobs they had done in the past. The difficulties participants faced in their work predominately

came from interactions with senior or clinical staff, the nature of the clients' illnesses and the problems inherent in the system in general;

"I'm still not there for the money but it would be nice to be paid in better terms of the crap we have to put up with, particularly from management and the challenging times with people we support. That would be nice especially if my contract is being presented as something else"

"I definitely think the work deserves to be paid better. There are bits in the role which can be very low skilled, just driving from A to B but at the same time there are bits which you really do need to be on your game, noticing signs or just when someone has had a bad day and that, you do need to be able to help them through that, stressing out or something like that. Every so often we get assaults, not necessarily at us but just somebody assaults somebody else and we are involved with one or more of the parties involved. Or people get suicidal and things like that so you do have to be able to cope with that and react appropriately and for that I think, I think it does definitely deserve more financial recognition".

"...one client had incontinence issues and craped all over the floor one time and it wasn't very enjoyable having to clean that up, that's not pleasant. I suppose when you are on the receiving end of some quite intense verbal abuse because someone is having a moment and even though you know they are having a moment and in ten, fifteen minutes they will have calmed down, and probably come and apologise, at the time that's not pleasant".

Eight participants also believed that the job requires a particular sort of person to do the job, which deserves greater acknowledgment;

"...we are dealing with people who do have these significant issues and it requires a certain type of person to deal with them and so it would be nice to be paid a bit better"

It was also noted by five participants that mental health support workers who had been in their job for many years, were not on much higher wages than when they first started;

“...the pay here is lousy, there are people that I have worked with who have worked here for five years without having a pay rise. So that’s a definite issue”.

Eleven participants claimed that there is no structure or automatic method around wage increases in support work, you have to wait for management to approach you about this or you have to demonstrate and convince them through a performance review:

“Pay varied between staff members... in my current job I started on lower pay but I managed to climb up consistently, systematically, they said these are the steps, this is what you need to do, this how you go up. In mental health support work it was very unclear, so that was very unrewarding.”

“...at a previous employment of mine we had an annual increment that you went up as a matter of course and you also had CPI adjusted increase every year, my organisation doesn’t have anything like that, you might get an increase but its not a given, you don’t automatically move up, you have to go through this performance review thing”.

This lack of consistency means that there is the potential for management have control over staff wages. This makes staff vulnerable if support workers do not have a good relationship with their manager. Managers have the power to withhold staff increases in wages, which is exemplified by one situation a participant found herself in;

“...I asked for a pay rise. I got my appraisal, you are supposed to get appraised every year, I got mine after two years, even though they are supposed to approach you...So once we got the appraisal done she gave me under average even though I was running a house... I had also trained probably ten staff members by then... So how is it possible an under average

worker was training future workers? So you could tell I was black listed. I wasn't the only one".

Four participants felt they did not want to bring up issues over pay with their bosses as they were afraid it could jeopardise their position or didn't feel it was necessary to ask for a pay increase because they are not doing this work for monetary reasons;

"I am getting a couple of thousand under what my contract says, if I really felt like it I could take it to my union but to be honest, it's just, to me in my heart it's like a like non-issue, I mean in all honesty it would be nicer to get better pay but it's not why I'm there at all. I just don't want to create any unnecessary tension."

These findings are consistent with the literature which indicates that most mental health support workers in New Zealand are dissatisfied with the remuneration levels of their job (Te Pou, 2010). Participants' perception that support work is not paid relative to job demands and other male-dominated occupations is also backed up by job analysis research (Bourgeault & Khokher, 2006; England et al., 2002; Public Service Association, 2008). The widespread discontent with the pay of mental health support work is analogous with experiences of home care workers from other fields such as elder care (Aronson & Neysmith, 1996; Denton et al., 2002).

While caring roles and 'mothering' are held in high regard by society, this respect does not convert into a high appreciation of care as form of paid labour. There is a social expectation that women 'should' take on nurturing and mothering roles purely for 'love', rather than pecuniary interests (Knijn & Kremer, 1997). England et al. (2002) argue that this perception extends to care labour so that workers are expected to accept a wage penalty, in effect to prove their level of intrinsic motivations for care work.

Dichotomous either/or discourses about love and money are prevalent in western society and foster ideas that the underlying motives for work should either be implicit for example deriving pleasure from helping others,

or explicit such as for financial reasons. Moreover, that care is most effective when it is carried out for intrinsic reasons, rather than for pecuniary interests (England, 2005; Folbre, 2001, 2006).

The compensating differentials theory suggests that lower wages screen out workers who do not gain intrinsic satisfaction from caring for others, implying that people who seek higher pay for care work are not going to provide a good service (England et al., 2002; England & Folbre, 1999). The idea that care is better if carers are driven by altruistic rather than monetary incentives is a deeply imbedded social ideology (England, 2005; England & Folbre, 1999; Engster, 2010).

The standard compensating differential theory is based on a number of fallacies. Not all people are motivated to do care work in order to gain intrinsic satisfaction. The lack of entry level requirements and availability of work due to workforce shortages may draw people into the occupation who cannot find work elsewhere and therefore have a purely financial impetus (Tronto, 2010). Some people may enter the job initially because of the intrinsically rewarding nature of the job, but the inherent job satisfaction may wear off over time. Research shows that the fulfilling aspects of a job only serve as a short-term buffer against inadequate working conditions (Rössler, 2012). Even if intrinsic motivations do foster better service quality, employees have minimal influence over work contexts that may suppress enjoyable aspects of the work (Denton et al., 2002; Paris & Hoge, 2010; Rössler, 2012; Salyers et al., 2013).

The argument that care work entails a wage disadvantage because the job is psychologically rewarding is biased (England, 2005). Most people are drawn to certain types of work because it is deemed to be interesting and less arduous than other jobs, or is satisfying to them at some level. These intrinsic drivers encourage the successful performance of all workers (England & Folbre, 1999; Folbre, 2006). England et al. (2002) and Folbre (2006) contend that the tendency of the 'comparative differential' theory to be applied to predominantly female based work and to emphasise the implicitly rewarding nature of labour associated with women as opposed to work carried out by men, is further evidence of discrimination against

women. England and Folbre (1999) reviewed the available literature and concluded that wage premiums are not always evident in jobs with undesirable characteristics. Therefore the compensating differential theory does not have an empirical basis (England & Folbre, 1999).

The collective benefits of care work are the result of the skills care workers have helped to cultivate in the direct beneficiaries of care and are dispersed throughout society (England, 2005). The true value and widespread social benefits of care labour are indiscernible and invisible are therefore not reflected in the wages of care workers (England, 2005; Knijn & Kremer, 1997; McCrae et al., 2008; Shepherd & Meehan, 2013). It is difficult for NGOs to prove their economic merit using traditional measures (Peters, 2010; Platform, 2013). It is inherently difficult to measure the 'social value' or performance of a service such as how well it cultivates principles of recovery, community participation and wellbeing. Positive outcomes for service users may also be the result of the work being conducted by multiple agencies (Platform, 2013). Accountability frameworks are needed which include indicators that measure the social value of services (Platform, 2013).

The supply and demand theory posits that conventional market forces of supply and demand can adequately regulate paid social care services (England, 2005). In reality the rationality underlying supply and demand logic does not apply to social care. This is because a third party, rather than the client, generally pays for formal care. Moreover, market forces do not take the relationship between quality of care and client outcomes into consideration (Charlesworth & Marshall, 2011; Tronto, 2010). The result is that an inadequately regulated care sector market subjects workers to low wages and clients to poor quality outcomes (Charlesworth & Marshall, 2011; England, 2005; Folbre, 2006; Tronto, 2010). Furthermore shortages in the supply of care workers in many countries outweighs demands for services and yet this has not led to more appealing wages for workers (England et al., 2002). Low wages combined with a reputation of bad institutional practices, limited career progression opportunities and dependence on restrictive government budgets, make recruitment and retention of employees in the care industry a serious challenge

(Bourgeault & Khokher, 2006; Charlesworth & Marshall, 2011; Rössler, 2012).

Clients

Twelve participants stated that working with clients and developing therapeutic relationships with them, is a very rewarding aspect of their job;

“The clients are amazing”

“The clients, I have to say they were really, really great to work with. A lot of them. Just because you learnt a lot and you could do a lot”.

Twelve participants stated that they find mental health support work very fulfilling because it enables them to help others;

“...because I am working so closely with people in a really critical time and just by supporting them, maybe people don't realise what your doing and you don't necessarily get rewarded from it, from other people, your rewarded by the work itself and that's a reward as a human being, to be able to do things that help other people.”

“I think despite a lot of the negative things I've said it can actually be a very rewarding job and if you have got a genuine interest in helping people in the community, it is actually very rewarding, as I said despite the problems that arise on a regular basis”

Nine participants explicitly stated that they were not doing the job for monetary purposes or that it was not a job people do for those reasons. Rather people derived a lot of pleasure from the relational aspect of the work;

“You get a very privileged look at people's lives and very personal aspects of people's lives which I find rewarding and a very special thing to be invited in to share that part of their life and to help or support in some way”

“...getting to know people is a special privilege, the work can involve quite private and intimate matters...”

Thirteen participants stated that seeing clients' progress was also very rewarding, whether clients were making small changes, moving into the community on their own or simply being kept stable;

“So a lot of it was very small steps. Just keeping the client well for six months was a really great feat”.

“The change that occurs isn't massive, over time it can be”

“The rewarding aspects were when people actually started to make changes in their lives and were doing the things they enjoyed doing and you could just feel it when you were around them. Yeah it was definitely a fulfilling job. When it was bad it was bad, when it was good it was really good”.

These findings are consistent with the literature that suggests that many care workers find meaningful work satisfaction in the relational aspect of their job. Intrinsic satisfaction from caring labour derives from finding fulfilment in the strong interpersonal bonds formed with clients and having a direct positive impact on others' wellbeing (Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011; Denton et al., 2002; England, 2005; England & Folbre, 1999; Folbre, 2006).

Four participants described how the configuration of their shifts or the physical set up of their work environment, such as working in a residential service meant they perceive their clients as 'family';

“...having meals with the clients, sleeping there and getting up in the morning, you become a bit like they are a part of your family really, so I think, I suppose one thing that nurtures me in the work is the relationships with the people I support.”

The blurring of boundaries between informal and formal care work has also been found in previous literature with mental health workers (Johnson et al., 2013). Research shows that the obscure boundaries between formal and informal caring relationships, can lead to carers developing a strong

sense of obligation towards their clients (Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011; Denton et al., 2002; England, 2005). Evidence of the moral demands support workers face was portrayed through comments by three participants that had witnessed other staff giving clients clothing, food, cigarettes or allowing them to contact them outside of work. Moreover one participant had observed that some staff did not appear to have strong 'professional' boundaries in their work with clients, which made their job more challenging and sometimes put other staff at risk;

"...we were supposed to have professional boundaries but some staff would do things such as give the clients cigarettes, and then one time a client came in and asked another staff for a cigarette and they said no and he threw a cup at her and that was because other staff had been doing that so the client had the expectation that all staff were gonna give them cigarettes, then when you say no they get pissed off and that could have been really serious".

"A lot of support workers refused to believe that professional boundaries were useful...Some of the support workers would give their phone numbers out to clients and things like that which others of us would absolutely refuse to even consider, because that's not even going to help anybody".

Feminist academics have argued that the inherent satisfaction that people derive from caring labour is a central source of exploitation which functions to conceal the unjust working conditions care workers experience (Charlesworth & Marshall, 2011; Denton et al., 2002; Folbre, 2001; Stacey, 2005). The exploitative arrangement is sustained through the obscured distinction between formal and informal caring work and the loyalty care workers develop towards clients (Denton et al., 2002; England & Folbre, 1999; Hochschild, 2012; Stacey, 2005).

According to the 'prisoners of love' theory, the intrinsic satisfaction carers' gain from their work, which occurs alongside the poor working conditions carers experience, puts carers in a precarious position. Carers must either

take some form of action such as a strike to improve their situation, leave their job, or are forced to accept the unjust wages and oppressive work conditions (England, 2005). Workers are well aware that the people they care for will suffer as a result of such action, which will have the most direct and harmful impact on care recipients (Denton et al., 2002; England, 2005; Engster, 2010). Care workers then become what has been described as 'prisoners of love' whereby they feel that they cannot abandon their clients or their work in order to demand higher wages and better conditions and thereby end up putting up with it by remaining silent or find ways to justify their situation (England, 2005; Engster, 2010; Folbre, 2001).

While the work with service users was often the most enjoyable aspect of the work it could also be the most challenging and frustrating. Six participants stated that most of the clients they are working with have very high and complex needs due to the nature of their mental illness. Most clients have had traumatic experiences in the past and turbulent relationships with their families, which can affect their interactions with staff. The tumultuous backgrounds of many mental health clients are supported by the literature (Caird, 2001; Pace, 2009a; Reid et al., 2005).

Ten participants spoke of how being at the receiving end of verbal abuse from clients was a very challenging aspect of the role. Verbal abuse was considered innate to mental health support work. In some services verbal abuse is a rare occurrence;

"...one of the residents in the house has quite a volcanic personality and will maybe throw things around a bit and stuff, not necessarily really at people but that has no doubt happened too, but that is few and far between and that's I guess what you are there for."

In other services it occurs on a daily basis. One participant described the high level of needs of the clients they work with, especially one client who had been removed from the service on numerous occasions for assaulting support workers and threatening behaviour but keeps getting placed back in their service after a short stint in hospital;

“...like a lot of people we support, they have been brought up in a environment where there wasn't any hope for them to start with and so they have been introduced to drugs and violence from a very, very young age through their parents and so now when you are trying to negotiate or reason, it can be very difficult to get any message through and there are a lot of assaults and that going on, a lot of abuse a lot of shouting, a lot of swearing and some days you might have some small break throughs and get what you are trying to get and other days its just like hitting a brick wall”.

Eight participants said that another difficult aspect of staff client interactions is constantly trying to get clients to do their daily chores and other activities;

“It can just be physically draining and mentally draining when you are negotiating like that all day and they are not the only client, because we are a level four, we have clients who typically have a lot of behavioural issues and so it can just be that the battle that you were trying to fight yesterday you will fight again today. An example is trying to get people to do their chores because we have a roster for the housework and trying to get people to do that or trying to get people to cook on their rostered day, that's just an on-going battle, and its one of the things that you can't just give up because it is your role, we are trying to transition the people back in to the community so it's an important part but it can be quite draining trying to obtain that.”

“The interaction with clients can be challenging because of the reluctance or push back you might to call it, that's probably there all the time. It may come and go but it's usually there with somebody.”

Six participants highlighted how emotionally draining working with clients with chronic mental health issues is and how difficult it could be to learn to switch off from work;

“There would be some clients that were just so, so heavily depressed or had so many issues that you would get dragged into that stuff and being quite naïve about the whole thing and not having the proper supervision or training, that just happens and it’s really difficult because you get brought into all their emotional issues and it really affects you and so that can be really difficult and completely emotionally draining.”

“It took a year working in the job to shut out work at home. That’s quite normal I learnt with other people. You end up mentally taking your work home. And that’s not until you get a grip, because it takes about three months to get used to a new job, but the mental element with mental health just took a lot longer, but once you learn to shut it off and not to worry then it becomes a lot easier, but I do remember that being quite difficult for at least a year”.

Four other participants stated that they did not find it so difficult to leave work at work;

“I have been doing this work for a long time and am pretty good at being able to leave things at the door when I leave and not get emotionally involved”.

Four staff also spoke of how disappointing and frustrating the work could be if a client was unable to achieve their goals or things fell through for them;

“It is certainly draining and stressful in the sense of when you want a particular outcome at a particular time and for it to happen in a particular way, and when it doesn’t and it takes longer, it’s not quite what you would want it to be or what you think the service wants... it is challenging in that way, you don’t always get there or what you want. A lot of time you do but it can be a bit of a challenge to get there”

The comments made by participants regarding their work with clients illustrates the inseparability of the emotional and practical tasks involved in

care work (Aronson & Neysmith, 1996). Moreover the results indicate how difficult many support workers find the negative aspects of the relational and emotional features of mental health support work. The participants descriptions of how challenging the work with clients can be, contradicts the assumption that the work is 'unskilled'. These findings reinforce the idea that the emotionally demanding nature of mental health support work is deserving of greater recognition.

The worth of certain skills in society are largely determined by the labour market, which is imagined as masculine. Consequently the skills required of female-dominated caring labour such as empathy and patience are not culturally coded as being important or significant (England, 2005; Tronto, 2010). Emotional and relational based labour are not highly visible and are perceived as a 'natural' female quality or simply requiring common sense and therefore goes unrecognised and unrewarded (McCrae et al., 2008; Shepherd & Meehan, 2013; Stone, 2000). Jobs culturally coded as masculine are deemed worthy of greater recognition and value (England & Folbre, 1999)

Caring skills are viewed as innate and are generally overlooked (Stone, 2000). They are not the sorts of skills or functions that are believed by society to warrant material rewards as this type of work relates to the traditionally unpaid care work undertaken by women and mothers (England et al., 2002). Care skills are perceived as less demanding or strenuous than skills required in non-care jobs and it is presumed that limited abilities are needed to meet the needs of those who require intensive caregiving (Bourgeault & Khokher, 2006; Stone, 2000). Domestic based care work is often paid worse than other female dominated occupations (England, 2005; Stacey, 2005).

Colleagues

The importance of relationships with colleagues in mental health support work was not a theme that has been recognised in previous literature. However findings from this research indicate that colleagues could have a major buffering effect on the poor work environment that support workers

experience. Twelve participants made positive comments about their colleagues;

“The colleagues are a very big part of how supportive things are.”

“The colleagues are fantastic because there is quite a diverse range of people”

“I find the staff are the biggest support for the company that I work, for me. We support each other strongly, which is quite nice.”

Colleagues are incredibly helpful to talk to about work issues and for informal peer supervision especially when staff are not receiving adequate individual supervision;

“So it is really helpful when you have got another staff member on, or doing activities together outside of work with co-workers, because they know what you go through. Not many other people know what the job is actually like”.

“My co-workers were good to talk to and to vent to, as we all understood the frustrating things we were going through”.

Eight participants recognised that it takes a special kind of person to do support work. Despite this, five participants stated that they felt sometimes organisations would hire staff that didn't appear to be particularly suitable;

“It seems to be the assumption that anybody who wants to help, and has some familiarity with mental health can just do the work, and do it well enough, and I mean yeah they probably aren't going to go on and do any harm to the clients, but they are not going to really help them and work within that recovery model which is what the organisation is trying to do”.

However six participants did not feel that there was a widespread social belief that anyone can do mental health support work;

“I don't think there is an assumption that's its not a difficult job, because when I tell people what I do they say 'oh that must be really challenging'.”

Denton et al. (2002) argues that the employment of care staff with limited qualities, skills qualifications and background relevant for care work is a common practice in the care industry which compromises the reputation of other highly skilled staff and perpetuates low remuneration expectations of the work. Moreover, the practise of hiring inappropriate or unqualified care staff feeds into the assumption that care work entails skills which anyone can posses and in particular requires abilities that are 'natural' qualities of women (England, 2005; Folbre, 2006).

Six participants also spoke positively about their relationships with other health professionals;

“I found my nurse particularly helpful because they have a lot of experience and they have been though really horrible experiences themselves. A lot of the time they know exactly what you have had to deal with in terms of behaviour so they are like a really valuable resource”.

“The psychiatric district nurses that we were involved with, we were all on the same page, we all knew how hard this job was and we knew that by and large we were very underappreciated but we all had the same focus and that was making sure these people were staying in one piece and when you've got that outlook on life and you really value that it has a very cohesive effect. There was a lot of solidarity between us and everyone else except psychiatrists but within our NGO there were some very qualified people, if anything there was a lot of admiration for the fact that we stuck with it in the face of all the of dangers and all the rest of it.”

Four participants did express some negative experiences of working with health professionals;

“Clinical staff don’t do it intentionally but they treat you like a little kid, like you can’t think for yourself, they feel they have to make all of the decisions and they have to micro-manage you. And you feel like saying to them, excuse my language, but ‘fuck off’, of course that’s not what I say, but it’s actually quite offensive and some of these people are the same age as me, with less education than me”.

“I never had any trouble with people not taking their meds. Although one time a woman took the wrong meds, it was my job to watch her take her medication, and we were talking, as I was still new and trying to build a rapport with her, and she took the wrong dose of medication. I felt really awful and I had to take her to the hospital, so med support is actually a really big responsibility, if they take the wrong medication it can be really serious, life threatening even. When I called the clinical team to tell them what had happened they made me feel really guilty and that I was a really stupid and made me feel terrible about it”.

The relationships with health professionals reported by support workers is reflected in previous research by Murray et al. (1997) which found that overall most health professionals are in favour of the establishment of the support worker role. However there are some mental health professionals who continue to have reservations about the ability of support workers which derive from their concern over support workers lack of training and professional regulation (Murray et al., 1997).

System

Three participants claimed to have quite a lot of success when working with clients on their goals;

“I do see a lot of change in the clients, for people who don’t they tend to not keep their support for long, for people who do want support they keep it and they use it”

Seven participants commented that the main focus of support work is predominately about supporting people to take their medication. Seven participants said the nature of service users' mental illness mean that in reality it is very difficult to work on 'recovery' as clients are so unwell;

"A lot of the time the goal setting just went out the window, a lot of what you used to have to write down in the report was fabricated because that was what they needed to hear. We discussed this, we did that, when in fact the client didn't even know what day of the week it was or what his name was. So very unrealistic a lot of it."

"Some people were just walking around talking to their voices constantly so they weren't even able cook or do much for themselves."

"The organisation did have a goal setting approach but it was very badly designed for mental health... You can't tell a 53-year-old guy what are your dreams and aspirations? So you need to say 'hey I know it is difficult to get out of bed, but do you know you have got eight hours that are really functional and you've got an unlimited car, and I can help so what do you like doing?' It's more of a realistic approach. So the company had a really good goal setting approach but it was not applicable to mental health".

Five participants comment that their work with clients is more analogous with caregiving than support work;

"...well I'm a glorified babysitter really".

There was a sense from some participants that mental health organisations had the recovery philosophy in their visions and values but this was simply rhetoric that organisations did not promote in reality. Nine participants often did not see recovery philosophy being put into practise either in their work with clients or the organisations treatment of staff through working conditions;

"Its not a role that I would say is recovery focussed, I don't think we are practising recovery focused principles, I think we are more carers and so that's what's we are doing, caring for people day after day. The organisation doesn't promote recovery at all, they have it in their visions and values and that's it".

Four participants said they had to work against the system or management a lot of the time to make the system work and to really help people, which put their job at risk;

"Like some of my colleagues, I worked under the radar, I worked covertly most of the time, I had to, otherwise I would have been dismissed. For example one client was being exploited...I decided to tackle this and my senior said to me they didn't want to know about it, this sort of thing could hit the newspapers and we could suffer adverse publicity and loose the DHB contract. So I worked under the radar and I threatened them myself and said if you don't do something about this I'll make sure that its dragged through the courts and I'll make sure of that, my client is well enough funded to see you guys wobble, there was a lot of things that you had to do covertly in order to make the system work".

The on-going problems and difficulties with the system that mental health support workers encounter, from trying to work within a recovery philosophy on the one hand and medical model on the other have not been widely documented. It has been recognised that mental health organisations are attempting to function from a distinct philosophical approach to clinical services (Mitchell, 2009). For some support workers working with clients with incredibly complex needs, the medical model and recovery model appear to be incompatible and fundamentally flawed.

The perception that many mental health organisations are not putting recovery principles into practise corroborates with previous literature that suggests that many services adhere to recovery rhetoric but have made limited progress in terms of putting principles into practice into reality

(Curtis, 1994; Jacobson & Curtis, 2000). Service user advocates contend that in the absence of a fundamental shift in power within the system, there is a strong likelihood that superficial initiatives, which foster dependence on the system rather than genuine community integration, will continue to be generated (Jacobson & Curtis, 2000).

The difficulty many support workers experience with putting recovery principles into practise through support work is also a common theme found in the literature (Shepherd & Meehan, 2013). According to Caird (2001) the problems support workers encounter with putting recovery principles into practise could be due to the fact that a lot of policy was written without the consultation of all the key stakeholders who are having to use the recovery principles to guide to their work on a day to day basis (Shepherd & Meehan, 2013).

Staff turnover

Five staff commented on the high staff turnover within their organisation and the associated problems with low staff retention;

“As a result of issues with pay and conditions we have a high staff turnover which is an added stress, an added reduction in the conditions of the work which in turn contributes to the high turnover itself, it’s a bit of a vicious circle, and the service, you’ve got so many people coming in through the doors, the people we support aren’t going to bother to try and get to know new staff if you’ve got new people coming in every few months wanting to talk to you, you don’t want to keep having to tell them your life story, all those sort of things feed in to the turnover, which makes me want to be somewhere else quite a lot of the time.”

Another participant pointed out that consistency in staff approach is crucial for service users recovery, but this goes out the window when temporary staff are always coming though.

While not all participants mentioned high staff turnover as an issue within their organisation nine participants referred to support work as a dead end

job which is attributable to a lack of job and pay progression, poor wages and overall working conditions;

“...it’s considered a dead end job and this is as far as you go with this qualification which is level five, you can get in from either doing 2 years of nursing training or doing level five certificate and I think that again this is feeding into the expectation or stereotype that people who do mental health support work haven’t got the brains or the knowhow or the motivation to learn more”.

“I think if you did have more pay and the pay was better then it would be the kind of thing that people might want to make a career out of”.

“For me, if organisations are able to reduce the high turnover I would say there needs to be better pay, better working conditions, a reasonable workplace, all the things that can go on to making for a better work environment for the staff is gonna help, I don’t think that’s going particularly well in the services as far as I can see it”.

One participant who was extremely dissatisfied with many of the working conditions in their organisation said that low staff turnover within their service was accredited to their great group of colleagues;

“We don’t get a high staff turnover but its because the team itself, the integrity of the team is really good, its healthy, its strong, its funny and I think that’s what keeps us there. And all out registered staff, they are all good people”.

Six participants stated that mental health support work was not a job they could continue doing because the job was too emotionally draining. Five participants felt it was too emotionally draining because they weren’t getting enough support to cope with the issues that came up in their work;

“That would be one of the other things that stopped me from working there forever as well, the emotional side of the work, it is just too much for a job, you couldn’t always just leave the

emotional aspects of the work at work, whereas in a similar voluntary role I did, you would deal with similar things but you could just leave it there, but I think that was because of the excellent supervision and training”.

The current absence of supportive and healthy work environments is substantiated by consistent research findings that illustrate high turnover and burnout rates of staff working in the mental health occupations (Paris & Hoge, 2010; Public Service Association, 2008; Rössler, 2012; Salyers et al., 2013). Stressful work settings are believed to lead to burnout by incrementally eroding workers' defence mechanisms over time to the point where they can eventually cause the psychological and emotional disconnection of workers (Paris & Hoge, 2010).

Burnout is an underlying cause of high staff turnover and is a complex and multifaceted problem requiring a variety of initiatives to ameliorate it (Rössler, 2012). A number of strategies have been put forward in the literature which are believed to help alleviate work stress and reduce the costly effects of burnout to health care facilities, patient-care and the well-being of staff members (Hare & Pratt, 1988; Paris & Hoge, 2010; Rössler, 2012) This includes increasing the availability of clinical supervision mentoring and training, improving the diversity of work tasks and developing well-defined goals for patient care (Murray et al., 1997; Rössler, 2012). Moreover, creating more informal and formal support structures, competitive material and non-material benefits and incentives, having adequate staffing levels, career progression opportunities, self care training, clear role expectations and guidelines, increased clinical support, monitoring of staff burnout and open and equal relationships with managers (Rössler, 2012). There is limited empirical research that validates the efficacy of these recommendations and no direct causal link regarding the relationship between burnout and staff turnover amongst mental health staff has been established.

Increasingly, researchers are arguing that it is not emotional labour per se that is the cause of burnout in care work, as emotional based work and connections built with clients are often a source of deep satisfaction and meaning that care workers gain from caring labour. Instead, high levels of

burnout and turnover within the health care workforce are the result of the emotional labour not being fostered and supported adequately through work settings and conditions (Aronson & Neysmith, 1996; Denton et al., 2002; Elwér et al., 2010; Stacey, 2005). This finding has been supported by research in the area of burnout and mental health workers.

Research is continuing to verify that organisational and contextual factors have a more significant impact on staff burnout rates than individual characteristics of staff (Rössler, 2012). Paris and Hoge (2010) assert that there needs to be greater attention and emphasis on organisational and system level change to complement individual interventions in order to address the high incidence of burnout amongst mental health staff. Salyers et al. (2013) state that further research is needed which investigates how organisational and institutional forces suppress and foster the inherent motivations of workers which leads to staff turnover (England, 2005).

Guidance.

Three participants were happy with the level of supervision and support they received from their organisation;

“The supervision helped, we were afforded two hours a month with the person of our choice, they had to be qualified.”

Two participants didn't refer to supervision in their interview or state whether or not they received formal supervision. Seven participants said that they did not get an adequate level of supervision relative to job demands and the level of needs of the clients they are working with. Six participants did not receive any support or supervision from their managers after they had a challenging or threatening experience with a client. Six support workers did not get any individual supervision whatsoever;

“We are a bit lacking in supervision with this particular company, I haven't had any supervision. I have been with this company for about fourteen or fifteen months and I haven't had any supervision there at this stage”.

Participants who did not get individual supervision described the supervision they did receive for support work as akin to group supervision;

“The general support, such as supervision, was really poor, especially comparing this with previous voluntary phone counselling work I had done, the level of supervision we had for that was incredible, whereas supervision in mental health support work, it was kind of more like a training, it felt like the person running it just wanted to teach their thing, as opposed to working through any issues that you personally might be experiencing”.

Moreover staff that did not receive supervision had to rely discussing issues with colleagues through informal supervision or friends and family outside of the organisation;

“The level of supervision we were receiving did not feel like it was adequate for the work we were carrying out with clients, there were certainly times where I would notice there were things I had done with clients that didn’t help them at all and then afterward, after talking about it with other people, I could see that if I had had the right support around this, as I was going through it, then it wouldn’t have been the issue that it was. So I had to talk to my co-workers or people outside of the organisation about the issues I was having with clients”.

The quality of management within an organisation appeared to be central in relation to how supported participants felt;

“There was another branch of this company in another city and their manager was apparently amazing and you could just tell the difference between the morale between the two staff members”.

Previous research has also highlighted that many support workers feel that more supervision is needed for their work (McCrae et al., 2008; Murray et al., 1997; Shepherd & Meehan, 2013; Te Pou, 2010). The lack of appropriate supervision potentially reflects the assumption that the work

is not worthy of requiring adequate supervision because of its association with 'women's work', despite support workers being on the front line of a complex, challenging and high risk client base (England, 2005). The inability of organisations to provide supervisions is also due to the low and unequal allocation of funding to NGOs (Platform, 2009; Shepherd & Meehan, 2013).

Three participants stated that they received excellent training;

"The training is actually fantastic, really good training, ranging from stuff like CPI stuff which is not quite a martial art but how to deal with potentially volatile situations, how to notice when they might occur and what to do afterwards all the way through to cultural training to suicide prevention training to things on autism, or more specialist sort of areas, we usually get several days worth of training each year".

Five participants stated that although training is available it is not always very well implemented;

"There was some training provided but the time constraints meant the training was hard to access and also the training wasn't really thought through very well. For example the training about keeping yourself safe, which is pretty basic when working with people out in the community who are psychotic, but that would have taken a horrible incident or a murder for example to actually do something about it and I think that hasn't happened yet not with a mental health professional yet anyway."

Eight participants stated that there is not enough training, or that the training that is provided is very bland and too generalised. Moreover training did not cover the broad range of skills required to conduct support work effectively. Participants noted that in particular there was not enough training about mental health issues, putting recovery principles into practise and counselling skills such as the right and wrong thing to say to clients. The paperwork was considered helpful by one participant in terms of assisting with putting recovery principles into practise with clients,

although three people stated the high amounts of paperwork interfered with carrying out day-to day work with clients.

Four participants said they often relied on training or skills they had obtained from previous work;

“I had the benefit of voluntary work training, which was really useful and I applied a lot of the skills I learnt at previous voluntary work to this job. I noticed some of my other co-workers hadn’t had this same training and they would have really benefited from something like that. At my previous voluntary work they trained you in counselling skills which was listening, reflecting, which takes you out of the ‘trying to rescue the person role,’ which a few of the support workers had that sort of mentality, that these were people that they were going to go in and rescue, they knew exactly what the clients needed and would boss them around and stuff like that.”

In seven cases, support workers did not receive a full induction or training before starting. One participant said that training in professional boundaries was the most important and helpful but they didn’t receive any training about this until they had been working there for eight months;

“And a lot of the clients as well have learned behaviours, you almost want to say emotional manipulation, but it’s not intentional it’s just the way they are and have learned to react to the people that come to help them so that they can get more help out of them and the other people in their lives, and not being aware of that and not being aware of your boundaries you do just become part of that, especially prior to the training I received about professional boundaries”.

A commitment towards enhancing the training needs of support workers has recently gained a lot of momentum (Caird, 2001; Cowan, 2008). However these findings indicate a lack of uniformity and varying levels of satisfaction with regards to the training that support workers receive. Moreover some support workers begin working with clients without receiving adequate induction or training. The lack of thorough preparation

for support work in some organisations again could mirror pre-existing beliefs that support work is not a highly skilled role (Stone, 2000; Tronto, 2010).

The amount of skills and training acquired from previous work experience that support workers often bring to support work or are expected to have was also observed by support workers in research by Roen (1999). Support workers are required to have a myriad of different skills in key areas but it is not remunerated accordingly (Caird, 2001).

Six participants feel that the Certificate in Mental Health and Addictions, which is the core training for support work, is a very limiting qualification, both in terms of the course content and ability to lead to job progression or pay increases;

“...it’s sort of assumed or decided that any further knowledge is in the view of a registered nurse, if you want to know more or be more professionalised in your understanding then you need to study to be a registered nurse because only RNs are allowed to have that knowledge, and that’s the attitude, rather than encouraging people to learn as much as possible.”

Eight participants felt that there is a lot of inconsistency in the way staff approach their work with clients;

“Its interesting because the diversity of the staff and also the nature of the role, there are quite a few staff having just come on board recently, I find that there is a little bit of variation in how people go about their work or tell you what you are supposed to be doing.”

“The clients would get moved around and work with different staff, so the clients had different expectations of staff as different staff had different personal boundaries and so it would be quite challenging to begin working with a client who had been with a support worker with very little boundaries and for them to accept working with a staff member with much clearer boundaries”.

Moreover it was observed by five participants that some staff have a patronising approach to their work with clients, which impacted the effectiveness of support;

“...it’s the gut reaction you get when you see someone that really needs your help and you just want to help them and do everything you can for them and I think that’s what it was and these clients would be with the organisation for a long, long time say up to 4 years, because they just weren’t having that support to go out and do their own stuff, whereas the clients I would work with and staff with a similar approach, we might only see them for five weeks for example and then they would be off, they have a got a job and they would be doing their own thing”.

One participant believed the lack of training for support work was due to a widespread belief that unregulated workers could misuse information;

“...a lot of people say they think the health care assistant, if they knew more they would try to work outside of their scope of practise, they would have more information than they would be able to use, they might misuse the information, there is all sorts of things like that, they might not be intellectually capable of understanding it, those are the sorts of attitudes that are swimming around out there, so that’s applicable also to the mental health support worker because we are still working in the same context, even though it’s in the community”.

This participant’s observation is supported by evidence in the literature. Murray et al. (1997) found that some health professionals did express concern that mental health support workers may be incapable of appropriately utilising information gained through further training.

Two participants stated that they get excellent feedback about how they are working. Four participants did not mention about feedback. While job autonomy was considered a positive aspect of support work, six participants said that they did not get enough feedback, which meant there

was often an uncertainty factor about whether or not you are working effectively with your clients;

“No feedback is one of the other things I really noticed, you just go in to visit your client, fill in your paper work, nobody checks it, nobody does anything, then you just kind of catch up with your supervisor and let them know how your going in terms of how close you are to finishing with your client and that’s really it, if you need to change the hours with them, nothing about the content of what’s actually going on with clients”

Six participants said they often had to decide on the spot how to best work with clients and are left wondering whether they had taken the right approach;

“There was no guidance around the decisions I was making when working with clients, I was very much working on a trial and error basis”.

The perception that some support workers feel they are not getting enough feedback corresponds with findings in the literature which suggest there is a sense of role ambiguity and confusion regarding best practice in support work (McCrae et al., 2008; Murray et al., 1997; Te Pou, 2010). The absence of feedback is potentially attributed to the autonomous nature of support work whereby support workers are frequently working alone with clients. Moreover the absence of individual feedback for staff is likely to be the result of the low levels of supervision support workers receive.

Because of the complexities and ambiguity inherent in the community mental health support worker role, supervision and the creation of safe working environment is essential for staff (Curtis, 1994; Rössler, 2012). Staff need to feel comfortable raising concerns without feeling as though their level of competency is being questioned (Curtis, 1994). Insufficient guidance and support has been linked to job dissatisfaction and high staff turnover (McCrae et al., 2008).

Safety

There was once again a wide variation in the working conditions relating to the safety of staff. One participant explained how their supervisors thoroughly ensure the safety of staff that are visiting clients for the first time in their homes;

“Usually our supervisor will scout out the places first as well, if we are ever going some place new we sort of have some brief as to what the layout of the land is going to be, the cell phone reception, whether there is steps that are broken or if its dark or anything like that, so we know this is not the sort of place I go to by myself or at night, or I don’t go inside, so we can establish those boundaries very easily”

On the other hand four participants working in the community described how they or their colleagues had been sent alone into isolating and dangerous situations with no cell phone coverage and no way to call for help;

“For example one of my colleagues... she got sent up to see a guy that was completely psychotic and when she got into the house she found out that she couldn’t actually get out, and the other thing was that the house was based in the country side and there was no phone coverage”.

“There was only really one particular time where the client was quite suicidal and they were remote and there was very little cell phone coverage and I couldn’t get in touch with anybody and in that situation you just feel really helpless. Basically I called an ambulance and got them out, with what little cell phone reception I could find. The client was definitely in danger and they seemed to be very physically unwell”.

Eight staff described instances where they or their colleagues had been put in a precarious position at work and then not received any forthcoming support from their managers regarding the incident;

“In one incident a client came into the office to stab me. That was a rather unfortunate incident. I didn’t get any support from my organisation, they threatened to sack me if I went to the media about it. It was such a dangerous situation and a list of pho pars one after the other and I was very upset about it and I said to them if something is not done about it and someone isn’t held accountable for it I will go to the media.”

Another example was when a staff member was advised by her manager to shift a client outside who was already unwell and agitated;

“I ended up getting screamed at, yelled at by the client from a metre away and all you can do is just keep your calm and just pray to God they don’t hit you. If they hit you then you’ve a lot of grounds to do a lot. But until they hit you all you can do is stand your ground and that’s when I had a client who was actually in the hallway making sure that I didn’t get hurt. And it wasn’t until the third attempt when I went back and called my manager and said look this is what is happening, it’s not productive at all. It’s just aggravating the situation and she still said no I just had to keep doing it... when I rang back probably about four minutes later she said leave it because you guys are going to be late. So she was more worried about getting my client late as opposed to what had actually happened. So it was one of things where it is all about getting the job done, because safety can be put secondary”.

As the examples demonstrate, it is not necessarily due to funding that staff safety is disregarded as some of the participants’ supervisors do take steps to ensure staff are protected;

“I think what it was, was that a lot of things were being taken for granted, there were a lot of professionals in our team but a lot had been taken for granted and just simple things like keeping yourself safe weren’t actually addressed, it wasn’t through lack of funding, as I was saying our particular NGO was very well resourced”.

There are other more subtle ways staffs' wellbeing is overlooked. For example one participant told of how incredibly psychologically draining and unpleasant their work can often be, yet their managers will not let staff take breaks off site;

"...the client just went off and were screaming at me and abusing me and then they rang the crisis team to tell them to come and get me... and this went on for probably an hour, where they just stood at the locked door and just screamed at me... by the end of it your really just fatigued... now that can happen through the day that sort of behaviour...so it would be really nice just to be able to go out for a walk or to jump in the car and go down to the water for half an hour, it would be really nice to do that but of course we can't do that. So that verbal abuse is really common in our house because there are several clients that will talk to you like that."

Three participants said that they are responsible for managing breaks themselves, but this sometimes meant they wouldn't get to take breaks at all due to heavy workloads;

"It's very common for people to not to take their breaks and not to have their full breaks".

Five participants comments indicate that staff' safety is also being put at risk as organisations cannot afford, or are unwilling to provide staff with the appropriate resources to conduct their work safely with high risk clients or clients who have a history of assaulting staff;

"The funding cuts are affecting our safety. A good example is when this client was coming back...we held some meetings and we involved the union like I said, and we had a list of the things we wanted, some of it included some training, we wanted radios, we wanted a behavioural plan made up like a flow chart, we wanted a clear glass put in the office door so we could see, because this client will just sit there and knock, knock, knock, knock on the door, so we wanted a clear piece of glass so we could communicate to them through the door,

without having to unlock the door, and so they promised all of this stuff and some other stuff, and that it would all be done, but the reality was that none of it got done before the client had arrived”.

While twelve participants stated that physical assaults were not particularly common in mental health, the unpredictable nature of the role means that the potential for danger always exists. Yet it appears that for a number of the participants staff safety is not a priority in the organisations they work for. These findings are commensurate with national and international literature demonstrating that workers who provide mental health care in clients are not being provided with adequate tools and support to conduct their work safely (Hutchings et al., 2011; Roen, 1999; Spencer & Munch, 2003).

Although workplace violence in mental health is inevitable, mediative responses from supervisors can help mitigate the negative effects and reduce future instances of violence (Hughes & Gilmour, 2010; Hutchings et al., 2011). Remedial support for worker victims can include arranging shift coverage, caseload restructuring and debriefing. Moreover, psychosocial support such as through individual counselling or structured training programmes that assist workers to vent emotions and develop coping strategies can be provided as well as instituting policies that favour robust reporting and response mechanisms (Hutchings et al., 2011; Spencer & Munch, 2003). Cell phones with GPD devices, staff sign in/sign out procedures, using risk assessment tools and buddy systems can help protect workers. Education and training are also vital aspects of a safe workplace (Lundrigan et al., 2010). Hughes and Gilmour (2010) contend that staff safety plans and policies need to incorporate the perceptions of workers and encourage worker input of staff.

Considering the needs of staff and their views in the development of safety protocols provides valuable insight and helps to ensure that the safety procedures will be beneficial and effective for staff. This can in turn will help lower the incidences of violence (Hughes & Gilmour, 2010; Hutchings et al., 2011). Instituting the views of staff into safety protocols cultivates a

sense of workplace security that positively affects workers approach to their work, contributes to increased job satisfaction and improves productivity. Moreover, staff who perceive their work environment as safe experience lower rates of work related incidents (Hughes & Gilmour, 2010). Client violence needs to be interpreted as an organisational issue, rather than by attributing blame to individual worker-victims (Hutchings et al., 2011). Addressing workplace aggression is not only about reducing incidents but also ensuring staff feel that safety is a top priority (Spencer & Munch, 2003).

Hierarchy

Many of the participants' responses indirectly indicated the presence of hierarchy within mental health organisations, through the way they are treated by senior staff within mental health.

Three participants felt they received very good support from their managers. For example they stated that supervisors are always there for them if they need debriefing after a challenging incident and will listen to their concerns and needs. Conversely, six participants appear to expend a lot of time and energy having to negotiate with management in order to advocate for better support and working conditions. Participants acknowledged that managers receive a lot of pressure from their senior management and therefore aren't always able to meet support workers needs. Nevertheless there was a strong sense by many participants that they don't feel valued by management for the work they do;

"My manager gave me no appreciation"

"No there is never any recognition it. There is no 'how are you feeling, that must have been quite hard'. But the team, what we will do, there might just be a pat on the back, and it's just an acknowledgement, 'hey I know what you're going through', or it may be 'do you want to talk, do you want to sit down and have a cup of tea?', yeah so we are good like that but we don't get that from management, we don't get management coming up and saying you handled that really well or anything like that.

“...more support rather than being criticised would be pretty nice, especially for more experienced staff like us you know, even for new staff, it’s just not nice, I know they have a contract with the DHB and they have a hard line to play, I suppose to keep, as our manager says, they are our bread and butter, but even so there is still a way to treat people with respect and dignity, and when it’s not been happening its pretty clear and obvious”.

Six participants felt that when issues came up in their work with clients, they were being blamed and criticised rather than supported and guided;

“As soon as you do something wrong, they come down so hard on you instead of supporting and training you. I mean that in all respect because I have had some really nice chats with the managers as well, but in general I don’t have a very supportive manager. How can they expect us to be recovery focussed if they are not treating staff in the same manner. It’s counter recovery.”

“My manager was the one that made things very complicated. She had a very authoritarian way of dealing with things...we had fortnightly staff meetings...in all honesty the staff meetings felt like a telling off. ‘Who is she going to pick on now?’ So they weren’t very productive”.

As five participants pointed out, the quality of management within a specific organisation appears to be central to the working conditions support workers experience;

“Your manager holds a lot of power if you’re a community support worker and I found that is true for any community support worker role because they are the ones that advocate for you...So if you want supervision, if you want resources, if you want higher pay, your appraisal, it all goes through your manager, so if your manger is not happy with you then you immediately are vulnerable to all those things that could help you and that could make you work better”.

"I value the work environments that reduce the tensions that I talked about between the dynamics, say if you're managers are good, colleagues are good, if the processes for addressing issues or tensions are effective and people are active at addressing them, that reduces those sorts of things so I value that, I value consideration of the workload, I don't think that always occurs. I sort of wonder sometimes if managers and people designing the services have ever worked in the service, actually spent some time carrying out all the duties they expect of people".

Five participants told of how they had been shunned by their managers for continually trying to get issues addressed and four participants felt they often were not listened to;

"...if I persisted in trying to bring some issues to the fore because there were some issues that needed to be dealt with, I was told to leave them alone and shut up or I wouldn't work with that organisation again... So that sums it up really that organisations are saying this to their workers, that really sums up the condition of mental health work here in New Zealand. At the end of the day it's the people they care for that suffer and that's the really sad thing about it, it's the vulnerable in society that suffer".

"I was black listed. She just made my working life very difficult, in very subtle ways, because she had a lot of power. Even if you could access anything, if your manager felt threatened then you were basically in mercy because you are so down the scale. In mental health there is a huge scale, especially in private organisations".

The relationship and treatment of some support workers by their managers led five support workers to feel that they are at the bottom of the organisational hierarchy;

"So you hope that your manager would know that even though they have to deal with the upper management side of things,

they are the person who can make a huge difference to you, to your work environment. Because you're at the bottom of the line. You're the one dealing with all the dirty work."

The reference to support workers doing the 'dirty work' is synonymous with comments made by home care workers in research conducted by Stacey (2005) with elder home care workers. Consistent with research findings there was no indication that support workers internalised any stigma associated with doing support, but instead feel a great sense of pride and satisfaction from having the ability to carry out work that is often considered socially undesirable (Stacey, 2005). Support workers find that issues related to being at the bottom of the hierarchy significantly contribute to work stresses and challenges they faced in their day-to-day work (Stacey, 2005).

This perception of being low on the hierarchy was also reinforced by four support workers' interactions with medical professionals in particular from psychiatrists and doctors;

"...if you're not a psychiatrist or an intellectual as far as they are concerned, then you're not really worth talking to at any sort of valuable level."

"..it is not a valued job, it is not a valued role. Because I was thinking... I will do this job for quite some time, even though there is no status involved and there is not an increase in pay and I get treated like shit on the hierarchy as far as being in my role, because there are people who won't even look at you if you are not as high up as they are or even talk to you because they are just too superior, because they are doctors or whatever but I just figure, I was thinking, being able to do this job, I can do more to help people in this job I think than in a lot of other jobs".

In general, six participants who were dissatisfied with their management felt that it came down to the fact that managers did not care for their staff;

“...she wasn't very good at caring for her staff members per se and I realise the extent of that now when I started in a new organisation because where I work now for instance, if something went wrong or if she heard about it the first thing she would do when she rings me is say 'are you ok?' and that's just amazing because my previous manager would be 'what have you done'.”

“There's just a lack of care from management, that's what it is, it's as if they just don't care. 'We'll we've got the budget, just do your job, we don't care what kind of job you do, just do it, and well get our budget next year and carry on'.”

The presence of hierarchy within mental health is corroborated by feedback from New Zealand based support workers who stated that placing equal value on all the different occupations and specialties in mental health was a pressing concern for the development of the mental health workforce (Te Pou, 2010).

Support workers perception that some health professionals do not have a high regard for their role, corresponds with the experiences of support workers in research carried out in the U.K. by Murray et al. (1997). Moreover it was found that some health professionals did in fact hold concerns over the capability of support workers (Murray et al., 1997).

According to the Public Service Association (2008), the low esteem afforded to the level of expertise required to carry out community care work is caused by gender inequality in society, as the majority of the community support workforce are women. This stance is consistent with the devaluation theory put forward by academics as one of many potential explanations for the disadvantages that accompany work in female-dominated occupations. The undervaluation theory proposes that the stigma attached to care work results from the association between domestic care labour and women and is therefore considered subordinate to work traditionally performed by men (England, 2005). Other authors have suggested that the stigma attributed to care work mirrors the marginalised status of the staff that have traditionally carried out low

waged service work and the low worth attributed to people with mental illness in society (Bourgeault & Khokher, 2006; Caird, 2001; Tronto, 2010).

Funding

Seven participants commented on the poor funding of NGOs, which has a dramatic affect on resources available for mental health support work. The low funding leads to low staff wages and services having to function on restrictive budgets. Services are also experiencing budget cuts and increasingly having to merge in order to meet operating costs. Fleet cars are being taken away from services meaning clients are missing out on attending activities in the community, staff numbers are being reduced which compromises staff safety and high client-staff ratios increase work load and lower the quality of care organisation are able to provide. Low funding also diminishes the ability of organisations to attract high quality staff;

“...its sort of a typical behaviour with NGOs, were not well known for running really good services, were not really well known for recovery focused practises. It’s like even the unions said to me there a few weeks ago, it’s typical NGOs, they are underfunded from the DHB to do a job that the DHB once did themselves, that cost a lot more money so now they have got a real small budget to work with and that affects the quality of the managers that they have and you end up with a shoddy service.”

“I found it challenging that mental health is a really under-resourced area in general. And you can feel it just by the lack of resources you have to work with. Like day activities for the guys. It’s really hard you have to think outside the box. There’s not much for them to do”.

Four participants commented that there did appear to be some good resources available for clients such as unlimited fuel for cars and funds for clients to access such as for creating a garden or other healthy lifestyle activities. Two participants said that organisations are doing the best they

can to pay staff and provide resources for clients within the budget constraints they experience.

One participant spoke of how funding cuts are leading to a growing number of services having to amalgamate in order to reduce staffing levels and costs, and described the impact this is having;

“the staff used to be able to do more, they would go out more with people, but now they are pretty much just at the house doing the basic things getting the basics done. I think for them and certainly for me the job would become less rewarding, it becomes more about care than support work, your doing things for people rather than supporting them to do it for themselves. Funding cuts make the services go backwards in terms of the recovery philosophy. ‘Recovery’ is all there in the paperwork and the policies though”.

The growing institutional demands for budget cuts as the overarching focus of many health care providers have been found to lead to care policies which encourage depersonalisation of the staff client relationship (Acker, 2012; Aronson & Neysmith, 1996; Denton et al., 2002). Care policies which promote the alienation of staff and clients goes against research showing that relational and emotional labour are the most rewarding and enjoying features of care work and are the aspect of care clients find most beneficial (Aronson & Neysmith, 1996; Denton et al., 2002; McCrae et al., 2008; Meek, 1998; Stacey, 2005)

Six participants pointed out that mental health NGOs are primarily focussed on money and keeping the services running within the tight budgets;

“I reckon its money focussed, that’s the only reason why the cuts and that were made. I think the clients are there to attract that budget that they have got to run the company, that’s what I think”.

“Instead of being driven by health outcomes, primarily from what I understand it’s about money, it’s about the

economics....I respect my colleagues and my managers and staff responsible for managing the budgets because they have had to make some difficult decisions around the level of staffing and service we provide, but they have managed to keep us afloat, as far as I understand we are in a viable position”

Six participants commented on how CEOs and senior management dominate funding and other key decision making activities within organisations, yet are out of touch with the reality of doing support work;

“...for example the CEO, he'd never been in a position of sitting in a room in a house with a person who is paranoid, delusional and psychotic. This guy was there to make money for the company, which he did, he made a great deal of money actually. But he had no idea about what being a support worker involved, it's a bit sad really”.

“They have no understanding. All they care about is budgets and finances. Where the various resources are going to. How much profit they make and whether their organisation looks good on paper.”

“We got a Christmas card signed by the CEO and it said ‘I hope you come back well rested in the New Year’. We were like ha! you're funny! People with disabilities don't suddenly stop having them over Christmas to give everyone a break, you know.”

One participant attributed the poor funding of NGOs to DHBs not funding NGOs equally. Two participants thought the lack of funding of mental health NGOs is related to the stigma attached to mental illness, which is consistent with the stigmatisation of care givers and receivers theory proposed in the literature (Caird, 2001; Tronto, 2010);

“I think mental health has that stigma that people bring it upon themselves and therefore if you work in that area you have to deal with the repercussions of that stigma.”

“People who need the support of the state and can’t work, can’t contribute in a way that is traditionally considered contributing, i.e. money, they are seen as a liability, so its like, well give this liability, rather than this person, as little money as possible, so that we can continue to have them exist, because it’s a thing we have to do, and that goes for people with physical and intellectual disabilities, people with mental health issues and elderly people”.

Issues around funding were also identified in the literature as a major impediment to mental health support work development (Charlesworth & Marshall, 2011; Peters, 2010; Platform, 2009; Shepherd & Meehan, 2013; Te Pou, 2010). Support workers have consistently stated that there should be standardised funding across the sector (Te Pou, 2010). This disparity of funding between clinical and non-clinical services leads to pay inequalities that impact mental health support workers from NGOs (Platform, 2009, 2015; Te Pou, 2010).

Since the inception of the deinstitutionalisation process, community mental health services have been underfunded (Richmond & Savy, 2005). Mental health services based on the dominant medical model of care as opposed to community health care continue to receive greater funding (O'Neil, Bryson, Cutforth, & Minogue, 2008; Te Pou, 2010). In order to sustainably meet future demands placed on the mental health care system caused by increasing fiscal pressures and a growing need for health care skills worldwide, the funding arrangement underpinning NGOs must be more equitable and flexible (Platform, 2013). The unfair distribution of funding that favours DHB services and negatively impacts NGOs has recently become the subject of the Fair Funding campaign currently being carried out by Platform Trust (Platform, 2013).

Funding restrictions result in organisation having to function on low budget which alter work environments and hamper the intrinsic rewards care staff receive from their labour (Aronson & Neysmith, 1996; Elwér et al., 2010; Folbre, 2006; Salyers et al., 2013; Stacey, 2005). Senior staff members responsible for organisational decision-making are not engaged in client contact to the same extent as carers and therefore can implement cost

cutting measures and limit resource availability without experiencing the repercussions (Charlesworth & Marshall, 2011; Engster, 2010; Tronto, 2010)

Charlesworth and Marshall (2011) argue that connotations of caring as an essentially unpaid feminine activity linger in the funding and tendering processes that underpin the structure of community care services. Symbolic representations of 'mothering' revolve around women carrying out care based labour for non-material reasons such as for 'love' and family obligations (England et al., 2002).

The low material worth attached to care labour by government funding bodies and social service agencies indicates concurrence with deeply ingrained gendered assumptions that care workers will be continually adaptable and willing to accept any work conditions on offer in order to demonstrate their dedication and desire to help others (Charlesworth & Marshall, 2011; England et al., 2002).

An individualistic ethos is prevalent in capitalist western societies, which emphasises values such as independence and self-sufficiency (Engster, 2010; Stone, 2000). Individualism perpetuates victim-blaming assumptions that imply that individuals are responsible for their own circumstances. Therefore caregiving needs are often perceived as a private and personal matter (Engster, 2010; Tronto, 2010). Widespread individualistic beliefs make populations dubious about wealth redistribution through tax systems. Greater wealth distribution could contribute to better pay and working conditions in care industries (Engster, 2010; Folbre, 2006; Stone, 2000).

Individualistic ideologies present a major obstacle for raising awareness about the significance of garnering greater support for care work related issues (Engster, 2010). Public decision making is also depended on prevailing social and gender ideologies of worth (England & Folbre, 1999). Stacey (2005) suggests that there is a societal ambivalence around whether services such as domestic caring should even be incorporated into the waged labour market or simply qualifies as informal, unpaid work (Charlesworth & Marshall, 2011).

The labour intensive nature of care work makes it impervious to automation and productivity gains and therefore it is very difficult to pay workers in the care industry relative to workers in other sectors with corresponding skill levels (Folbre, 2006). The funders of care services may not be able to afford higher care costs, or are unwilling to pay. Therefore care recipients would have to go without (Engster, 2010). The other option is that care workers are forced to accept a wage which is low comparative to the social benefits deriving from their work and the labour intensive nature of their job (England et al., 2002).

As funding availability for care services so low, higher staffing costs would potentially mean that clients in need would go without care so cost cutting measures are instead usually implemented. Such strategies are believed to have a negative effect on staff and the quality of care for clients (Charlesworth & Marshall, 2011; Tronto, 2010). However, there is gap in knowledge regarding whether the working conditions of staff does in fact compromise the wellbeing of the service users (Charlesworth & Marshall, 2011). More empirical evidence documenting a negative impact of poor workers conditions on care quality could help strengthen the argument for improved work conditions of care staff (Folbre, 2006).

Gender schemas that devalue women alongside prevailing individualistic ideologies, reinforce the low social regard for this work and cause populations to perceive modest pay and work conditions as fitting for carers (Charlesworth & Marshall, 2011; England & Folbre, 1999).

Suggestions for addressing issues associated with support work

A number of different solutions were identified by participants regarding how they believed the issues they faced in mental health support work could be addressed. Each participant's response was unique and no themes were established.

One participant stated that more family involvement is needed and that support workers should be working with families as much as they do with service users. Another believed that managers need to under go greater scrutiny and appraisal and work surveys should be administered each

year in order for support workers to have a say about what is good and bad about their job. Other response included having experienced support workers train new staff, improving relationships between managers and support workers and that better strategies to improve poverty in general would help in support work. Other participants believed high turnover of staff needs to be addressed through better pay, working conditions and work environments for staff. Many of these initiatives could be ameliorated with greater investment in mental health services. However some of these suggestions could be implemented without huge costs such as more respectful and relationships between managers and staff.

One participant suggested that there needs to be more supervision, feedback, training and oversight of support workers which was also stated in feedback from workshops with New Zealand based support workers (Te Pou, 2010). In particular, one participant mentioned that some staff do have a good understanding of mental illness, policies, procedures and legislation which dictate many aspects of support work. This participant also said that many support workers are illiterate and there are widespread problems with poor communication in mental health support work which is consistent with findings in the literature (Te Pou, 2010). Only one participant believed that a professional association for support workers is required. This participant felt that if support workers were to get accredited through a national accrediting body then support workers would have more support on a national level. This in turn could help alleviate some of the problems associated with the working conditions of support work, give the job a higher status and provide greater support for staff if things go wrong.

There is on-going debate in the literature regarding whether or not professionalisation leads to positive outcomes for both staff and clients. However the regulation of this work could ensure that higher standard of working conditions are met. Historically, professionalization has led to improved status and working conditions for staff (Cowan, 2008). Support workers in New Zealand based workshops also advocated for the increased professionalisation of support work (Te Pou, 2010).

England et al. (2002) assert that current systems, which supply care through the amalgamation of low levels of government funding and free market forces based on the premise of 'supply and demand', produce an insufficient level of care required for a society to flourish (Stone, 2000). Public support for care labour is needed which recognises the valuable contribution care work makes to human capital and the social fabric of society (England & Folbre, 1999; Knijn & Kremer, 1997). Care work generates diffuse gains for all of society rather than private returns, therefore it is impossible for the market forces to capture the true value of care work and make the indirect and direct recipients of care pay for the benefits they receive. This reflects inadequacies of 'rational' capitalist market forces, to provide a social system that fosters the production of human capital and capture the benefits that arise from caring labour (England et al., 2002).

The broad social value of care work should be recognised by evenly distributing funding costs to society at large (England & Folbre, 1999; Knijn & Kremer, 1997). The Government is primarily responsible for the provision of care labour in society and the higher subsidy of care workers wages (Denton et al., 2002; Stone, 2000). The government has the capacity to implement a tax scheme that can improve wages of care workers and disperse the costs equitably (England & Folbre, 1999; Folbre, 2001; Knijn & Kremer, 1997). Government funding of education is one example of established opinion about the collective gains that result from a publicly funded system, which aims to ensure a well-educated general population. England and Folbre (1999) suggest that an analogous argument should be made for greater public subsidization of the wages of workers in other caring vocations. However the willingness of the government to carry out such an initiative is highly dependent on the ideological stance of those in positions of power and the public regarding caring labour (Charlesworth & Marshall, 2011; England, 2005; Folbre, 2006; Knijn & Kremer, 1997; Tronto, 2010). Addressing and altering pervasive individualistic ethos is essential in order to successfully mobilise public support for more just conditions and wages of care workers (Stone, 2000).

Dependence on care is a universal human phenomenon with different needs presenting themselves at different stages throughout each person's life (Stone, 2000). Individuals also have a moral obligation to support caring as all citizens are beneficiaries of caring both directly and indirectly (Engster, 2010). Everyone is entitled to receive adequate care due to our innate vulnerability and dependence on others for survival. In return therefore, citizens have an inherent social obligation that requires us to give back to society, by supporting the care of others (Knijn & Kremer, 1997).

Gaining greater public support is one of the main challenges for achieving pay equity for care workers (Engster, 2010). Widespread individualistic ideologies lead to the belief that individuals are autonomous and responsible for the planning of care related contingencies on their own (Knijn & Kremer, 1997). Working as caregiver is also considered a 'chosen sacrifice' individuals make in order to help others (Charlesworth & Marshall, 2011; Stone, 2000). The belief that workers should sacrifice monetary reward in return for intrinsic job satisfaction implies that individual workers need to give up their own needs and interests in order to advance the quality of support for service users (Stone, 2000). This stance suits those in positions of power as it deflects attention away from structural inequalities and the obligations of government funding bodies and care agencies to address the exploitation of workers in the care industry. Moreover, this line of reasoning fails to recognise the inextricable link between the quality of employment for people providing services to vulnerable populations and the level of care being received (Charlesworth & Marshall, 2011; Knijn & Kremer, 1997).

The belief that 'money drives out love', that care workers main impetus should be helping others rather than money, is often held by carers themselves (Charlesworth & Marshall, 2011). This ideology has a paradoxical effect whereby care workers are held in high regard by society but also denied an appropriate wage for the work they do (England, 2005). Such contradictory thinking about love and money promotes the idea that the commodification of care destroys genuine and virtuous motives for care work, which in turn discourages care workers from being paid decent

wages (England et al., 2002; Engster, 2010). When these dichotomous discourses about love and money are internalised it creates an obstacle for the successful organisation of workers as it prevents care workers from seeing their work conditions as exploitative. Therefore the strength of collective action against poor conditions of work is reduced (Charlesworth & Marshall, 2011; Stacey, 2005).

Conclusions

The aim of this research was to explore a feminist perspective, which states that care work is devalued by society due to it being similar in nature to the unpaid domestic labour that has traditionally been undertaken by women. More specifically this research aimed to explore the extent to which this feminist theory can be applied to community mental health support work in New Zealand and the impact that such an association may have on the value placed on this work.

The results of this research demonstrate that the job tasks involved in mental health support work are similar in nature to the domestic labour that has traditionally been undertaken by women. Mental health support work requires emotional and relational skills that are often invisible. Moreover support workers undertake tasks that overlap with job tasks performed by health professionals. The available evidence also indicates concurrence with feminist theory, which suggests that there is a substantial lack of value placed on community support work, which is manifested through substandard working conditions. Widespread dissatisfaction with the wages in support work was a significant finding as low wages are the most tangible example of the lack of value placed on this work (Charlesworth & Marshall, 2011).

While there were some shining examples of excellent support and organisational conditions experienced by support workers these cases were the minority. Some of the descriptions of the working conditions paint a disturbing picture. The working conditions experienced by community mental health support workers are characterised by a number of main themes. Aside from low wages the results of this research indicate that working with service users and other colleagues are the most rewarding

aspects of this work which may have a buffering affect on the negative working conditions. However support work is also extremely emotionally demanding. Some participants felt the system was not effective as many clients were too unwell to work with. High staff turnover in support work and the associated problems were also highlighted. Low levels of supervision is characteristic of support work and training is often perceived as too bland and generalised. The safety of support workers is often not a high priority. The presence of hierarchy within organisations and health care was identified. Moreover, the poor funding of mental health organisations is deemed an important contributor to the issues related to support work.

The findings from this research overlap with previous literature. A review of literature found that support work is perceived as 'unskilled', many support workers experience role conflict, exploitation and unsafe and unsupportive work environments. Moreover previous research findings also suggest support work is not funded or remunerated adequately in relation to job demands and expectations.

The sample size of this study was too small to make any broad generalisations but the results suggest that further investigation into the state of the working conditions of mental health support workers in New Zealand is warranted. Further qualitative and quantitative research with larger sample sizes in this area is needed to verify the findings. Some of the other limitations of these findings are that only one researcher was available for the analysis of the data. My own experience of this work could have unintentionally biased my findings. More researchers involved in the collection and analysis of data could assist with research validity and reliability. Moreover this research was conducted from the perspective of a New Zealand European and there were no Māori participants. Therefore the results of this research did not entail a variety of cultural perspectives.

Greater incentives for participation may be needed. Most research with low waged service workers have offered monetary compensation for participation, which could help boost sample sizes. Future qualitative and quantitative research could focus on the direct impact of working

conditions on the health and wellbeing of staff, on job dissatisfaction and staff turnover. Moreover future research could aim to uncover whether the working conditions of staff has an effect on the quality of care provided to service users. Future research could also examine whether cultural and religious beliefs influence care workers acceptance of working conditions. More job analysis research, which compares the working conditions of staff in female and male dominated occupations, could also help to build scientific evidence of gender structural discrimination.

These findings could be of use to mental health NGOs organisations who are interested in understanding the views of their staff and wish to improve their organisational environment within the context of budget constraints that they are forced to operate in. This research could also be of use to funding and planning bodies and those in key decision making decisions, as this research helps to elucidate the impact of the low funding of NGO organisations.

NGOs currently play a significant role in the mental health and addiction sector and are well positioned to be able to tailor their services to effectively cater to the needs of community members it serves and thereby support the Government with meeting its strategic objectives (Peters, 2010; Platform, 2013). The potential of NGOs to further contribute to innovative and practical solutions within the mental health and addiction sector is often not recognised due to a widespread misunderstanding about the nature, role and purpose of NGOs by funders, DHBs, Government departments and citizens (Peters, 2010). Greater investment and engagement with NGOs is required in order for community mental health services in New Zealand to be sustainable (Peters, 2010; Platform, 2015).

In order to be able to meet future demands placed on the mental health care system caused by increasing fiscal pressures and a growing need for health care skills worldwide, the funding arrangement underpinning NGOs must be more equitable and flexible (Platform, 2009, 2015). Currently NGOs only receive 30% of funding but deliver 90% of services (Platform, 2013). The provision of more effective community care could reduce the overall costs and efficiency of the mental health care system (Peters, 2010). A large amount of the costs involved in acute mental health care is

attributed to lengthy and recurrent inpatient admissions by a small proportion of chronic service users (Peters, 2010). Community based services are appropriately located to enable collaboration with government to enhance, develop, implement policy across a number of sectors such as social development and to enact public policy (Peters, 2010).

The results of this study have implications for gender equality, social justice agendas. The subjugation of emotional-based labour in society is epitomised by the widespread undervaluation and inequalities experienced by non-professional care workers who carry out this work (Aronson & Neysmith, 1996; Stacey, 2005; Stone, 2000). Care labour is symbolically associated to 'women's work', which affects people's judgment of the jobs worth (Bourgeault & Khokher, 2006). While care work may indeed constitute many aspects that are akin to 'good mothering', affording no material value to this essential skill is unjust (Engster, 2010; Folbre, 2006; Stone, 2000). While 'mothering' is highly revered and respected in society, it has not traditionally been associated with monetary rewards (England, 2005). Valuing care work is at the heart of any society that expects decent, compassionate and productive citizens (England et al., 2002).

England and Folbre (1999) maintain that much more work is needed to substantiate theories about the undervaluation of care work. For example the causal mechanisms underlying the social inequalities associated with care work need to be further elucidated. However Folbre (2006) also states that future research should place a greater emphasis on the impact of low pay and poor conditions on workers and ways to address this, rather than simply theorising about the causes of the issue. It is well documented in the literature that more research is needed which investigates the working conditions, rights and job roles of care workers (England, 2005; Knijn & Kremer, 1997).

Poor wages and work conditions may have a direct negative impact on workers and lead to workforce shortages (Aronson & Neysmith, 1996; Charlesworth & Marshall, 2011; Engster, 2010; Public Service Association, 2008; Rössler, 2012; Stone, 2000). The Public Service Association (2008) assert that caring work needs to be valued, in order to enable high quality service provision (Knijn & Kremer, 1997). Research shows that when

support workers do not feel their contribution to the mental health team is valued higher levels of work dissatisfaction are reported (Murray et al., 1997). Factors impacting on job satisfaction in mental health include having adequate resources, diverse job tasks, being valued, supported and not feeling excluded from the organisation (Denton et al., 2002; Murray et al., 1997; Rössler, 2012; Salyers et al., 2013). Community mental health support workers in New Zealand based workshops have indicated that a low value placed on the work they do is a significant issue (Te Pou, 2010).

This research has also highlighted that the inherent satisfaction people derive from working with others can obscure the structural forces that undermine the value of care work (Folbre, 2001). The pervasiveness of emotional exploitation in care industry is also a significant source of potential future workforce shortages (Aronson & Neysmith, 1996; Bourgeault & Khokher, 2006; Stacey, 2005). As women have increasingly broader work opportunities available to them, many may choose to forego occupations that will turn them into emotional hostages (Folbre, 2001).

Care work produces direct and indirect, individual and collective benefits that pervade our lives (England, 2005; England et al., 2002). There are number of other reasons identified in the literature as to why addressing the disadvantages experienced by workers in the care related industry is a significant, social and collective issue. Oppressive work conditions have a negative impact on the wellbeing of staff leading to job dissatisfaction, burnout and workforce shortages (Rössler, 2012). This is a particular concern in the face of growing demands for a variety of different care services. Poor employment conditions can have a detrimental effect on the quality of care provided to clients (Charlesworth & Marshall, 2011; Knijn & Kremer, 1997; Public Service Association, 2008). Everyone requires care from a range of social and health care institutions at some point in their life span, in particular for example as children, in old age or when ill (Engster, 2010; Stone, 2000). The poor working conditions experienced by care workers contributes to gender discrepancies in society such as the gender wage gap (England, 2005; Stone, 2000). Therefore issues relating

to the care sector are of relevance to the collective wellbeing of society (England et al., 2002; Engster, 2010; Stone, 2000).

England et al. (2002) state that the best way for citizens to support sustainable change which enhances collective wellbeing, the welfare of individuals who carry out care work and require care, is through national dialogue, political action and collective organisation (Stone, 2000). Furthermore, systematic changes at all levels in the way care work is recognised and remunerated is required (Charlesworth & Marshall, 2011; England & Folbre, 1999; Knijn & Kremer, 1997; Tronto, 2010). For example at the organisational level, management best practice knowledge needs to become more widespread and utilised. Management best practice includes more collective evaluation of service provision and changes in management structure that empower staff to have a greater input in decision making processes (Charlesworth & Marshall, 2011; Tronto, 2010). At the macro level, cultural discrimination against women and the resulting inadequate public and government support for care labour needs to be addressed (Folbre, 2006; Knijn & Kremer, 1997).

The widely accepted principle that caring involves skills that are innate to women and that 'virtuous' women should be willing to provide care services 'out of the goodness of their hearts' has perpetuated the exploitation and disadvantage experienced by workers in care industries (Folbre, 2006; Knijn & Kremer, 1997). Funding mechanisms need to support positive work conditions of staff, rather than continue to depend on workers to sacrifice their own interests in order to ensure the wellbeing of the most vulnerable members of society (Charlesworth & Marshall, 2011; Stone, 2000).

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Appendices

Appendix One: Template for recruitment letter

Appendix Two: Template for recruitment poster

Appendix Three: Participant consent form

Appendix Four: Participant information sheet

Appendix One: Template for recruitment letter

Dear (name of gatekeeper from organisation),

My name is Gabrielle Taylor and I am Masters student from the University of Waikato. I am currently undertaking a research project as part of a Masters of Applied Community Psychology degree. I am writing to seek your assistance with recruiting community mental health support workers who work for Non Governmental Organisations (NGOs), for my research project. I understand that your organisation advocates for positive change within the community mental health support system and appreciates the crucial contribution NGO mental health support workers make to the lives of the people they serve. Therefore I thought that you would be a relevant organisation to approach.

The aim of this research is to explore a feminist perspective, which states that care work is devalued by society due to it being similar in nature to the unpaid domestic labour that has traditionally been undertaken by women. More specifically this research aims to explore the extent to which this feminist theory can be applied to community mental health support work in New Zealand and the impact that such an association may have on the value placed on this work. This study is being supervised by Neville Robertson and Michael O'Driscoll from the School of Psychology at the University of Waikato and has been approved by the University of Waikato Psychology Research and Ethics Committee.

I would really appreciate it if I could display some recruitment posters on noticeboards around your organisation to invite any of your members/staff/students who are community mental health support workers to volunteer to be interviewed by me. I would also welcome the opportunity make a brief presentation of between five and ten minutes at a meeting/class. I could also send you a recruitment poster you could forward to your staff/students/members if you think that is appropriate. Also would you be able to put me in contact with any other NGO

community mental health support workers who may be willing to participate in this research?

Participation in my research would involve interviews with support workers of up to one hour. Information obtained in the interviews will be confidential and anonymous. The results of this research will be incorporated into my thesis report or could potentially be utilised in presentations or published in journal articles. I would be willing to provide you with a written summary of the report.

I would greatly appreciate any type of assistance you would be able to provide in order to help facilitate recruitment for this study. I will phone you to meet with you to discuss this further in a few days time. Alternately feel free to contact me on taylorgabr@gmail.com or phone 022 123 9698.

Thanks very much,

Appendix Two: Recruitment poster

COMMUNITY MENTAL HEALTH SUPPORT WORKERS

WANTED FOR RESEARCH PARTICIPATION

I am looking to talk to men and women over the age of 18 who currently, or have worked in the past, for a Non Governmental Organisation (NGO) as a community mental health support worker.

Participation in this research would involve an interview of up to one hour about some of your experiences and perceptions of your work. Your information and identity will remain completely anonymous and confidential. The results of this research will be incorporated into my thesis report and potentially utilized in presentations or published in journal articles on this topic.

If you are interested or would like more information please feel free to contact me by text, phone or email on **0221239698** or **taylorgab@gmail.com**. If you text, ring or email me I can contact you back with further details about the study. Your views would be greatly appreciated in this research.

Thanks very much,

Gabrielle Taylor

***This research has been approved by the University of Waikato
Psychology Research and Ethics Committee.***

Appendix Three: Participant consent form

A completed copy of this form should be retained by both the researcher and the participant.

Research Project: _____

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
I have read the Participant Information Sheet (or it has been read to me) and I understand it		
I have been given sufficient time to consider whether or not to participate in this study		
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet		
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study or decline to participate in any part of the research activity at any time without penalty		
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study		
I understand that the information obtained through the interviews such as verbatim quotes, will be incorporated into the researcher's thesis report and may also be used in publications or presentations on this topic		
I know who to contact if I have any questions about the study in general		
I agree to having my interview recorded		
I understand that the interview recording will be securely stored on the researcher's laptop for up to two weeks until it is transcribed and anonymised and then the original recording will be deleted		
I understand that I may withdraw or correct any, or all of the information I provide, by contacting the researcher up to two weeks after receiving a summary of my interview		
I wish to view the transcript of the interview		
I wish to view the summary report of the final study		

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Psychology Research and Ethics Committee (Associate Professor John Perrone, Tel: 07 838 4466 ext 8292, email: jpnz@waikato.ac.nz)

Participant's name (Please print):

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (Please print):

Signature:

Date:

Appendix Four: Participant information sheet

My name is Gabrielle Taylor and I am currently undertaking a research project as part of a Masters of Applied Community Psychology degree. The aim of this research is to explore a feminist perspective, which states that care work is devalued by society due to it being similar in nature to the unpaid domestic labour that has traditionally been undertaken by women. More specifically this research aims to explore the extent to which this feminist theory can be applied to community mental health support work in New Zealand and the impact that such an association may have on the value placed on this work. This research is being supervised by Neville Robertson (scorpio@waikato.ac.nz) and Michael O'Driscoll (psyc0181@waikato.ac.nz) from the School of Psychology at the University of Waikato

Research participation will involve an interview of up to one hour, which will be audiorecorded for transcribing purposes only. A suitable time and/or venue for the interview to take place will be negotiated between you and I. I will ask participants a number of open ended and exploratory questions. These questions intend to elicit responses, which describe your day to day work as a community mental health support worker and your experiences and perceptions of your job. Questions will be asked about what makes your job easy, challenging, rewarding and unrewarding. Moreover, how you think the positive aspects of your work can be enhanced and the negative aspects addressed and what you think some of the sources of the issues facing community mental health support workers are. Participants will be asked to give examples to back up their responses. I will ask participants to elaborate on their responses relating to their working conditions, supervision, work organisation, job tasks, relationships with co-workers, workload, their work history or any other issues that are of particular significance to them. The interview recording will be securely stored on my laptop until it is transcribed and made anonymous. The original recording will then be deleted.

Participation in this research is completely voluntary and you may refuse to answer any question you do not feel comfortable answering. Moreover, you can withdraw from the research process at any time without any explanation or penalty. You will need to supply me with an email address so that I can send you a copy of the interview summary as soon as possible after the interview has taken place. I will send you a summary of your interview to ensure that I have adequately interpreted what you have

said. I will contact you or you can contact me, to discuss any changes you would like made to the interview summary.

You may withdraw any or all of the information provided in the interview, up to two weeks after you have received the interview summary. If I am not able to get in contact with you or I do not hear back from you, I will assume that you would not like to make any changes to the interview summary. Information collected from these interviews will undergo a thematic data analysis and will be interpreted from a feminist/gendered perspective. If you would like to receive a summary of the final results of the study, I will also send this to you.

Every effort will be made to protect the identity and confidentiality of the participants of this research. The only personal information obtained during this research may be your first name, gender, ethnicity and an email address. You may use a code name if you wish. As soon as possible after the interview has taken place, I will transcribe the interview. During transcription all personal information will be made anonymous. The interview recordings may only potentially be heard by either of my supervisors, however the main reason for the recording is to assist with accurately transcribing the interview. The information gathered through interviews will be incorporated into my thesis report. I may use your verbatim quotes, however no response provided will be linked directly back to you in my final report. The findings from this research may also be used in presentations or journal publications. The final thesis report will be externally examined and a copy of the report will be held in the University of Waikato library thesis database.

Please take time to consider whether you agree to participate in this study in light of the information provided. This research has been approved by the School of Psychology Research and Ethics Committee of the Faculty of Arts and Social Sciences, University of Waikato. Any questions about the ethical conduct of this research may be sent to the convenor of the Research and Ethics Committee (Associate Professor John Perrone, phone 07 838 4466 ext 8292, email: jpnz@waikato.ac.nz). If you have any further questions about this research please do not hesitate to contact me at taylorgab@gmail.com or on 0221239698.

Thank you,

Gabrielle Taylor