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Consumer perspective employment in the psychiatric service system: a Victorian view on safety issues *

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Abstract

Opportunities for consumers to explore our employment within the psychiatric service system are urgently needed. This article raises issues and dilemmas concerning un/safety and consumer perspective employment, for ongoing debate and discussion. I identify as a psychiatric service receiver and use the word 'we' generally to refer only to consumers, not to 'people in general'. The word 'consumer' as described here refers to someone who has received a psychiatric service. The Mental Health Statement of Rights and Responsibilities defines 'consumer' as:

> *A person making use of, or being significantly affected by a mental health service (Australian Health Ministers, 1991, p16).*

Keywords

occupational health and safety, consumer, consumer consultancy, safety, psychiatric service system, consumer academic, quality improvement

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Consumer perspective employment as opposed to 'participation'

'Consumer participation' historically confuses paid consumer consultancy with being a 'well' role model for 'sicker' consumers, or with being a 'representative' of *all consumers.* Or, to give another example, it confuses consumer perspective delivery of training to mental health practitioners with the idea that we must, by definition, need training ourselves in order to participate in this 'very complicated' mental health system. I will draw a distinction between what is currently termed 'consumer participation' and what I call *consumer perspective paid employment in the psychiatric service system*.

This article concentrates only on those of us who are employed *precisely because of* our consumer experience, and who are essentially *trading* our consumer perspective and are employed for that purpose. Consumer consultancy within Mental Health Services is now the prime manifestation of consumer perspective paid employment.

It is noted there are consumers occupying other roles within the mental health service system, for example as support workers in the non-government sector who are not necessarily employed solely for their consumer perspective. As well, there are those who have had experience of mental health service usage, but who are not 'speaking out' about those experiences.

Another application of 'consumer perspective paid employment' briefly examined here, is the provision of consumer perspective training and education to mental health practitioners. Both consumer consultants and independent consumer

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perspective workers have engaged in this form of work, directly and indirectly, for years. Here, I focus specifically on the role I currently occupy at the Centre for Psychiatric Nursing Research and Practice within the University of Melbourne as Consumer Academic. Although this role is an example of work that may be a part of a 'search for healing' that does not *endanger* us, it still reveals challenges about consumer perspective worker safety.

Paid work roles for self-identified consumer employees - the system meets the consumer consultant role

The Victorian Mental Illness Awareness Council (VMIAC), the peak consumer body in Victoria, commissioned the work later known as the 'Understanding and Involvement' (U&I) Project (Epstein & Wadsworth, 1994) and its antecedents (McGuiness & Wadsworth, 1991; McCarthy & Salvage, 1993). The project ultimately presented a 'model' for both the creation and carrying out of consumer consultancy in clinical settings and produced a handbook for staff-consumer consultants (Wadsworth & Epstein, 1996).

In late 1996, the first four consumer consultants in Victoria were employed at the Royal Melbourne Hospital. Having consumers working in clinical settings, traditionally the place for consumer as sick person only, was a critical turning point in manifesting a concept of consumer participation. The U&I project placed emphasis on dialogue, and used a participatory action research model in its design, to which consultants were introduced. Theoretically at least, attention was paid to the importance of consumers acting as consultants to staff as well as to consumers, hence the initial name, staff-consumer consultant. Acute units or wards were recognised as busy places not easily lending themselves to reflective practice, so structures to facilitate ongoing interest and support through the early developmental years of the research preceding the 'model', were crucial and these were maintained as the four consultants began carrying out their role.

At this time, Victoria was in the throes of some of the most major reforms ever undertaken in the mental health service system. The demise of the stand-alone facility, co-location with urban general hospitals, radical disposal of thousands of inpatient beds, shorter inpatient stays, the birth of health networks and concomitant devolution of management to these structures – the effects of all these reforms were just starting to be felt.

Armed as we were with quite sophisticated approaches to working collaboratively with staff, we found, not surprisingly, that staff had trouble figuring out how to use our role, found us a difficult presence, and had no real desire (in some ways, understandably) to deal with the problems articulated by consumers – on top of all of the other radical service system changes they had to contend with. If, for example, we wished to raise the issue of people not having anything meaningful to do, to whom did we raise it? How was it then followed up? How did we make sure there was action taken? How did we report back to consumers? How did we do all this in four hours twice a week? There were in fact no local structures built into the workplace itself for our roles to be negotiated with management and staff, or to keep momentum of the new role going.

In the orientation provided to us prior to our employment as staff-consumer consultants, we were urged to be 'more professional than the professionals' (Wadsworth & Epstein, 1996, p43) and 'learn the ways' of the organization in order to participate in it. We didn't question the idea that consumers needed to be trained in the art of conducting

meetings, minute taking, behaving correctly, and understanding, for example, the 'very complex concepts and language' of the medical model, quality improvement, clinical and management practices and their rationale. Beliefs of this kind though, have acted as exclusionary factors when it comes to applying for, and being seen as 'successful' applicants for consumer consultant positions. Instead of our unique perspective being valued for the wisdom it contains, born out of our experience of disability, whether or not the disability affects us 'in the now', we often felt obliged to disown it. And in so doing, disown the very foundation upon which rests our unique perspective and which connects us to those service users with whom we work.

Within a year of the introduction of the first staff-consumer consultants, the Department of Human Services provided what was to become recurrent funding for the statewide introduction of similar roles for every Area Mental Health Service.

Un/safety and the consumer consultant role: issues and dilemmas

Being told: 'You are just the same as any employee', sounds good, sounds egalitarian, but in fact, we aren't the same. A consumer who works in the clinical setting is not providing a service in the traditional sense. Further, we do not yet have enough experience of safety or access to decision-making to have experimented with what we might need and hence begin to articulate those needs. If we think learning the language of the psychiatric service system is the secret to our being taken seriously, then we are in danger.

It is the responsibility of any organisation we work in to provide the conditions we need in order to do our job (Findlay, 2000). Instead, organisations initiated discussions with consumer workers about de facto contracts regarding what to do when they 'got sick' or if the consumer consultant 'needed support' - and discussions about which staff member might provide that support.

While the U&I model stressed the need for consultants to work in pairs, primarily as a measure to strengthen consumer perspective and keep the workers safe, in many cases, consultants were 'split up' to 'cover more ground', or even employed as solo consultants. There was no imperative for organisations to make the sorts of changes to their traditional way of doing things, that would enable consumers to use their creativity in order to work within them, or influence attitudes of staff.

Quality improvement framework

The U&I model positioned consumer consultancy within the framework of quality improvement. Yet, if we were employed to improve the quality of services, how did we speak about the disappearing act of all those hospital beds, of all those people we knew about who couldn't access hospital when they deemed it necessary? How did we speak about quality, if we weren't allowed to define what quality was? How did we speak about quality if all we knew was what we had been offered to date – especially if it was at odds with clinical opinion? How did we speak about consumer experience that was outside the framework of 'quality' and just plain 'not good enough' or in the worst cases, inhumane? How could we legitimately be the activists we were, without being told to 'watch what we say, and to whom' or have our efforts disregarded either overtly or covertly. Although the U&I model stressed systemic, not individual, advocacy, how could that really be played out?

If the emphasis and responsibility for occupational health and safety is not placed squarely back on the organisation, the

consumer can feel an unbearable sense of personal failure, not just within the context of their employment, but at the level of their personhood. The issues that impel one to become an activist are inseparable from one's self. In fact, the vital mechanisms that would best support consumers have been largely left up to those individual services to decide upon, not given to consumers to work out, and rarely have they been addressed to the consumer workers' satisfaction.

Some things learned through teaching

Many of the observations already made here about our un/safety in working as employees of clinical services also apply to a more removed role – teaching post-graduate psychiatric nursing students in a higher education setting. There is isolation in being the sole provider of a minority perspective. In teaching what is not welcome, exposing difficult 'truths', or questioning clinical discourse, the 'teacher' runs the risk of unwittingly internalising any discomfort engendered in others. Further, nursing students, rather than engaging with this perspective, might resent and so ignore it, regarding it as an intolerable intrusion on the 'real' learning that has to be achieved in an extremely demanding year – how to conduct interviews, make assessments, diagnose and treat 'mental illness'. Yet part of the freedom of the role lies in being able to articulate such issues, think about them, talk about them and write about them.

The consumer academic role within the Centre for Psychiatric Nursing Research and Practice has allowed me to find my own working pace, to think and act for myself, to create varied ways to do consumer perspective work that are original, supported, and more safe than in constrained clinical settings. It is understood the role must be enhanced by a variety of other paid consumer perspective input, and the project team supporting the role has a majority consumer presence.

During the last decade, many resources, campaigns, consultations, committees and projects have been developed through Australia's National Mental Health Strategy. But very few resources are ever given directly to consumers, for example, to be used to create the kinds of vital infrastructure we need in order to be able to participate more safely. If we had a fully resourced 'place of our own' then I believe we might start to purchase the safety we require and are owed. We would be well placed to share and articulate our experiences about safety and un/safety – decide how best to manage these issues for ourselves. We would have a place from which to launch projects, be contracted for our consumer perspective services – whether in training, or developing consumer provider services, or tendering for government projects, or providing an alternative to, and support for, those engaged in service based consultancy.

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