Identity, power, and authenticity: a qualitative case study exploring the experiences of staff with lived experience of mental health problems within a UK mental health trust.

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Abstract

The National Health Service (NHS) is expected to set a precedent for other UK organisations to follow in relation to addressing the health and wellbeing needs of its staff. However, most NHS organisations are facing unprecedented financial and employment challenges, predominantly due to a surge in demand for services and a shortage of personnel and resources. This results in a high-stress environment where employees are constantly working at maximum capacity and grappling to meet patient needs. As a consequence, rates of mental ill health among the workforce are alarmingly high, with burnout and exhaustion being significant factors.

While it is important that organisations prioritise the mental health and wellbeing needs of their workforce, especially at a time when the risks of poor mental health are high, it is crucial to acknowledge the paradigmatic shift highlighted in this thesis. Clinicians, as a consequence of their lived experience of mental health problems, can and do add significant value to their organisation by enhancing patient care and challenging cultural norms. However, they require support in order to fulfill their role and maintain their own wellbeing. This study is particularly interested in the lived experience narratives of clinicians with severe and enduring mental health problems working in a UK mental health trust. Glen Forest claims to value lived experience as part of its broader cultural approach, and this research aims to understand how these clinicians are empowered to utilise their experience to improve patient care.

This thesis adopts a qualitative case study methodology to challenge the dominant narrative, by giving prominence to the voices of individuals who have both professional experience and personal lived experience of mental health problems. It accomplishes this through interviews with 24 policy makers, 12 clinicians with lived experience, and a focus group of Peer Support Workers. The research explores how societal stigma and organisational policies impact these individuals, shaping their identity, influencing power dynamics, affecting their sense of value and belonging in the workplace, and ultimately impacting patient care. Additionally, the study investigates the specific challenges faced by staff with lived experience and emphasises the potential for their happiness and productivity as employees when provided with appropriate and timely support.

The findings of this study clearly indicate that the case study organisation falls short of the necessary criteria to be considered an Exemplar Employer, since employees with lived experience are forced to hide their true identities and disregard their personal experiences. From an organisational development standpoint, it is crucial to analyse the work environment of clinical staff with experience of severe and enduring mental health problems. This analysis carries important implications for shaping mental health trust policies, education, and guidance, and holds the power to influence other NHS trusts and employers in the health and social care sector.

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Published Papers and Conference Presentations

Papers

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Conchar, C. and Repper, J. (2014). 'Walking Wounded or Wounded Healer?', **Journal of Mental Health and Social Inclusion**, Vol. 18, No. 1: pp. 35-44.

Clifford, N., Clarke, M. and Conchar, C. (2023). 'Turning Hierarchy on its Head: Are Parallel Learning Partnerships the Solution to Creating Inclusive Cultures in Healthcare?' **BMJ Leader**, Vol. 7, Suppl 2: pp.1-7.

Conferences

'Practicing What We Preach'. Nottinghamshire Healthcare NHS Foundation Trust/ ImROC Conference, Nottingham, 2013.

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List of Acronyms

ACAS	Advisory, Conciliation and Arbitration Service
CIPD	Chartered Institute of Personnel and Development
CPN	Community Psychiatric Nurse
DHSC	Department of Health and Social Care
DoH	Department of Health
DRC	Disability Rights Commission
DWP	Department for Work and Pensions
EHRC	Equality and Human Rights Commission
HM/HMSO	Her Majesty's/ Her Majesty's Stationery Office
HR	Human Resources
HSE	Health and Safety Executive
ImROC	Implementing Recovery through Organisational Change
LE	Lived Experience
LIBW	Living in Both Worlds
LSE	London School of Economics and Political Science
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NMC	Nursing and Midwifery Council
NMHDU	National Mental Health Development Unit
NRES	National Research Ethics Service
ONS	Office for National Statistics
PHE	Public Health England
PM	Policy Maker
PSW	Peer Support Worker
SCMH	Sainsbury Centre for Mental Health
SWLSTG	South West London and St. George's Mental Health NHS Trust
TSO	The Stationery Office
UCL	University College London
UN	United Nations
WHO	World Health Organisation

Glossary of Terms

This glossary aims to define key terms used within this thesis, with the goal of clarifying key concepts and fostering a common understanding.

1. Clinician

The term 'clinician' is traditionally used to denote a registered healthcare professional, such as a doctor, a nurse, or a therapist, who provides direct patient care, and sometimes diagnosis. They have specialist training in their respective fields, such as medicine, nursing, psychology, or therapy, and use their expertise to assess, treat and manage patients' health conditions (Northern Devon Healthcare NHS Trust, 2024). Within this thesis, the definition of clinician has been expanded to include any mental health professional who comes into direct contact with patients and provides them with care and support whether they are registered with a professional body or not. This includes Peer Support Workers, who work directly with patients, as part of a multi-disciplinary team.

2. Lived Experience

Lived experience is a complex and multifaceted concept that cannot be defined by a single definition or explanation (Hawke et al., 2022). Within qualitative research it is a term often used to describe the personal knowledge and understanding of individuals, based on their first-hand involvement or direct experiences. This contrasts with information that is acquired through secondary sources constructed by others, such as books, the media, or hearsay (Given, 2008; Marshall et al., 2011; von Hippel et al., 2022).

Professionally, individuals with lived experience may use it to the benefit of themselves, colleagues, and/or patients, or to influence academic research. It can be used to refer to individuals who have experience of significant life challenges such as stroke or cancer but is more commonly used in the mental health arena to refer to those individuals with personal experience of current and/or past mental health problems (Roennfeldt and Byrne, 2020; Jones et al., 2021). Within this thesis, it describes staff who, as defined by Hawke et al. (2022, p.2300), possess:

> one or more psychiatric diagnoses, often driven by multifactorial causality and accompanied by intersecting problems with stigma, discrimination, social determinants of health, impacts on functioning and quality of life and mental health service utilization.

Staff with lived experience of mental health problems may or may not define themselves as peer workers and may not be open to others about their lived experience, preferring instead, for a multitude of reasons, to conceal it and simply on-hand to positively influence their own workplace practices- both clinical and non-clinical.

3. Mental Health Problems

Within this thesis the term 'mental health problems' is inclusive and represents a range of conditions that affect a person's emotional, psychological, social, and sometimes physical well-being (WHO, 2024). These problems can impact on how individuals think, feel, behave, and interact with others (American Psychiatric Association, 2024). Mental health problems can be diverse and vary in severity, ranging from mild to severe (Hawke et al., 2022). Some commonly known mental health problems include:

depression, anxiety disorders, post-traumatic stress disorder, schizophrenia, and bipolar disorder.

Severe and enduring mental health problems, sometimes referred to by researchers as "severe and persistent mental illness" (von Hippel et al., 2022, p. 1002), however, are a distinct category of mental health problems that are characterised by their chronic and persistent nature, significantly impacting on an individual's daily functioning and overall quality of life. **All of the participants with lived experience within this study identified as having severe and enduring mental health problems.** These conditions often necessitate long-term management and support. Examples include schizophrenia, bipolar disorder with psychotic features, severe major depression, borderline personality disorder and treatment-resistant anxiety disorders (WHO, 2024). Individuals experiencing severe and enduring mental health problems often require a comprehensive treatment approach. This may involve a combination of medications prescribed by psychiatrists or other specialised healthcare professionals, as well as psychotherapy techniques such as cognitive-behavioural therapy. Additionally, psychosocial interventions, peer support networks, community-based services, vocational rehabilitation assistance, housing support programmes, and ongoing monitoring from a multidisciplinary team comprised of specialist mental health professionals may be necessary (Hatfield and Dening, 2020; Hawke et al., 2022). The multidisciplinary team may include psychiatrists, psychologists, nurses, social workers, and peer support workers.

The terms 'mental health problems' and 'severe and enduring mental health problems' will be used as the predominant phrases throughout this thesis to describe what others commonly refer to as mental illness, mental health conditions, mental health issues,

poor mental health, mental distress, mental impairments, mental disorders, and so forth. However, as advised all of the participants with lived experience involved in the study identified as having severe and enduring mental health problems.

4. Mental Health Professional

For the purpose of this thesis, the descriptor 'mental health professional', signifies any staff member who provides mental health care to patients in a recognised therapeutic and/or support capacity (see Clinician above). According to NHS England (2024a):

> this includes, but is not limited to: Peer Support Workers, community psychiatric nurses, clinical psychologists, mental health social workers, mental health occupational therapists, mental health community connectors.

5. Peer Support Worker

Within the mental health field, a 'Peer Support Worker' is someone who has personal lived experience of a mental health problem and uses that experience to provide support, guidance, and encouragement to others facing similar challenges, as part of a dedicated role (von Hippel et al., 2022; NHS Careers, 2024, NHS England, 2024b). Peer Support Workers work alongside other mental health professionals as part of a collaborative or multidisciplinary team. They may facilitate support groups, lead educational workshops, provide one-on-one mentoring or coaching, assist with accessing resources and services, share coping strategies based on their own experiences, help advocate for the needs of those they support, and/or contribute to system change (Roennfeldt and Byrne, 2020; Watson and Repper, 2022; NHS Careers, 2024).

As outlined earlier, Peer Support Workers are not traditionally classed as mental health professionals and/or clinicians as they are they are more likely to use their own lived experience rather than academic or skills-based training in their work. However, this disregards the notion that Peer Support Workers are 'experts by experience', who undertake ongoing training in relation to their healthcare role and are measured by their competencies, just as a registered nurse, a psychologist, or an unregistered healthcare assistant would be. Relegating Peer Support Workers to be classed as non-clinical, or non-mental health professionals, is likely to reinforce the unhelpful and potentially stigmatizing concept of 'us' and 'them' and undervalues their professionalism in promoting and enhancing recovery-orientated approaches within the mental health system.

It is important to note that not all Peer Support Workers disclose or share their mental health problem(s). Levels of disclosure depend on key issues such as professional and personal boundaries, the audience, individual choice, and so forth. While some may share matters around diagnosis with others (full or select), some may simply disclose by the inference of their role title that they have lived experience of mental health problems.

6. Peer Worker

A 'Peer Worker' is an umbrella term which, within the context of this study, describes any member of staff who has lived experience of severe and enduring mental health problems, who uses these life experiences in the workplace. This includes peer support workers, peer trainers, clinicians/mental health professionals, and any other colleagues with lived experience.

It is noteworthy that this definition differs from that used by researchers such as King et al. (2020, 2023) and Roennfeldt and Byrne (2020), who separate peer roles from those of registered mental health professionals with lived experience, instead describing peer workers as "staff employed in designated lived-experience roles" (King et al., 2020, p. 1048). Conversely, those with lived experience in non-designated roles are referred to as "mental health professionals with personal lived experience (MHPle)" (King et al., 2023, p. 2).

This thesis, while acknowledging the potential distinctions used by others, is more inclusive, adopting the literal definition of "peer", which is "a colleague usually of equal standing" (Taylor, 2019, p. 300). Instead, the term Peer Support Worker is used to describe only those staff employed in designated lived-experience roles, where relevant. As highlighted earlier, this study includes both Peer Workers and Peer Support Workers within the definition of clinicians and mental health professionals.

7. Policy Maker

'Policy makers' refers to senior managers and other colleagues who have key managerial and leadership accountabilities within an organisation. These individuals are responsible for developing and executing policies, devising strategies, making decisions, and developing guidelines that govern the organisation's actions and operations (Howlett et al., 2020). Policy makers, it is posited, have inferred power to shape and influence the organisation's ideology, culture and therefore, policy.

Chapter 1: Introduction

1.0 Introduction

The intention behind this opening section is to provide an understanding of the personal and professional motivations behind this study. This approach serves to establish a solid foundation for the subsequent research and will introduce the narrative upon which the study is built. The latter part of this introductory chapter presents the study within the broader context of existing literature and shows its significance in healthcare research. Lastly, it provides an outline of the structure of the thesis.

1.1 Inspiration, Motivations and Reflections

> I love those who can smile in trouble, who can gather strength from distress, and grow brave by reflection. 'Tis the business of little minds to shrink, but they whose heart is firm, and whose conscience approves their conduct, will pursue their principles unto death. (Thomas Paine- The American Crisis, 1776 p. 176).

Working in Equality, Diversity, and Inclusion is not simply a job it is a vocation. We wear our hearts on our sleeve; yet have no uniform or other work attire to take off at the end of the day, except perhaps an ID badge. Our personal beliefs, values and behaviours impact on our professional standing and vice versa, because it is integral to who we are. Consequently, we are judged on our actions, or indeed inactions, both personally and professionally.

Challenging harassment and discrimination is a major part of my Equality, Diversity and Inclusion role and is reflected in my personal obligations. I possess a strong sense of justice and a

desire to help others, particularly those who are treated unfairly because of who they are. In my professional role I observe staff with lived experience of mental health problems being judged to be "less than"; where eyes are rolled when they speak, and patronising smiles follow when they mention their lived experience. However, I also see strength and a determination to promote change, not only from staff with lived experience, but allies and supporters, who no matter how bad it gets keep smiling and trying to do their best within their sphere of influence.

I remember being at a large Trustwide event in 2011, where Michael West (King's Fund) was on the stage delivering an empowering speech on compassionate leadership. I was standing at the back of the conference venue with one of the organisation's very senior managers, a colleague who was publicly open about their lived experience of severe and enduring mental health problems. Our conversation was as follows:

[Colleague]: I really think we should do more work with Michael [West], as his approach to compassionate leadership is what this organisation needs.

[Me]: Absolutely. But we need to empower our managers to empathise with and understand their teams… and of course challenge poor behaviours.

[Colleague]: Yes, but isn't it great that because of me being open about my mental health problems staff are able to be themselves at work?

[Me]: Of course, but unfortunately that's not everyone's experience [name]; many staff still have to hide their mental health problems from managers and

colleagues.

[Colleague]: [Annoyed grumble] Well where's your evidence Catherine?

[Me]: I see it lots of times in different services across the Trust.

[Colleague]: Yes, but where's your **real** evidence?

[Me]: Okay, I'll get some.

[Colleague]: Good!

This ignited my motivation and inspiration to undertake a PhD in this area, compounded by my strong motivation and desire to bring about meaningful change. I understood that in order to effectively advocate for transformation, I needed solid evidence to support my claims. By embarking on a PhD journey, I aimed to not only provide this crucial evidence, but also demonstrate my dedication and commitment to the cause. Like many of the staff with lived experience that I encountered, I was eager to see tangible improvements, and I knew that obtaining evidence through a PhD would lend credibility and authority to my arguments. With my unwavering determination and passion, I was fully committed to seeing this endeavour through to its completion.

Furthermore, I have always been drawn to the world of academia and research, and after completing my master's degree I knew that pursuing a PhD was a logical step for me. Moreover, due to my job working in a mental health trust, I was particularly interested in the field of mental health and wanted to learn more about and contribute to the existing knowledge and understanding in this area. I had come across Foucault's (2006) perspectives on the history of madness in my work, and I was enthralled by the contradictions and tensions that he discussed in relation to mental health service provision. I was curious to learn if his findings on

control, punishment, and compassion translated into the 'mental health in employment' field. I saw value in conducting an empirical inquiry to gain insights into the structures and contexts that shape these experiences. I believed that understanding these tensions and their implications for clinical staff with mental health problems could ultimately lead to better support and improved wellbeing.

1.2 Situating the Study

1.2.1 Background

Research suggests that while a number of organisations have policies in place around employee mental health, there is often limited understanding and awareness of how best to support employees with mental health problems (Boorman, 2009b; LSE, 2012; Richards et al., 2016; King et al., 2020). Exploration of the available literature emphasises that although some work has been done and progress made, action is still required to ensure that staff that have lived experience of mental health problems are represented, valued, and supported in the workplace (Paynter and Rivers, 2015; Morgan and Lawson, 2015; Byrne et al., 2016; Stirrup et al., 2022). Studies suggest that people with mental health problems continue to face barriers, including discrimination, within employment (Conchar and Repper, 2014; Paynter and Rivers, 2015; Byrne et al., 2016; Colomer-Pérez et al., 2020). This research, however, is largely based on individuals' perceptions of their experience and therefore cannot be authenticated.

Despite this, data from UK Labour Force Surveys (ONS, 2010; ONS, 2013; ONS 2021) as well as other empirical studies (Perkins et al., 2009; Walker et al., 2014) clearly indicate that people with mental health problems are less likely to be in employment, are more likely to be in lower paid jobs, and more likely to live below

the poverty line than those without such problems. This increases exponentially for those with severe and enduring mental health problems. This is despite alternative evidence suggesting that individuals with lived experience of mental health problems bring an additional level of competence to their clinical roles within mental health trusts. These individuals can serve as valuable assets to the organisation (Paynter and Rivers, 2015; Byrne et al., 2016; Kundra and Salzer, 2019; King et al., 2020).

1.2.2 Research Gaps

This thesis aims to challenge the prevailing narrative found in the existing literature on mental health in the workplace, which suggests that the employment of staff with lived experience is difficult to sustain. By focusing on the perspectives of clinical staff with lived experience of severe and enduring mental health problems, which includes Peer Support Workers, as well as policy makers within a mental health provider organisation, it will contribute to bridging an identified gap in knowledge and enriching our understanding of their unique experiences.

Specifically, it seeks to ascertain how clinical staff with lived experience perceive their work in light of their mental health problems and how their employer (a mental health trust) supports them. By doing so, it aims to contribute to the literature on mental health and employment. In addition, this research offers exclusive insights into the policies and practices of an NHS trust, which could be instrumental in shaping strategies and approaches in this particular setting.

The research questions addressed in this study are: How does a mental health trust support clinical staff with lived experience of

mental health problems; and how do these staff experience work, in light of their mental health problems?

A case study methodology was utilised in a mental health trust in the UK to gather data. The main sources of data were interviews and a focus group, which were examined through inductive thematic analysis.

1.2.3 Contribution

This thesis offers unique findings that have not before been presented around mental health and employment and the value of lived experience. The findings are presented as a conceptual understanding of organisational experience within a mental health trust using three key themes: Narrative versus Experience, Identity, and Power of the Powerless. Each of these themes are explored independently and then combined to provide insights into workplace culture and its impact on staff experience.

This research significantly adds to the existing body of knowledge on mental health in the workplace by highlighting the specific needs of clinical staff with lived experience. It also argues that there is a disconnect between the organisational narrative and the actual experiences of these staff. As such, the main contribution of this thesis is to critique the current dominant narrative by offering evidence that clinical staff with lived experience can and do succeed, adding value to the organisation though their lived experience.

The thesis contends that it is essential to improve organisational policies and practices in order to adequately recognise and fulfil the workplace needs of clinical staff who have lived experience working in the NHS and other similar settings.

1.3 Structure of the Thesis

The structure of this thesis consists of eight chapters, starting with this introduction. Below are concise summaries of the following seven chapters.

Chapter 2 – Literature Review

This chapter provides a comprehensive review of the relevant literature and existing research pertaining to the subject matter. It begins by outlining the approach to conducting the literature review, including the identification and evaluation of source materials. It presents an overview of the relevant legislation, policies, and data from within the UK, drawing upon global examples to support the discussion within the framework of equality, diversity, inclusion, and human rights. It then delves into a discussion surrounding the prevalence of mental health problems in the UK, highlighting its significance in political, social, and economic terms, especially in regard to employability and employment.

Next, it provides a contextual understanding of mental health and mental health problems, further emphasising their prevalence within the workforce. It then examines employment and its accessibility, exploring themes such as employer perceptions, the disclosure of mental health problems prior to employment, and the potential impact of workplace processes on staff members with mental health problems. It offers an analysis of the initiatives implemented by various public sector organisations to support individuals with mental health problems in the workplace. This chapter concludes by justifying the need for an in-depth study in this area of employment practice and outlines the research's

objectives, derived from the findings of the literature review and focused on addressing the research questions first introduced.

Chapter 3 - Methodology and Methods

Overall, this chapter serves as a roadmap for the empirical study, providing a clear structure and foundation for the research to be conducted, ensuring that it is guided by pertinent theories. This chapter outlines the research methodology and philosophical assumptions underpinning this thesis. It presents the reasoning behind specific choices made, incorporating both ontological and epistemological assumptions. It provides a practical justification for conducting the research, outlining the approaches used to gather and analyse data, along with their rationale and purpose. It then provides an overview of the case study organisation. The research design and methods are also discussed, including the recruitment of participants, data collection methods, and data analysis techniques. Moreover, ethical considerations are outlined, focusing on aspects such as obtaining informed consent from participants, safeguarding individuals, and ensuring the confidentiality of data. The chapter concludes with the researcher's personal reflections and reflexivity, which include consideration of the limitations and delimitations of the study and potential biases in the research process, while emphasising the pivotal role played by the researcher.

Chapter 4: Findings- Case Study Analysis and Theory Building: Narrative Versus Experience- Policy Makers' Perspectives

This chapter is the first of three that examine and present empirical data. Its focus is on the findings from interviews with senior managers and staff who have significant influence over the organisation's ideology, culture, and policy, namely its policy

makers. By highlighting significant trends and patterns observed in the data this chapter will demonstrate how these policy makers shape and influence the organisation's narrative and provides insight into the organisational context for staff with lived experience. It also explores the leaders' personal views and experiences of the organisational narrative, as well as the challenges they face. This chapter sets the context for Chapters 5 and 6, which will feature the accounts of staff with lived experience of severe and enduring mental health problems and the extent of workplace support provided by the Trust, as well as these staff's experiences in light of their mental health problems.

Chapter 5: Findings- Exploring the Identity of Staff with Lived Experience

The second data analysis chapter examines clinical staff with lived experience's response to the work environment. It explores how societal influence heavily impacts their identity and the perpetuation of stigma surrounding mental health problems. The chapter also delves into the challenges faced by these staff members, such as navigating their dual identities and the personal pursuit of an identity that allows them to utilise their lived experience to help others.

Chapter 6: Findings- The Power of the Powerless

This third and final findings chapter considers the autonomy, or lack thereof, that these staff members have in utilising their lived experience for the benefit of others. It explores how these individuals comprehend and navigate the conflicting emotions of power and powerlessness in their work environment. It further examines the influence of these intertwined concepts on their personal and professional lives. It concludes by examining the interviewees’ perspectives of the organisational rhetoric, evaluating

the impact of both formal and informal policies and practices. It specifically examines the role of boundaries and disclosure in empowering or disempowering staff members.

By studying this theme, it provides a framework to determine the level of support provided to staff with lived experience by the case study organisation.

Chapter 7: Discussion and Conclusions

This chapter serves as a summary of the vertical arguments presented in each of the data chapters and also addresses the research objectives outlined in Chapter 2. Moreover, it endeavours to weave together the horizontal themes found throughout the data chapters into a cohesive narrative. It provides an in-depth analysis and interpretation of the findings and discusses the implications of the results in relation to the existing literature and theories. This chapter provides valuable empirical and theoretical insights that will enhance our understanding of the subject matter based on these findings. The chapter also explores any discrepancies or contradictions observed.

Furthermore, it draws together the conclusions reached and offers specific recommendations based on the findings and analysis conducted throughout the research. These recommendations aim to address the challenges identified in the case study organisation and propose strategies for improvement. The chapter also considers the feasibility and implementation of these recommendations and discusses any potential barriers that may arise. Lastly, it highlights the strengths and limitations of the study, recommendations for future research, and the author's reflections on the research process, including an exploration of being an inside researcher.

Chapter 8 – Conclusion

The final chapter of this thesis provides of a concise summary of the research findings. It emphasises the significance of the research and its contribution to the field and discusses how this work has the potential to contribute to further research, clinical practice and policy. It concludes with a final reflection on the thesis.

Chapter 2: Background and Literature Review

2.0 Introduction

The concept of mental health has developed over time. Influenced by key factors such as technological, economic and social change as well as religious ideology and climate change, this area of scientific study reflects the philosophical perspectives of the society in which it resides (Manderscheid et al., 2010; Massazza et al., 2022; Bagasra, 2023). Accordingly, definitions of mental health, or ill health, and the language used to define and describe it, appear to be fragmented, based on each society's knowledge and understanding of the human psyche (Miller and Hubley, 2017; Horwitz, 2020). This study, however, aims to be inclusive and therefore all language that indicates a mental health problem, be it impairment, illness, condition, disorder, dysfunction, distress, disability, issue, diagnosis, and so forth, will be considered within this thesis. While the term 'mental health problem' will primarily be used throughout this thesis, participants' autonomy to choose their own language and descriptors when discussing their mental health has been respected.

The aim of this research is to determine how a mental health trust supports clinical staff with lived experience of severe and enduring mental health problems, whether Peer Support Workers or otherwise, and how these staff experience work in light of their mental health problems. In order to address this question a comprehensive review of the literature available on this topic was required. This chapter begins with a presentation of the literature review strategy and the way in which source materials were identified and assessed. This was conducted via a narrative review using a systematic approach. The second section provides a review of legislation, policy and data from within the context of the United

Kingdom, drawing into the discussion pertinent examples of knowledge and innovation from across the globe as required, set within a framework of equality, diversity, inclusion and human rights.

Section three provides a discussion on the prevalence of mental health problems within the UK and why this is deemed important to address in political, social and economic terms, particularly in relation to employability and employment. An explanation of what mental health and mental health problems are follows to provide context around prevalence within the workforce agenda. Section four examines employment and access to it, exploring key themes such as employer perceptions, pre-employment disclosure and the potential impact of workplace processes on staff with severe and enduring mental health problems. Section five provides an account of the responses of a number of public sector organisations who have developed policies and practices aimed at supporting people with mental health problems in the workplace. The chapter concludes with a justification for an in-depth study into this area of employment practice and highlights the aims and objectives of this research, based on the findings of the literature review, and the research questions being addressed.

2.1 Literature Review Strategy

A systematic search of the literature was undertaken to identify, define and interpret the employment experiences of people with lived experience of mental health problems, in particular those employed by mental health providers. The eight key medical/health databases relevant to this field of study were interrogated accordingly (Table 1), with no publication date restriction. The search strategy used a combination of free text terms (searching

the title, abstract and keywords) and relevant controlled vocabulary headings customised for each database, as well as advanced search syntax (truncation, Boolean logic AND/OR, and proximity searching) to ensure all relevant publications were identified. The search terms included the following themes, with synonyms to describe each: Health Personnel, Mental Health / Mental Health Disorders, Lived Experience, Return to work and Workplace. The full details can be seen in Table 2. References were imported into EndNote reference software and duplicates were removed.

One challenge of this search was the identification of search terms that retrieved relevant papers. Various terms used picked up superfluous publications due to ambiguity in titles of papers, for example the employment support provided by mental health practitioners, as opposed to the employment support needs of mental health practitioners. This resulted in the need to constantly review existing search terms and use the approach identified below (Table 2) as part of a systematic search to develop new search parameters. 765 documents were identified during the scoping exercise using key search terms amended appropriately to include both UK and American nomenclature. All sources not available in the English language were excluded due to lack of resources. An additional 96 documents were identified and selected following further inquiry using Google Scholar, researching the key authors identified in the database search and their respective citations.

Table 1: Literature Search Results

Databases Interrogated		No. of Documents Identified
A.	British Nursing Index	37
B.	CINAHL	77

C.	EMBASE	336
D.	MEDLINE	155
E.	PsychINFO	87
F. G. H.	Social Sciences Citation Index Web of Science Web of Knowledge	73
I.	Google Scholar	96

Table 2: Key Search Terms

Key Search Terms	
1.	HEALTH PERSONNEL/HOSPITAL PERSONNEL/MEDICAL PERSONNEL/HEALTHCARE PERSONNEL
2.	MENTAL HEALTH CARE PROFESSIONAL/MEDICAL PROFESSIONAL/MENTAL HEALTHCARE PERSONNEL
3.	MENTAL HEALTH PRACTITIONER
4.	IMPAIRMENT, HEALTH PROFESSIONAL/ HEALTH PROFESSIONAL AS PATIENTS
5.	PSYCHOLOGY/PSYCHIATRY/ PSYCHIATRIC NURSING
6.	SOCIAL WORK/ SOCIAL WORK, PSYCHIATRIC
7.	PSYCHOTHERAPY
8.	MENTAL HEALTH/ MENTAL DISORDER*/ MENTAL DISORDER, CHRONIC/ MENTAL ILLNESS/ MENTAL DISEASE
9.	"PERSONAL PROBLEM"
10.	"PERSONAL EXPERIENCE"
11.	"LIFE EXPERIENCE" / "LIVED EXPERIENCE"
12.	LIFE CHANGE EVENTS/ LIFE EVENT
13.	"RETURN TO WORK"/ VOCATIONAL REHABILITATION/ VOCATIONAL/ RECOVERY
14.	WOUNDED HEALER/PEER SUPPORT
15.	MANAGER/EMPLOYER/" WORKPLACE"/ WORK PLACE/ "WORKING CONDITIONS"/WORK RELATED
16.	ORGANISATION/ORGANIZATION/BUSINESS/FIRM(S)/ COMPANY(IES)
17.	EMPLOYMENT/ UNEMPLOYMENT/ EMPLOYMENT PRACTICES

Abstracts were obtained for each identified paper from the systematic database search and examined to determine whether

they met the inclusion criteria. Of the 333 papers selected two could not be sourced due to the fact that they were dissertation abstracts only available from the host university. The remaining 331 sources were assessed through critical reading for relevance and value to the theme of this paper, and via a RAG (red/amber/green) rating; 47 were identified as green/high relevance, 194 amber/some relevance, and 90 red/little or no relevance. All 96 academic papers sourced through Google Scholar were classed as green/high relevance. All documents were quality appraised to ensure impartiality and academic integrity, designating opinion pieces to the role of background information only. In order to contextualise the study, legislative, policy and guidance documents, collectively described in scholarly circles as 'grey literature'[1] were sourced from government, academic, employer organisation and business industry websites for review. Accordingly, 77 additional documents, all of which were identified as having high/some relevance to this study, were included.

Through detailed reading of the 414 sources with high /some relevance, a number of key themes emerged in relation to the employment experiences of people with lived experience of mental health problems. Some of these works focused simply on the stigma attached to mental health problems and the ensuing difficulties often faced by people with lived experience of mental health problems in securing suitable employment (Ezzy, 1993; Bird, 2001; Huxley and Thornicroft, 2003; Tal, 2009; Lidz and

[1] At the Grey Literature Conference in Luxembourg in 1997 (expanded in New York in 2004), 'grey literature' was defined as: "…information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial publishing […] i.e., where publishing is not the primary activity of the producing body." (Farace and Frantzen, 2005).

Smith, 2016; Hampson et al., 2018), while others explored the experiences of employees with lived experience of mental health problems across the various stages of employment (Read and Baker, 1996; Bodman et al., 2003; Thornicroft, 2006a, 2006b; Perkins et al., 2009; Williams et al., 2016; Cohen et al., 2016; Thomas et al., 2019). By carrying out a thematic analysis (Braun and Clarke, 2014), a number of sub themes were also identified and categorised within the broader themes as follows:

2.2 Context: Mental Health and Employment

2.2.1 Legislation and Policy

2.2.2 Champions of Change

2.3 Why Mental Health Matters

2.3.1 Key Facts

2.3.2 Blockages and Barriers

2.4 Mental Health and Mental Health Problems

2.5 Employment

2.5.1 Access to Employment

2.5.2 Recruitment and Selection

2.5.3 Employer Perceptions

2.5.4 Pre-Employment Disclosure

2.5.5 In the Workplace

2.5.6 Promotion Prospects

2.5.7 Termination

2.6 Organisational Response

2.2 Context: Mental Health and Employment

2.2.1 Legislation and Policy

Current UK equality and inclusion legislation sets out clear duties for all public sector organisations in relation to those groups designated as 'protected' by the Equality Act (2010). As providers

of public services, the government views such organisations as having additional moral and social responsibilities and consequently expects them to be fully inclusive in all of their policies and practices (Department of Health, 2002, 2012a, 2012b; DWP/Royal College of Psychiatrists, 2008; Boorman, 2009b; Department of Health/DWP, 2009; DWP/ Department of Health, 2009; Her Majesty's Government/ Department of Health, 2011; Stevenson and Farmer, 2017; Health and Safety Executive, 2019; DWP, 2018, 2022; WHO 2022a, 2022b).

Within the healthcare setting this translates to the expectancy of health providers to deliver high quality patient-centred services that meet individual need, while displaying enhanced levels of sensitivity and compassion (Department of Health/Department for Work and Pensions, 2009a, 2009b; Stevenson and Farmer, 2017). Research into the health and wellbeing needs of healthcare staff in the UK and beyond has identified clear parallels between organisations' staff wellbeing and the quality of the services they provide (Leiter et al., 1998; Firth-Cozens 2001a,b; Shanafelt et al., 2005; Hassan et al., 2009; Wallace et al., 2009; West et al., 2011; Mabala et al., 2019; Schrøder and Assing Hvidt, 2023). The correlation between staff wellbeing and patient care is highlighted in the Boorman Report, whereby the author maintains that health providers should "have their own house in order" by providing progressive employment practices that actively support the mental health and wellbeing of their workforce (Boorman, 2009b). Boorman further asserts his belief that the NHS in particular "has an opportunity to lead by example" (Boorman, 2009a, p.6).

Evidence, however, suggests that despite the huge raft of legislation and governmental expectations, many employers, including NHS trusts, still struggle to adequately meet the health

and wellbeing needs of their staff (Boorman, 2009b; Hassan et al., 2009; Shaw Trust, 2010; West et al., 2011; DHSC/DWP, 2015); Mental Health Foundation, 2016; Stevenson and Farmer, 2017; Shaw Trust, 2017; NHS England, 2021; CIPD, 2022; NICE, 2022; DWP, 2022). Accordingly, staff with disabilities, including mental health problems, continue to encounter daily barriers such as stigma, harassment and discrimination in the workplace (Read and Baker, 1996; Wahl, 1999; Sayce, 2000; Thornicroft, 2006a; Krupa et al., 2009; Beresford et al., 2010; Jensen et al., 2017; TUC 2017; Khan and Boardman, 2017; Fleming et al., 2019; Wilson and Finch, 2021; ACAS, 2023a; EHRC, 2023; Stuetzle et al., 2023).

2.2.2 Champions of Change

One of the main philosophies of the UK disability rights movement is the belief in the sanctity of human rights and social inclusion. Despite ongoing debates (Hughes and Paterson, 1997; Dewsbury et al., 2004; Samaha, 2007, TUC, 2017, EHRC, 2023) as to whether the 'social model of disability' is an appropriate descriptor for the goals of the modern disability rights movement, it is clear that this term has served a purpose in moving the definition of disability from one which focused on the individual's impairment, to that of the barriers imposed on the individual by society, whether they be economic, social and/or physical (Burchardt, 2004; Beresford et al., 2010; PHE, 2014; Hampson, 2022). As Dewsbury et al., (2004, p. 145) point out:

> The 'Social Model' has undoubtedly been the dominant paradigm…redefining disability in terms of a disabling environment, repositioning disabled people as citizens with rights, and reconfiguring the responsibilities of creating, sustaining and overcoming disablism.

The introduction of 'reasonable adjustments' for disabled people emanated from the social model of disability and was first introduced into UK law in 1995 via the Disability Discrimination Act (1995). Under the Act employers are required to proactively implement changes to working practices and/or the working environment and remove any physical barriers, to ensure that disabled employees are not disadvantaged when doing their jobs (EHRC, 2013). This in effect means that a disabled employee can work as effectively as a non-disabled person providing appropriate adjustments are made: for example, provision of ramps for a wheelchair user to facilitate access; or a buddying system to provide support if needed for people with hearing impairments or anxiety issues (Mind, 2022; ACAS, 2023a, 2023b; Hulse et al., 2023; EHRC, 2023).[2]

It therefore seems appropriate that this discussion be set within a framework of Equality and Human Rights, particularly in relation to the paradigms of inclusion and the Social Model of Disability. This seeks to reinforce the social, political, moral, and legislative framework in which public sector organisations, including healthcare trusts, are required to operate.

2.3 Why Mental Health Matters

2.3.1 Key Facts

Determining the prevalence of mental health problems within the

2 It should however be noted that it was not until the implementation of the UN Convention on the Rights of Persons with Disabilities in 2008 (UN General Assembly, 2008), that the failure of organisations to provide reasonable adjustments for disabled people, both as an employer and service provider, was legally defined as an act of discrimination (Lord et al., 2010). The Equality Act (2010) later reinforced this within UK legislation.

UK is a complex task due to the varying estimates identified in studies (Halliwell et al., 2007). However, the 'Psychiatric Morbidity Among Adults Living in Private Households, 2000' study (Singleton et al., 2001, p. 32), the 'Adult Psychiatric Morbidity in England, 2007' study (McManus et al., 2009, p. 221), and the Mental Health Statistics Report (Baker and Kirk-Wade, 2023) and NHS England (2023), identified that approximately 1 in 4 adults (23.4%) experienced at least one psychiatric mental health problem in any given year. This figure, in addition to the more common mental health problems such as anxiety and depression includes more serious and long-term conditions such as schizophrenia and bipolar affective disorder as well as drug and alcohol dependence. It is this figure, generally accepted within both clinical and consumer/survivor circles, which has been used extensively in the media to raise awareness of and challenge the stigma often associated with mental health problems and is a key headline in the Mind and Rethink Mental Illness campaign 'Time to Change' (Mind and Rethink Mental Illness, 2011). Using the statistic 'one in four' as a key measurement, suggests that the majority of people living in the UK may have a mental health problem themselves at some time in their lives and/or regular contact with someone who does.

Of particular importance to this study is the fact that the aforementioned Psychiatric Morbidity Studies (Singleton, 2001; McManus, 2009) identified that the incidence of mental health problems decreases significantly in individuals over 65 years of age. The London School of Economics (2012, p. 1) study and the Mental Health Statistics Prevalence Report (Baker and Kirk-Wade, 2023) corroborate this finding, reporting that almost half of all ill health for people under 65 relate to mental health problems. This suggests that mental health problems are more pervasive within

the working age population, which indicates a potential impact on employment. A report published by Deloitte in 2022 confirms this proposition, identifying that mental health problems cost the UK economy an estimated £56 billion per annum in 2020-21, equating to £1,500 to £2,400 per employee, depending on geographical region (Hampson, 2022. p.22). This considerable sum, however, only encompasses the costs to employers in the form of sickness absence, reduced productivity and staff exit due to mental ill health, and not the additional charges to the UK health bill in the form of NHS treatment costs (Hampson, 2022).[3] Furthermore, according to the Department of Health Policy on 'Mental Health and Employment in the NHS' (DoH, 2002, p. 57) employers who support and retain staff with mental health problems save themselves an estimated £80,000 in recruitment and training costs in lieu of securing a replacement.

2.3.2 Blockages and Barriers

The World Health Organization (WHO) report 'Advocacy for Mental Health' (2003) and the later Mental health at Work Policy Brief (WHO, 2022a) identify a number of on-going challenges to social inclusion which affect people who experience mental health problems. Barriers identified include lack of employment opportunities, violations of human rights, lack of parity between physical health and mental health, exclusion due to the stigma often associated with mental health, and insufficient implementation of policy. It is therefore not surprising that some researchers postulate that individuals with experience of mental health problems often hide this from their employer and their colleagues as a means of self-preservation and protection, whether

3 In 2019-20 it is estimated that the economic and social cost of mental health problems in the UK as a whole was approximately £117.9 billion. This equates to £100.8 billion in England alone (McDaid and Park, 2022, p. 10).

or not justified within the given context (Fisher, 1994; Adame, 2011; Wallace, 2012; Cohen et al., 2016; CIPD/Mind, 2018; Grant et al., 2019; Baldwin et al., 2023; King et al., 2023).

Despite the Department of Health's acknowledgement in 2002 of the detrimental impact of the Clothier Report (Clothier, 1994) on the nursing profession which, deliberately or not, prohibited the employment of individuals with mental health problems within the caring professions,[4] a number of authors such as Brandon (1999b), Bracey (2002), Burton (2010), and Wallace (2012) believe that this report fostered lasting repercussions. Philip Burnard, a professor at Cardiff University, writes that although having been diagnosed with bipolar affective disorder, he has only experienced a limited amount of stigma, attributing it to his ability to "pass as normal" (Burnard, 2007, p. 809).

Despite the potential for hostility and the prospect of stigma, particularly in the years surrounding the arrest of Beverley Allitt (1991) and the corresponding Clothier Report (Clothier, 1994), a few mental health professionals took the decision to reveal their mental health problems. These individuals include Dr. Rachel Perkins OBE, a former consultant clinical psychologist in London who shared her diagnosis with colleagues in the early 1990's (Perkins, 1999), and Dr. Rufus May, a clinical psychologist in Bradford, who 'outed' himself following qualification in 1998 (May, 2010). Both Perkins and May attribute their public disclosure of their mental health problems as essential to their practice, for as Perkins (1999, pp. 144-145) writes:

4 "If by excluding people with certain clearly definable characteristics we could be sure of excluding those who might harm vulnerable patients, then it would be worth taking the risk which such a policy would entail of incidentally excluding some people who would have made good nurses" (Clothier et al., 1994, para 2.1.4, p. 11).

> I could see no way of keeping quiet about my own madness while providing a service for people with mental health problems. What would this say about the way I viewed those with whom I worked? What would it say about the 'them and us' divide, which blights mental health services? … I believe that as long as most people use mainstream mental health services it is my duty to improve them and make them more responsive to the views and wishes of those who need them.

Perkins (2010) recounts the positive changes that have taken place since 1994, the year her employing NHS Trust began to actively recruit people with mental health problems. She does however acknowledge that a number of individuals still experience fear and terror at the thought of disclosing a mental health problem to their employer for fear of losing their job. "A complete waste of talent" Perkins (2010) categorically declares in an online video.

Although a considerable step forward from the supported work placement schemes set up for disabled people, the senior roles undertaken by individuals such as Perkins and May are however privileged. Many others, according to Burton (2010), still cannot share their diagnoses at work for fear of repercussions: stigma and/or losing their jobs. This is supported by other researchers including Grant et al. (2019), Edan et al. (2021), and Baldwin et al. (2023). When discussing the findings of their study into the lived experience of ten UK doctors, Grant et al. (2019, p. 680) conclude:

> This study reinforces that these doctors are currently working in a culture that supports negative messages about mental illness among doctors, leading to commonly held views that mental illness is equal to weakness…

Since 2009, considerable emphasis has been placed on encouraging and supporting people with mental health problems in the workplace, backed by the government supported 'Time to Change' campaign. Key policy documents such as 'No Health Without Mental Health (Her Majesty's Government/Department of Health, 2011); 'No Decision About Us Without Us' (Department of Health, 2012b); 'Local Action on Health Inequalities: Increasing Employment Opportunities and Improving Workplace Health' (PHE, 2014); and 'Employing Disabled People and People with Health Conditions' (DWP, 2022), as well as the numerous policy guides and campaigns from employer and activist organisations such as the CIPD, ACAS, Mindful Employer, and Mind are ready available to influence and advise. The questions one must seek an answer to are, what difference have they made, if any? and what work more work still needs to be done to ensure that staff with experience of mental health problems are both valued and supported at work?

2.4 Mental Health and Mental Health Problems

Largely synonymous with the term 'mental wellbeing', mental health can be described as a continuum that illustrates an individual's state of emotional and psychological wellbeing at a particular point in time, based on any number of internal or external factors (Warr, 1990; Tudor, 1996; Keyes, 2002, 2007; Lamers et al., 2011; Richards et al., 2016; Stevenson and Farmer, 2017; CIPD/Mind 2018; Hulse et al., 2023). Within policy and research, mental health is generally categorised in terms of good mental health/positive wellbeing, and poor mental health/mental health problems, as opposing ends of the spectrum (NIMHE, 2005; Halliwell et al., 2007; Department for Work and Pensions/Department of Health, 2009a, 2009b; WHO, 2010, 2022;

ACAS 2012, 2023a, 2023b; NHS England, 2021). The challenge however, according to the World Health Organization (2022c, p. 1), is not for the individual to reach the uppermost levels of positive wellbeing, but simply "a state of wellbeing that enables them to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community". This suggests that people with mental health problems can, if supported, achieve positive mental wellbeing.

The term 'mental health problems' encompasses a variety of conditions from stress, anxiety and depression to potentially more serious diagnoses such as bipolar disorder, schizophrenia, psychosis, severe depression, and obsessive-compulsive disorder. (Department of Health, 1999; Knapp et al., 2007; SCMH, 2007; NHS Employers, 2008; DWP/DoH 2009b; Richards et al., 2016; CIPD/Mind 2018). The available literature, however, suggests that the main focus of studies in relation to the impact of mental health in the workplace has been on the more "common" (DWP/DoH 2009b, p. 10) mental health conditions such as stress, anxiety and depression, largely treated within primary healthcare (Singleton and Lewis, 2003; SCMH, 2003; Halliwell et al., 2007; SCMH, 2007; NHS Employers, 2008; DWP/DoH 2009b; Mind, 2011a; CIPD, 2012a; Morgan, 2015; CIPD/Mind 2018, CIPD, 2022; ACAS, 2023a, 2023b). Such an emphasis on these conditions is not surprising as according to the report 'Fundamental Facts about Mental Health' (Mental Health Foundation, 2016), 37.3% of the population received treatment for a common mental health problem in 2014, 10.4% of whom are taking psychiatric drugs, largely prescribed by their GP. Unlike those with severe mental health problems however, approximately 50% of people with 'common mental health problems' are no longer affected after 18 months (Singleton and Lewis, 2003; DHSC/DWP, 2015).

Evidence suggests that individuals with 'more severe' mental problems, that is, conditions such as bipolar disorder, schizophrenia, psychosis, severe depression, and obsessive-compulsive disorder are by far the most disadvantaged within employment (Sayce, 2001; Perkins and Rinaldi, 2002; Huxley and Thornicroft, 2003; NMHDU, 2007; DWP/DoH 2009b; Maine and Lange, 2010; HM Government/DoH, 2011; Stevenson and Farmer, 2017; TUC, 2017; DWP, 2022; Stuetzle et al., 2023).

2.5 Employment

2.5.1 Access to Employment

Perkins et al. (2009), using data derived from the 2009 Labour Force Survey, state that the employment rate of people with mental health problems is worryingly low. It is important to note, however, that this data includes people with both common and severe mental health problems. Sayce (2001) has often asserted that the number of individuals with mental health problems in employment is much lower than any other group of disabled people; a fact confirmed by data from the 2016 Labour Force Survey, whereby 50% of people in the UK with disabilities as a whole were in employment compared to 26.2% of individuals with a mental health problem (TUC, 2017).

According to research, the percentage of individuals with severe mental health problems in employment within the UK is much lower and indeed has been consistently falling for the last 40 to 50 years (Marwaha and Johnson, 2004; Perkins et al., 2009). Huxley and Thornicroft (2003), using data from the 2002 Labour Force Survey, state that in the UK only 10% of people receiving secondary mental health care have a job. However, the most recent 'Public Health Profiles' report (Office for Health Improvement

and Disparities, 2023) using 2019/20 data highlights this percentage as having fallen to 9.1%. Furthermore, Huxley and Thornicroft (2003) add that people with severe mental health problems are generally more poorly paid, earning two thirds of the average national hourly rate. Such inequity in pay rates is supported by Edan et al., (2021) in a paper exploring how Australian healthcare staff with lived experience perceive Human Resource systems, process and practices. This suggest that even when individuals with mental health problems successfully secure a job, their lived experience is devalued and furthermore they are discriminated against by not being paid a fair wage. This supports the Equality and Human Rights Commission (EHRC, 2018) campaign, which calls on the UK Government to mandate Disability Pay Gap reporting, in line with current Gender Pay Gap reporting.

Such information needs to be considered alongside data which indicate that 35% of adults with long-term mental health conditions say they want to work, in comparison to only 28% of individuals with physical health conditions (Halliwell et al., 2007, p. 70). The desire of individuals with severe mental health challenges to be in work is further illustrated by the results of a survey of psychiatric hospital patients conducted in Bristol in 1996. This survey concluded that 87% (n = 39) of respondents wished to be in work, despite the fact that they had on average been unemployed for 3 years (Butterworth and Dean, 2000). Despite being undertaken over 25 years ago, current ONS data (ONS, 2021) suggests the situation has not improved; an assertion corroborated by disability rights organisations such as Mind (2022) and the Mental Health Foundation (McDaid and Park, 2022).

This indication of low employment of secondary mental health service users is supported by a study by Perkins and Rinaldi (2002)

into unemployment rates of people with long-term mental health problems in the London Borough of Wandsworth. This research identified that only 8% of people using secondary mental health services within the borough had a job, decreasing to 4% for those diagnosed with schizophrenia. This is comparable with data from American studies by Drake et al. (1998) and McQuilken et al. (2003) who found that competitive employment rates for people with severe mental health problems (McQuilken et al., 2003) averaged between 10% and 20%.

A study of 778 individuals with varying experiences of mental health problems, who responded to a survey commissioned by the mental health charity Mind in 1996, highlighted the vicious circle of apathy and low expectations often experienced by individuals in disadvantageous positions. 39% of respondents stated their belief that they had been denied a job due to their psychiatric history, while 69% claimed that they had been dissuaded from applying for jobs, for fear of being treated unfairly (Read and Baker, 1996). Research also suggests that people with mental health problems may experience a number of other discriminatory behaviours on a daily basis as a result of their psychiatric histories, exacerbating existing perceptions of discrimination in relation to employment processes. These may include difficulties around family and parenting rights, housing, health and social care, insurance, the justice system, media, relationships etc. (Read and Baker, 1996; Wahl, 1999; Sayce, 2000; Thornicroft, 2006a; Beresford et al., 2010; Jennings et al., 2017; Baldwin et al., 2023).

Tal et al. (2009) however, remind us to be cautious when presenting data illustrating self-reported perceptions of discrimination in relation to disabilities. Whilst they accept that many such reports may be legitimate, they identify that

researchers need to acknowledge the potential for bias, as job seekers, in an attempt to self-preserve "may attribute their lack of success to employers' prejudice rather than their own lack of competitiveness" (Tal et al., 2009, p. 86).

2.5.2 Recruitment and Selection

According to Perkins and Rinaldi (2002) one of the biggest barriers to employment for those with mental health problems in general, is a result of employers' reluctance to consider individuals who have a history of mental health problems. By referencing Manning and White's 1995 study, they assert that this is even greater for individuals with more severe and enduring mental health problems. This study concluded that 66% (n = 72) of the personnel directors who responded to a survey questionnaire would never employ someone with schizophrenia (Manning and White, 1995). This is supported by a more recent study by Dolce and Bates (2019) exploring the views of American Human Resources professionals towards recruiting people with psychiatric disabilities. Based on the data obtained from the focus groups, it was concluded that individuals who revealed their personal background before receiving a job offer would most likely be eliminated during the screening stage of the recruitment process.

Link et al. (1997), in an American study of individuals with severe and enduring mental health problems identified that 75% of the 84 men interviewed would not declare their mental health problem to a prospective employer for fear of immediate rejection. Furthermore, 60% of the cohort stated that they would not even consider applying for a job if they believed an employer would not appoint someone who had spent time in a psychiatric unit.

A formal investigation by the former Disability Rights Commission (DRC, 2007) into disabled people's access to the nursing, teaching and social work professions also supports the assertion, stating that people fear disclosing their lived experience of mental health problems to a potential employer. The DRC Report identified that the Clothier Report (Clothier, 1994) resulted in the stigmatisation of those who have or have had mental health problems. This, it states "has led people to be excluded from training and employment… [often being] 'driven underground' by attitudes, policies and practices that are frequently discriminatory" (DRC, 2007, p. 10). This claim is supported by the earlier Department of Health Report 'Mental Health and Employment in the NHS' (DoH, 2002), which confirmed that the Clothier Report had resulted in people being excluded from NHS employment due to the use of "inappropriate criteria" (p. 9).

Research, however, suggests that the exclusion of people with known mental health problems from employment, particularly within the caring professions, was already well established prior to publication of the Clothier Report (Jones, 1991; Fisher, 1994; Perkins, 1999; Adame, 2011; Wallace, 2012). The Clothier Report (1994), one could suggest, simply brought it to the attention of employers and fuelled an already well-established debate based largely on ignorance and fear.

2.5.3 Employer Perceptions

In the UK, under the Equality Act (2010) and its precursor, the Disability Discrimination Act (1995), an individual is protected in all aspects of recruitment and employment from discrimination as a direct consequence of their disability. In 1998, Glozier et al. conducted a study, aimed at exploring the impact of the stigma of mental health problems within recruitment. Having surveyed 200

UK Human Resource Directors, the research established that a mental health diagnosis had a considerably negative impact on an applicant's employment prospects compared to someone with a physical disability such as diabetes. It is noteworthy that the variances in judgment between the two conditions were found to be based on perceptions of poor performance as opposed to beliefs about potential sickness absence. The research, however, concluded that the claims relating to the poor performance of people with mental health problems were unsubstantiated and that:

> the attitudes of employers towards people with mental illness do not reflect the known facts, [and consequently] unfounded stigma regarding job performance expectation is a major hindrance to employment… (Glozier, 1998, p. 798).

A comparable study commissioned by the Department for Work and Pensions in 2001 yielded similar results. The data highlighted that only 37% of UK employers would consider employing someone with a history of mental health problems, in contrast to 62% with a physical disability (Department for Work and Pensions, 2001, p. 31). This conclusion is reflected in the Time to Change Report (Mental Health Media/ Rethink/ Mind, 2008), which states "stigma and discrimination [amongst other things] stops people getting jobs" (p. 3). This emphasises the influence that the perceptions of employers have on the life chances of people with mental health problems. It is important, however, that the final Time to Change Report (Crawshaw, 2012) identified a 9% decrease in the levels of discrimination experienced by individuals with psychiatric histories seeking work between 2009 and 2010 (p. 10). Such a decrease in perceived levels of discrimination is refuted by researchers such as Hart et al. (2020) who advocate that stigma and discrimination are

rife within the UK and Ireland labour markets. This, they assert, has a huge detrimental impact in particular on young people between the ages of 16 and 24 who have complex needs, of which 61.8% are unemployed. Lidz and Smith (2016) suggest a similar pattern within the Australian youth labour market. Such a disparity reminds researchers to actively question the reliability of research data, particularly those relating to self-selecting studies where there is an absence of longitudinal data. The importance of comparing statistics with the longitudinal datasets such as those available through the UK annual Labour Force Surveys (ONS, 2021, 2023) is vital to providing comprehensive, high-quality research.

2.5.4 Pre-Employment Disclosure

It is worthy of note that the Equality Act (2010), which came into effect on the 1 October 2010, explicitly prohibits employers to administer pre-employment health questionnaires, except in limited circumstances. The aim of this stipulation is to eradicate any possible discrimination at the application stage, an area where it was believed that unfair decisions were often made based on medical disclosures, particularly in relation to mental health problems (Lockwood et al., 2012). This requirement clearly mirrors that contained in the Americans with Disabilities Act of 1990 (Madan and Williams, 2010). This was an important and welcome change for disabled individuals and disability rights campaigners, as research had confirmed that pre-employment questionnaires could discourage people from applying for jobs due to anticipated discrimination (SHiFT, 2009, p. 8).

In the Equality Act (2010), as in its predecessor the Disability Discrimination Act (1995), it is important to note that there is no requirement for an individual to disclose their disability to an employer, with only one exception. This is where the individual's

disability may, while carrying out the requirements of the job, constitute a risk to the health and safety of themselves and/or their colleagues as detailed in the Health and Safety at Work Act (1974). Evidence provided by the UK Health and Safety Executive however, has been critical of employers, implying that that they "continue to demonstrate ignorance about the real safety risks of different disabilities and conditions of ill health… and use health and safety requirements as an excuse for denying employment to those thus affected" (Jacoby et al., 2005, p. 1984). This, they conclude, pertains to unjustified discrimination based on "unfounded and prejudicial fears" and "overprotectionism" (Hurstfield et al., 2003, p. 18). Such assertions can be exemplified in an excerpt from the Nursing and Midwifery Council website in the section titled 'competencies' which reads:

> If you have a disability or a health condition, or a conviction or a caution, it will not necessarily prevent you from entering a programme or from registering as a nurse or midwife or from continuing your career as a nurse or midwife. However, if you have a disability or a health problem you may need to seek advice about whether you can be adequately supported to be capable of providing safe and effective practice without supervision (Kane and Gooding, 2009, p. 5).

Not only are these words open to manipulation and bias, which could easily be used as a means to discriminate, the fact that disabilities and health conditions are referred to in the same sentence as criminal convictions might encourage perceptions of risk. It is therefore not surprising that during a formal consultation of the document, clear evidence emerged of the need to amend this 'competency' (Kane and Gooding, 2009). The new text is much more positive, suggesting that although good health is a pre-

requisite for nursing or midwifery practice, it does not preclude people with disabilities or long-term health conditions. Instead, the focus is on ensuring that individuals, in order to be fit to practice, are able to "demonstrate suitable attention to their personal needs and should not, for example, abuse or be dependent on alcohol or drugs" (NMC, 2013). Mental health problems in general are not seen as a concern, only mental health problems that are both "serious" and "unmanaged" (NMC, 2013).

2.5.5 In the Workplace

Once individuals do overcome the barriers to gaining employment, perceived or real, evidence suggests that there are a number of other potential challenges an individual with a mental health problem can face once in employment. Research suggests that these challenges can be present at all stages of the employment relationship: on the job, promotion prospects, termination of employment etc.

The aforementioned study by Read and Baker (1996) for the mental health charity Mind into the experiences of people with mental health problems, concluded that 38% (n = 296) of respondents reported having been harassed, intimidated or teased at work, while 34% (n = 265) stated that they believed that they had been forced to resign or were dismissed due to their psychiatric history (Read and Baker, 1996, p. 8). It may be surprising to note that the study identified the health and social care sector as the worst reported offender as 20% (n = 53) of those who believed that they been unfairly dismissed from their jobs were nurses, other caring professionals, or other NHS employees (Read and Baker, 1996, p. 8).

A similar study conducted in Ireland (MacGabhann et al., 2010) discovered that 43% (n = 132) of respondents believed that they had been discriminated against at work due to their mental health problem, citing examples such as being bullied, ignored, avoided, and the victim of practical jokes. Indeed, some stated that it became so bad that they felt forced to resign. This is in contrast to an acknowledgement by the vast majority of respondents that work was essential to their recovery: a place where they could "maintain normality, and have respite from other stressors" (MacGabhann et al., 2010, p. 26); a conclusion shared by a growing number of mental health researchers across the world (Evans and Repper, 2000; Sayce, 2001; Perkins and Rinaldi, 2002; Huxley and Thornicroft, 2003; Warner, 2005; Dunn et al., 2008; Leufstadius, 2009; Tal et al., 2009). As stated earlier, however, it is important that researchers acknowledge the limitations, as a form of credible evidence, of self-reports of employment discrimination upon which these studies are based. Individuals are subject to perceptual errors and potential bias, based on an innate desire to protect themselves (Tal et al., 2009). Similarly, employers asked to comment on their recruitment practices towards people with mental health problems may not respond in the same way to a theoretical question, as they would do in reality (Link et al., 2004). This may be attributed to factors such as social pressure to be 'politically correct' and legislative awareness (Penn and Nowlin-Drummond, 2001). Such reports therefore need to be supported with additional evidence if they are to be of value to the area of research (Tal et al., 2009).

Warner (2005) highlights that it is important to note that some mental health problems do have a substantial and negative impact on an individual's ability to obtain and maintain employment. Consequently, he claims that many individuals with mental health

problems are not able to move directly into full-time jobs, leading one to conclude that fewer hours and less responsibility can in some cases be beneficial. Nevertheless, this relies on key support packages for individuals affected, such as wage subsidies and living allowance protection. Furthermore, individuals whose mental health condition developed in their youth may never have worked in the first place and are likely to need added support (Perkins et al., 2009). According to the Perkins and Rinaldi (2002), research indicates that if individuals with severe mental health problems receive sustained and suitable support then the figures suggest that over half (58%) can be sustained in competitive employment. For others, "employment would be a realistic option if they were provided with right levels of support and received consistent, encouraging messages around the positive effects of appropriate work" (Perkins et al., 2009, p. 31). It is also important to remember, however, that some people with mental health problems are able to secure employment and have successful careers without any assistance. As Perkins et al. (2009, p. 103) write:

> Many people with mental health problems are reliable and conscientious workers who are fully capable of performing well in pressurised and responsible positions…For some people, mental health problems will have no effect on job performance, for others their mental health may affect their work only temporarily.

Furthermore, in their recent research, Elliott and Reuter (2022) shed light on the significance of individuals with lived experience in the workforce and the contributions they can bring to an organisation. This study, examining the benefits and challenges encountered by working professionals with lived experience of

mental health problems who engaged in employment, concluded that such individuals can, with the right level of support, perform well at work, and provide added benefits to the working environment such as increased empathy with the experiences of clients and unique insights that inform and enhance their work. The notion of increased empathy is supported by other researchers such as von Hippel et al. (2022) and Stuetzle et al. (2023), who suggest that mental health professionals who have personal experience of mental health problems can utilise their lived experience to augment their empathic understanding of their clients, ultimately fostering stronger therapeutic relationships. Furthermore, von Hippel et al., (2022), propose that mental health staff with lived experience may be less susceptible to burnout linked to the belief that their clients were not making progress in treatment, due to their personal understanding of the challenges of recovery.

2.5.6 Promotion Prospects

Prospects of promotion for people with psychiatric histories is another key issue identified within the literature, however, empirical studies in this area are limited (Glozier, 1998; Mental Health Foundation, 2002; Office of the Deputy Prime Minister, 2004; Thornicroft, 2006b; Knapp et al., 2007; Tal et al., 2009; CIPD 2011). Studies from America, the UK and beyond suggest that those fortunate to find and sustain employment often find their opportunities for progression limited because of their mental health problem (Bird 2001; Mental Health Foundation, 2002; Knapp et al., 2007; Tal et al., 2009; CIPD, 2011; Cohen at al., 2016; Edan et al., 2021). The aforementioned study by Glozier (1998), for example, concluded that of the 31 UK HR directors who responded to the question on employing someone with depression 58% (n = 18) stated that they would never appoint someone as an

executive whom they knew to have this diagnosis. This was in contrast to only 5% (n = 2) who stated that they would never employ such an individual in a clerical position, and 6%, in a manual role. However, the examples offered to substantiate this cannot be authenticated, as, like so much of the evidence available, they are based on individual perceptions of discrimination or the responses of employers to hypothetical questions.

The formal investigation report of the UK Disability Rights Commission (DRC, 2007), by examining the regulation of and practices within the nursing, teaching and social work professions, concluded that there was evidence to suggest that the career prospects of people with mental health problems were being negatively affected as a result of discriminatory attitudes and practices. The report established that people with mental health problems were sometimes singled out for workplace investigations into their fitness to practice due to perceptions of risk. Particular concerns were expressed in relation to the nursing profession, where it was suggested that such investigations had damaged individuals' opportunities for promotion even when no evidence of risk was found. The difficulty with this report for the researcher, as with previous evidence, however, is that the conclusions are based on perceptions of employers and regulatory bodies, not on an examination of empirical evidence in the form of case management reports and statistics, as these were unavailable.

Bird (2001) highlights that one of the key issues identified in a UK survey of 556 people with mental health problems in employment relates to their experience of being given what they perceive to be demeaning jobs with little or no career prospects. A similar study conducted by the Mental Health Foundation (2002, p. 20) found

that 17% (n = 70) of participants alleged that they had been denied promotion because of their mental health problem. Although this statement is again based on perceptions, it can be contextualised by evidence affirming that UK employees who had severe and enduring mental health problems earned only two-thirds of the national minimum wage rate at this time (Office for National (ONS) Statistics, 2002; Huxley and Thornicroft, 2003). American research suggests that such discrimination is endemic; 56% (n = 733) of respondents in a study reported that they had been advised by friends, family, work colleagues, employers etc. to settle for jobs much lower than their skills, knowledge and experience due to their mental health status (Wahl et al., 1999). It is not clear however, if such advice was intended to be a supportive gesture or not, although the fact that 70% (n = 918) of respondents reported that once their mental health status was known they felt that they were treated by others as less competent (Wahl et al., 1999), suggests their perception was that it was largely not viewed in this way. This has parallels with the findings of a study conducted by Edan et al. (2021), who use the term "psychiatric gaze" to define how staff with lived experience of mental health problems describe their constant scrutiny in the workplace for reasons they believe are related to their mental health disclosure.

2.5.7 Termination

Another key theme within the literature relates to the ending of the contractual relationship between the employer and employee. Becker et al. (1998) suggest that retaining a job is often harder for people with mental health problems than securing one in the first place; an assertion supported by Williams et al. (2016). In addition, Burchardt (2003), based on an analysis of the longitudinal datasets from the 2002 Labour Force Survey for the Department

for Work and Pensions, asserts that people with mental health problems, in comparison to other health conditions, are twice as likely to lose their jobs as soon as the condition arises. A survey by Mind in 2011 (Mind, 2011b) confirmed that people's views of disclosing a mental health problem to an employer were unchanged; 22% of individuals who declared a mental health problem stated that they had been fired or forced to resign as a result of this declaration.

Research conducted by a user-led team for the Mental Health Foundation in Bristol identified that 31 (55%) of the survey respondents, who believed they had lost their jobs due to mental health problems, had tried unsuccessfully to find other work or study opportunities (Bodman et al., 2003). The 45% who were able to secure new employment reported that their new job involved less responsibility, fewer hours and less or no pay (p. 10).

2.6 Organisational Response

One of the first key initiatives set up to tackle discriminatory workplace practices in relation to mental ill health in the UK was the Mindful Employer Charter (the Charter) in 2004. The Charter, initiated and administered by Devon Partnership NHS Trust, is clear in its intent and purpose. Its marketing information clearly states that its purpose "is not an accreditation or a set of quality standards nor a policy or target", but simply an "indication of a willingness to work towards better practice" (Mindful Employer, 2013, p. 1).

An independent evaluation of the Mindful Employer Charter by Sheffield Hallam University in 2012 confirmed that it had been successful in achieving its aims, namely providing a valuable

service by supporting the employer who "with the right support… can continue to deliver their business" (Frost, 2012, p. 33). In 2013 1,089 employers had signed up to the Charter, representing just over 1.25 million employees (Mindful Employer, 2013). This increased to 1,350 employers in 2023 (Mindful Employer, 2023), however updated data identifying how many staff are employed by Mindful Employer signatory organisations are not available. If, however, one was to calculate the number of employees as a proportion, based on the 2013 data, this would equate to 1.55 million staff employed by signatories. The 2023 August Labour Market Overview (ONS, 2023), states that the number of people over 16 in the UK workforce is 30.2 million which suggests that there are approximately 28.65 million employees who do not work for a Mindful Employer. This indicates that the opportunity exists for a large number of employers to engage with the Charter should they choose. Furthermore, recent research into employers' practices regarding mental ill health in the workplace (CIPD, 2019, p. 4) concluded that only 9% of organisations had a standalone employee mental health policy. This showed only a small improvement of 8% from a previous study in 2006 (Shaw Trust, 2010, p. 10). Furthermore, the Shaw Trust's 2017 report 'Mental Health at Work Still the Last Taboo', aimed at understanding the changes to the thinking of British business since their 2010 report concluded that in spite of a raft of UK legislation and policy 56% of UK employers stated their reluctance to recruit an individual with lived experience of mental health problems; an increase of 5% from their earlier report. While it is anticipated that this may have increased in recent times due to the enhanced focus on health and wellbeing post COVID pandemic, and the increased numbers of Peer Support Workers employed within mental health service provision (Adams et al., 2022; Watson and Repper, 2022; Smit et

al., 2023), there is little to suggest that there is considerable improvement in this regard (Burley Law, 2022; Smit et al., 2023).

Mindful Employer, however, is not the only organisation working in this area. As mentioned, there have been a plethora of guidance documents and national campaigns in the UK, particularly since 2009, led by governmental, employer and activist organisations. These are summarised in Tables 3 and 4.

Table 3: Key UK/European Policy and Campaigns pre-2009

Year	Title	Author/ Publisher	Type	Brief Description
1948	The Universal Declaration of Human Rights	United Nations (UN General Assembly, 1948)	Universal Declaration	Declaration made by world leaders to guarantee the rights and protections of all human beings.
1995	Disability Discrimination Act (DDA)	HMSO/ TSO (Disability Discrimination Act, 1995)	Act of Parliament	A UK Act of Parliament aiming to end the discrimination faced by many people with disabilities, including individuals with mental health problems. Key areas focused on include employment, education, the provision of goods and services.
1989	Consumer Involvement in Mental Health and Rehabilitation Services	World Health Organization, Geneva (WHO, 1989)	Discussion Document	A discussion document that highlights the rationale for, and consequent importance of, engaging service users in decisions about their own health care. The document outlines the position of the World Health Organization which views individual

				involvement in personal healthcare decisions as an enhancement to the healthcare system.
1998	Changing Minds Campaign	Royal College of Psychiatrists, 1998-2003 London (Crisp, A. H., 1998)	Chairman's Statement on behalf of the Campaign Management Committee. Campaign Website no longer accessible.	Campaign by the Royal College of Psychiatrists to actively tackle the problem of stigmatisation of people with mental health problems. The target groups included doctors, children and young people, the employers, the media, and the general public.
1998	Human Rights Act	HMSO/TSO (Human Rights Act, 1998)	Act of Parliament	Codifies the protections of the European Convention on Human Rights into UK law, which all public bodies have a duty to comply with. Sets out fundamental rights and freedoms, which include the right to liberty and security and protection from discrimination in respect of these rights and freedoms.
2003	Employment for People with Mental Health Problems	Department of Health/ National Institute for Mental Health in England (DoH/NIMHE, 2003)	Policy Briefing	Summarises the findings of a review of research evidence and expert opinion about occupational interventions for people with mental health problems, as commissioned by the Department of Health in 2001. Amongst other things, the report highlights that people with mental

				health problems are less likely than any other group of disabled people to be employed.
2003	The Economic and Social Costs of Mental Illness	The Sainsbury Centre for Mental Health (SCMH, 2003)	Policy Paper	Report into the economic and social costs of mental health problems in England. Estimated cost £77.4 billion in 2002/3.
2003	Improving Working Lives and Practice Plus Standard	Department of Health (DoH, 2003)	NHS Standard	Government standard to help make the NHS a model employer. It aims to improve recruitment and retention to support the modernisation of the health service. NHS organisations are required to demonstrate their commitment to improving the working lives and workplace wellbeing of their employees. This includes investing in more flexible, supportive and family-friendly working arrangements that will foster diversity, tackle discrimination and harassment, and nurture the professional growth of staff.
2003	Life's Labours Lost: A Study of the Experiences of People who have Lost Their Occupation Following Mental Health	Mental Health Foundation (Bodman, R. et al., 2003)	Research Report	Research study into the experiences of people who have lost their job following mental health problems. The report identifies the personal and social costs of discrimination on individuals and suggests ways that such effects may be minimised.

	Problems			
2005	Disability Discrimination (Amendment) Act	HMSO/TSO (Disability Discrimination Amendment) Act, 2005)	Act of Parliament	The Disability Discrimination (Amendment) Act (2005) extended the Disability Discrimination Act 1995 to include public transport and introduced a duty on public bodies to promote equality for disabled people.
2005	The Management of Health, Safety and Welfare Issues for NHS Staff	NHS Employers (NHS Employers, 2005)	Policy Report	Policy and guidance document which clearly outlines the duties of NHS organisations to support people with mental health problems, and to encourage them to work in the NHS. Also provides practical advice on risk assessment, employees' responsibilities, reasonable adjustments, stress management etc.
2005	Making It Possible: Improving Mental Health and Wellbeing in England	Care Services Improvement Partnership/National Institute for Mental Health in England (NIMHE, 2005)	Best Practice Guidance	A best practice framework to support the development and delivery of actions to improve mental health and wellbeing in England.
2006	Actions Speak Louder: Tackling Discrimination Against People with Mental Illness	Mental Health Foundation (Thornicroft, G. (2006b)	Research/ Change Report	Highlights the impact that discrimination has on individuals with mental health problems, based on evidence from across the globe. The report underlines the importance of engaging

				service users as a catalyst for attitudinal change and sets out a policy agenda for change.
2007	The Fundamental Facts: The Latest Facts and Figures on Mental Health	Mental Health Foundation (Halliwell, E., et al., 2007)	Policy Report	Facts and figures on mental ill health, presented in an accessible format, with the aim of improving understanding and awareness of mental health problems, therefore allowing better health promotion, prevention and treatment.
2007	Maintaining Standards: Promoting Equality- Professional Regulation within Nursing, Teaching and Social Work and Disabled People's Access to these Professions	Disability Rights Commission (DRC, 2007)	DRC Formal Investigation Report	Formal investigation into the professional regulation requirements within nursing, teaching and social work. The investigation concludes that these regulations often deter disabled people from accessing, entering or remaining in these professions and can have a detrimental impact on their lives.
2007	Work, Recovery and Inclusion: Employment Support for People in Contact with Secondary Mental Health Services	National Mental Health Development Unit (NMHDU, 2007)	Policy Briefings	Government commissioned policy briefings undertaken by the NMHDU, aimed at promoting social inclusion and eradicating social injustice through government-led strategies. The policy briefings highlight the high priority level the government affords to mental

				health and employment and its commitment/ planned actions to address the issues and improve outcomes for individuals with mental health problems.
2007	Mental Health at Work: Developing the Business Case	The Sainsbury Centre for Mental Health (SCMH, 2007)	Policy Paper	Highlights the importance to employers of effectively managing mental health problems in the workplace, quantifying them in financial terms to illustrate why supporting staff with mental health problems makes good business sense.
2008	Stigma Shout: Service Users and Carer Experiences of Stigma and Discrimination	Time to Change (Mental Health Media/ Mind/ Rethink Mental Illness, 2008)	Research Report	This report sets the scene to determine the future impact of the newly launched national three government backed campaign (2008-11) to change people's understanding and perceptions of individuals with mental health problems. The research report provides valuable evidence as to where and how to target the campaign based on service users' and carers' experiences of stigma and discrimination.
2008	UN Convention on the Rights of Persons with Disabilities	United Nations (UN General Assembly, 2008)	UN Convention	The Convention reaffirms the human rights and fundamental freedoms of disabled people and asserts that they should be able to enjoy them on a basis equal to that of non-disabled people. It also recognises the

				barriers disabled people continue to face in actualising their human rights and identifies measures that governments should take to remove these barriers and ensure that disabled people are protected.
2008	High Quality Care for All: NHS Next Stage Review Final Report	Department of Health (DoH)/ TSO. (Darzi, A. 2008)	Governmental Review into the NHS	Identifies the importance of expanding mental health and wellbeing services in the community, including better mental health promotion. Includes a pledge to improve workplace equality, staff support, staff empowerment, and staff health and wellbeing.
2008	Mental Health and Work	Royal College of Psychiatrists/ DWP DWP/Royal College of Psychiatrists (2008)	Independent Report	Report commissioned by the cross-government Health Work and Wellbeing Programme to inform policy and guide action in relation to health and employment. This report feeds into Professor Dame Carol Black's review of health-related factors that influence working life in Britain and makes recommendations.

Table 4: UK National Guidance and Campaigns Focussing on Mental Health: 2009-2023

Year	Title	Author/ Publisher	Type	Key Themes
2009	NHS Health and Wellbeing: Final Report (Boorman Report)	Department of Health (DoH) (Boorman, S., 2009b)	Review Report	Review report, which identifies a number of recommendations for change to improve the health and wellbeing of all NHS staff, with an emphasis on physical, mental and social contentment.
2009	Working Our Way to Better Mental Health	Department for Work and Pensions, and Department of Health (DWP/ DoH, 2009b)	Command Document: Framework for Action	Defining clear links between mental health and employment, this report shows the vital role employment has to play in improving mental health and wellbeing. The document aims to establish a cross-government approach to tackling the cost of unemployment and the ensuing waste of individual talent.
2009	Working for a Healthier Tomorrow**:** Dame Carol Black's Review of the Health of Britain's Working Age Population	DoH/ DWP (DoH/ DWP, 2009a)	Review Report	Review of the health of Britain's working age population, commissioned by the Secretary of State for Health and the Secretary of State for Work and Pensions. Central to the review is an acknowledgement of the high human, social and economic costs of impaired health and wellbeing to the UK workforce.

2009	Realising Ambitions: Better Employment Support for People with a Mental Health Condition- A Review to Government	DWP (Perkins, R., et al., 2009)	Command Document: Review Report	Report presenting the findings of a review into the high levels of worklessness and therefore exclusion and marginalisation of people with mental health conditions. Provides recommendations that could be realistically implemented in the medium term without any new resources or new primary legislation.
2009	Promoting Mental Wellbeing at Work	The National Institute for Clinical Excellence (NICE) (NICE, 2009)	Guidance Document	Guidance for employers on promoting mental wellbeing through productive and healthy working conditions. Focuses on interventions to promote mental wellbeing through productive and healthy working conditions.
2009	Line Managers' Resource: A Practical Guide to Managing and Supporting People with Mental Health Problems in the Workplace	SHiFT (SHiFT et al., 2009)	Good Practice Guidance	Practical guidance for people managers on managing and supporting staff with mental health problems within the workplace.
2009	Work, Recovery and Inclusion: Employment Support for People in Contact with	Her Majesty's Government (HM Government, 2009)	Good Practice Guidance	Promoting the fact that people with mental health conditions can and do work, despite evidence that those with severe mental health conditions are significantly under-employed. Emphasises

	Secondary Mental Health Services			the message that work is good for mental health and is key to recovery. Aims to significantly increase the number of people who access secondary mental health services in employment by 2025.
2010	A Review of Pre-Employment Health Screening of NHS Staff	The Stationery Office (TSO) (Madan, I. and Williams, S., 2010)	Review Report	Review of the effectiveness or lack therefore of pre-employment health screening for NHS staff. Recommends a review of current guidance identifying clear and explicit criteria whereby pre-employment screening is required in a limited number of instances.
2010	Hear My Voice: The Experience of Discrimination of People with Mental Health Problems in Ireland	Dublin City University/ Amnesty International Ireland MacGabhann, L. M. et al., 2010)	Investigation Report	Research into the experiences of people with mental health problems in Ireland, which highlights the discrimination and unfair treatment encountered daily by this often-marginalised group.
2010	NHS Employers Open Your Mind Campaign	NHS Employers (NHS Employers, 2010)	NHS Campaign	Mental Health and Employment Campaign and work programme aimed to help NHS organisations deliver the public sector agreement (PSA) 16. Campaign aims to reduce the stigma and misperceptions around mental health and employment and will enable employers to create a better

				working environment for all staff, improving working rates for those with mental health problems.
2010	Attitudes to Mental Illness	SHiFT/ DoH (SHiFT/ DoH, 2010)	Research Report	Findings of the 2011 study into attitudes of adults in England towards mental illness. Report highlights a number of significant changes over time since this annual survey's inception in 1994.
2010	No Health Without Public Mental Health: The Case for Action	Royal College of Psychiatrists, London (Royal College of Psychiatrists, 2010)	Position Statement	A position statement by the Royal College of Psychiatrists, advocating that mental health is a key public health issue, which has an impact at all levels of society, and accordingly should be set as a priority across all government departments.
2010	The Economic and Social Costs of Mental Health Problems in 2009/10	The Sainsbury Centre for Mental Health (SCMH, 2010)	Policy Paper Update	An update of the 2003 report into the economic and social costs of mental health problems in England. Estimates an increase in costs from £77.4 billion in 2002/3 to £105.2 billion in 2009/10.
2010	The Equality Act	HMSO/TSO (Equality Act, 2010)	Act of Parliament	The Equality Act (2010) replaced existing anti-discrimination laws with one single Act, simplifying the law and making it more accessible. It also strengthens the law in relation to tackling discrimination and inequalities across all of the nine defined 'protected

				characteristics'. The Act protects individuals who have or have had a disability, including mental health problems, as well as those perceived to have a disability.
2010	Mental Health: Still the Last Workplace Taboo?	Shaw Trust (Shaw Trust, 2010)	Research Report	Independent report aimed at charting business attitudes to mental health since the Trust's first study in 2006. Report highlights a number of positive and negative changes in business attitudes since 2006.
2010	Towards a Social Model of Madness and Distress? Exploring What Service Users Say	Joseph Rowntree Foundation (Beresford, P. et al., 2010)	Research Report	Report explores mental health service users' views about social approaches to madness and mental distress and their relationship with the social model of disability.
2011	Time to Change	Mind and Rethink Mental Illness (Mind and Rethink Mental Illness, 2011)	Government Backed Media Campaign	Government backed media campaign aimed at challenging mental health stigma and discrimination in England.
2011	Mindful Employer- A Practical Guide to Supporting Staff with a Mental Health Condition	Mindful Employer (Mindful Employer, 2011)	Good Practice Guidance- Line Manager's Resource	Good practice guidance produced by Mindful Employer, aimed at providing practical guidance and advice for managers in supporting staff with mental health problems.
2011	Managing and	CIPD	Good	Good practice guidance for

	Supporting Mental Health at Work: Disclosure Tools for Managers	(CIPD, 2011)	Practice Guidance	managers on supporting staff with mental health problems. This guidance was developed by the CIPD in partnership with Mind as a result of the data and intelligence that highlighted that mental health, in particular stress, is the biggest cause of long-term sickness absence among all workers.
2011	Taking Care of Business: Employer Solutions for Better Mental Health at Work	Mind (Mind, 2011a)	Business Summit Report	Summary report of Mind's 2011 business summit, aimed at identifying the challenges employers experience in supporting staff with mental health problems. The report highlights the debate and identifies the recommendations made by the sixteen business organisations that participated in the summit.
2011	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages	Her Majesty's Government/ DoH (HM Government/ DoH, 2011)	Outcomes Strategy Supporting Document	A cross government mental health strategy, which sets out six shared objectives aimed at improving the UK's mental health and wellbeing and improving outcomes for people with mental health problems through the provision of high-quality services.
2012	No Decision About Us Without Us	DoH (DoH, 2012b)	Guidance Document	Guidance and information document, developed in partnership with eight mental health organisations. The main aim of the document is

				to inform people who use mental health services, carers and the public of the Government Framework created in response to the 'No Health Without Mental Health Strategy' and encourage them to use it to drive change in their locality and hold local services to account.
2012	Advice for Employers on Workplace Adjustment for Mental Health Conditions	DoH (DoH, 2012a)	Guidance Document	Practical advice, guidance and resources to enable employers to effectively explore and consider reasonable adjustments for people with mental health conditions in partnership with the individual concerned.
2012	Mental Health is Your Business-Workplace Policy	Equality and Human Rights Commission (EHRC, 2012)	Policy Guidance	Guidance for employers on developing an effective workplace policy, which actively supports staff with mental health problems. This, the EHRC asserts, will enable mental ill health to be managed better, benefiting both employer and employee.
2012	Promoting Positive Mental Health at Work	ACAS (ACAS, 2012)	Good Practice Guidance	Good practice guidance aimed at improving workplace cultures by getting employers and employees to talk about mental health and providing managers with the tools and confidence to deal effectively with mental health problems.
2012	How Mental Health Loses Out in the	London School of Economics and Political	Policy Report	Report highlighting the inequalities that exist due to the NHS' unequal treatment

	NHS	Science (LSE, 2012)		of mental illness in comparison to physical illness. This, it is asserted, is the case despite the fact that mental illness accounts for 23% of the total burden of disease, yet only receives 13% of the NHS health expenditure.
2012	Absence Management: a. Full Report b. Public Sector Summary c. Private Sector Summary	CIPD (CIPD, 2012a, 2012b, 2012c)	Annual Survey Report	Highlights the findings of the CIPD's thirteenth national survey of absence management trends, policy and practice. This report provides benchmarking data for organisations on absence levels and highlights the costs and causes of absence. Separate public sector and private sector summaries are also available.
2013	Beyond the Usual Suspects	Shaping Our Lives: A National Network of Service Users and Disabled People (Beresford, P., 2013)	Research Report	A research report exploring why some groups tend to be left out of involvement and engagement activities and/or face more barriers, often resulting in organisations consulting 'the usual suspects', perpetuating health inequalities. Following on from this report, practical guidance was published aimed at encouraging individuals who wish to make a difference to get involved in supporting organisations and services to better understand and include all of their service

				users on equal terms.
2013	Mental Health (Discriminatio n) Act	HMSO/TSO (Mental Health Discrimination Act, 2013)	Act of Parliament	The Mental Health (Discrimination) Act 2013 has been heralded by organisations such as Mind as removing the last significant forms of discrimination from our society in relation to mental health problems. The Act repealed certain provisions that prevented people with mental health conditions from serving as Members of Parliament, members of devolved legislatures, jurors, or company directors.
2014	Local Action on Health Inequalities: Increasing Employment Opportunities and Improving Workplace Health	Public Health England (PHE)/ UCL Institute of Health Equity (PHE, 2014)	Evidence Review/ Policy Report	Policy report building on the Marmot Review into the important role of good employment in improving health and reducing health inequalities. Provides a summary of evidence on the effects of unemployment and poor working conditions on health and the unequal distribution of these effects. Outlines potential actions that can be taken.
2015	Helping People with Mental Health Problems Find Work	DHSC/DWP (DHSC/DWP, 2015)	Independent Review Report	Report highlighting the findings of the review of a pilot of scheme aimed at helping people with mental health problems, who are claiming Employment Support Allowance, find paid work.
2016	Fundamental	Mental Health	Policy Report	This report provides statistical

	Facts About Mental Health	Foundation (Mental Health Foundation, 2016)		and associated information on mental ill health, with the aim of providing evidence to answer the questions asked about mental health by professionals, service planners, people with lived experience, politicians, the media etc.
2017	Mental Health: Still the Last Workplace Taboo?	Shaw Trust (Shaw Trust, 2017)	Research Report	Independent research report providing an update as to what British businesses now think about mental health in the workplace compared to the 2009 report (Shaw Trust, 2010).
2017	Thriving at Work. The Independent Review of Mental Health and Employers	Department for Work and Pensions and Department of Health and Social Care (Stevenson and Farmer, 2017)	Independent Review Report	Review report commissioned by the UK Prime Minister aimed at ascertaining how employers could respond to and better support their staff, including those with lived experience of mental health problems.
2017	Mental Health and Employment	Trades Union Congress (TUC) TUC (2017)	Research Report	Using data from the Labour Force Survey, this report examines the employment of disabled people, in particular those with mental health problems. The report highlights a significant gap between the employment rates of disabled and non-disabled people and strongly asserts that the TUC would like this gap to be eliminated.

2017	Employment and Mental Health	Royal College of Psychiatrists (Khan and Boardman, 2017)	Position Paper	An occasional paper from the Royal College of Psychiatrists following roundtable discussions with key stakeholders into mental health and employment from an occupational psychiatry perspective. The paper provides an account of the roundtable meeting and highlights the College's future priorities.
2018	People Managers' Guide to Mental Health	CIPD/Mind (CIPD/Mind 2018)	Guidance Document	Good practice guide for managers to help them effectively manage and support staff with mental health problems in the workplace. Provides an overview and definitions of mental conditions, guidance on good practice in recruitment, prevention, and intervention, as well as support mechanisms and recommended contacts.
2018	Voluntary Reporting on Disability, Mental Health and Wellbeing	DWP/DHSC (DWP and DHSC, 2018)	Support Framework	Framework developed by the Government to guide and support employers to record and report data on disability, mental health and wellbeing in the workplace.
2019	Health and Wellbeing at Work	CIPD (CIPD, 2019)	Survey Report	Report exploring the health, wellbeing and absence in UK organisations based in an industry survey completed by over 1000 UK Human Resource/ People professionals. The report

				highlights key issues to help support workplace improvement and identifies key areas of action for employers.
2019	Tackling Work-related Stress Using the Management Standards Approach	Health and Safety Executive/ The Stationery Office (Health and Safety Executive, 2019)	Guidance Document and Toolkit	Introduces the Six Management Standards of work design, asserting that if these are not properly managed, they result in reduced productivity and increased sickness absence. It describes the Management Standards approach and how following it can help employers meet their legal duties in relation to effectively managing work-related stress. It provides management tools, including top tips and a checklist.
2021	Unemployment and Mental Health: Why Both Require Action for Our COVID-19 Recovery	Health Foundation (Wilson and Finch, 2021)	Policy Report	Report highlighting the connection between mental health and unemployment, including causational factors. Highlights the particular impact of the pandemic on employment of people with mental health problems, and actions that the government can take to support both individuals and organisations, in particular improved employment support services and flexible employment opportunities.

2021	NHS Health and Wellbeing Framework	NHS England NHS England (2021)	Cultural Change Toolkit	High-level cultural change toolkit to support staff support services and senior leaders. Provides resources and guidance on these resources to help improve the health and wellbeing of healthcare staff.
2022	Employing Disabled People and People with Health Conditions	Department for Work and Pensions (DWP, 2022)	Guidance Document	Guidance document which aims to support employers to improve their awareness and understanding of disability, with a view to recruiting and retaining individuals with disabilities and/or long-term conditions.
2022	Mental Health at Work	WHO WHO (2022a)	Policy Brief	WHO briefing, which aims to encourage policy makers to take action to improve mental health experiences within the workplace. In addition to highlighting the links between mental health and employment, it outlines the duties of employers, as well as the rights and responsibilities of workers and other stakeholders to prevent harm, protect and promote mental health and wellbeing in the workplace and support people with mental health problems to be the best that they can be at work.
2022	WHO Guidelines on Mental Health	WHO WHO (2022b)	Guidance Document	Guidance document, which provides evidence-based recommendations and

	at Work			interventions based on identified areas within the Mental Health at Work Policy Brief referenced above (WHO, 2022a).
2022	The Economic Case for Investing in the Prevention of Mental Health Conditions in the UK	Mental Health Foundation and LSE (McDaid and Park, 2022)	Policy Report	Report provides an overview of the economic case for the prevention of mental health conditions. Uses a prevalence-based costing approach using data on prevalence from the 2019 Institute of Health Metrics and Evaluation Global Burden of Disease study.
2022	Mental Health and Employers: The Case for Investment-Pandemic and Beyond	Deloitte LLP (Hampson, 2022)	Policy Report	Report on employee mental health, examining the impact of the pandemic on mental health in the workplace. Considers key issues such as longer hours, job insecurities, and fear of COVID. Argues from an employer investment perspective that there is a £5 return for each £1 spent on wellbeing support.
2022	Index Insights 2020/21	Mind (Mind, 2022)	Research Report	Report highlighting findings of a workplace survey, which assessed over 42,000 staff from 114 organisations in England and Wales in 2020/21. Provides data on key workplace matters such as disclosure to employer, prevalence of an organisational wellbeing culture, levels of workload, and staff awareness of

				mental health problems.
2022	Supporting Mental Health at Work: Guide for People Managers	CIPD/ Mind (CIPD, 2022)	Guidance Document	Guidance document providing information and practical advice for managers, to enable them to provide effective support for staff experiencing stress and other mental health problems.
2022	Mental Wellbeing at Work	NICE (NICE, 2022)	Guidance Document	Positional paper and guidance from the National Institute for Health and Care Excellence (NICE). Highlights policy and workplace interventions to help create and maintain appropriate conditions for an effective, supportive and inclusive workplace culture.
2023	Reasonable Adjustments for Mental Health	ACAS (ACAS, 2023a)	Guidance Document	Employer guidance to support employers to appropriately respond to staff experiencing mental health problems at work. It provides an overview of possible reasonable adjustments for mental health both at an individual and a policy level.
2023	Supporting Mental Health at Work	ACAS (ACAS, 2023b)	Guidance Document Web format (downloadable)	Advice and guidance for both staff and managers on mental health in the workplace. Manager information includes a summary of mental health and the law, and how to support and manage staff mental health and wellbeing at work. Guidance provided for staff focuses on how to look after their own mental health and where to access

				specialist help and support.
2023	Mental Health Statistics: Prevalence, Services and Funding in England	House of Commons Library (Baker and Kirk-Wade, 2023)	Research Briefing	Research briefing highlighting key data, including prevalence of mental health conditions, waiting times for treatment and funding costs.
2023	Keeping Well at Work: A Practical Guide for Staff	Mindful Employer Mindful Employer (2023)	Good Practice Guidance	Practical advice and guidance for staff to help support their mental health and wellbeing.
2023	Mental Health and Employment Partnership Evaluation for the Life Chances Fund	Government Outcomes Lab, University of Oxford Hulse et al. (2023)	Interim Evaluation Report	First interim report of the Mental Health and Employment social impact bond project, which supports people with mental problems and/or learning disabilities to find and retain paid work. Evaluates the effectiveness of five new funded projects delivering Individual Placement and Support (IPS) services.
2023	United Nations Convention on the Rights of Persons with Disabilities: UK Independent Mechanism	EHRC EHRC (2023)	Policy Report	Report published by the EHRC, which describes the steps taken by the UK Government to implement the EHRC's 2016 recommendations aimed at improving disabled people's rights to independent living, employment and standard of living in the UK.

2.7 Literature Review Conclusions

Research therefore suggests that although much work has been done and progress has been made, action is still required to ensure that staff with mental health problems are represented, valued and supported in the workplace. Studies, largely based on individuals' perceptions of their experience, suggest that people with mental health problems continue to face barriers, including discrimination, within employment. Although this cannot be authenticated due to paucity of studies available, data from UK and American labour force surveys clearly indicate that people with mental health problems are less likely to be in employment, are more likely to be in lower paid jobs and more likely to live below the poverty line than those without such problems. This increases exponentially for those with severe and enduring mental health problems (ONS, 2009, 2021). It is also worthy of note that approximately 133,000 staff are employed by the NHS in England to provide care for those in need of mental health support (Nuffield Trust, 2022); a number of whom will have lived experience of mental health problems themselves (Boorman, 2008a, 2008b; Stevenson and Farmer, 2017; Stirrup et al., 2022; Fisher, 2023).

2.8 Research Gaps

Having reviewed the literature, it is evident that very clear policy guidance is available to organisations on how they can provide a supportive working environment for staff with lived experience of mental health problems if they choose to do so. Despite practical guidance being available from employer and service-user organisations such as Mindful Employer (2011, 2023), the Chartered Institute of Personal Development (2011, 2019, 2022; CIPD/Mind 2018), Mind, (2010, 2022; Mind/Rethink Mental Illness, 2011), ACAS (2012, 2023a, 2023b), The Equalities and Human

Rights Commission (EHRC) (2012), and NHS Employers (2005, 2020), the academic literature on this important area is limited. Consequently, a number of research gaps have been identified which inform the research aims and objectives. These are as follows:

- In-depth understanding of the experiences and support needs of all clinicians with lived experience of mental health problems working in mental health services
- Specific practical guidance for mental health providers on supporting the mental health and wellbeing needs of **all** clinical staff, particularly those with lived experience of severe and enduring mental health problems
- An analysis of the impact of national anti-stigma campaigns on the working lives of NHS staff with lived experience of mental health problems.

2.9 Research Objectives and Aims

The overall purpose of this study is to determine how a mental health trust supports clinical staff with lived experience of mental health problems and how these staff experience work in light of their mental health problems. In doing so, this research aims to identify and explore those organisational values and practices, which can effectively support staff with experience of mental health problems. Having completed the literature review, and using a UK mental healthcare trust that is a national provider of mental health services as a case study, these are the aims and objectives:

- Review policy, research and practice literature to identify the case study mental health trust's employment practices in relation to employees who have experience of mental health problems

- Explore staff with lived experience of mental health problems' experiences of the Trust's employment practices
- Examine the support provided in the Trust from the perspectives of policy makers towards staff with lived experience of mental health problems
- Explore the challenges and benefits of employing staff with lived experience of severe and enduring mental health problems.

2.10 Research Questions

Having completed the literature review the research objectives are to investigate:

- How does a mental health trust support clinical staff with lived experience of mental health problems? and
- How do these staff experience work, in light of their mental health problems?

In the following chapter (Chapter 3) the methodology and methods used to explore and respond to the study's aims, and therefore the research questions will be highlighted. The researcher will also identify why their own experiences underpin their methods and why reflexivity is vital to the authenticity and trustworthiness of the study as advised by Koch and Harrington (1998).

Chapter 3: Methodology and Methods

3.0 Introduction

This chapter describes the research methodology and philosophical underpinnings for this study and how it informed the methods, from participant recruitment through to analysis and interpretation of the findings. Firstly, a working definition of the terms 'methodology', 'epistemology' and 'ontology' are offered, followed by an exploration of the rationale for determining the chosen methodology of qualitative case study, including why other methodologies were not utilised. It introduces the case study organisation, before describing the methods employed, starting with the recruitment strategy for the study, the data collection methods used, the identified ethical implications of the research, and the mode of analysis. It concludes with the researcher's reflections and reflexivity, taking into account the study's limitations as well as potential biases in the research process. It underscores the vital contribution of the researcher within the study.

3.1 Methodology

3.1.1 Determining the Methodology

In research terms 'methodology' can simply be described as the strategy by which research is to be conducted and which identifies the specific methods that are to be used to collect the necessary data (Howell, 2013; Mbuagbaw et al., 2020). However, it is important to note that the methodology adopted by the researcher denotes their theoretical stance, which is underpinned by their philosophical outlook, and the nature of the research questions (Benton and Craib, 2001; Greatrex-White, 2004; Mason, 2005; Denzin and Lincoln, 2005; Crotty, 2009). Guba (1990, p. 17)

describes this as a paradigm, a way of looking at the world:

> …the net that contains the researcher's epistemological, ontological and methodological premises' […] a basic set of beliefs that guides action.

This chapter will now describe the philosophical underpinnings of this thesis, situating it in terms of its ontology, epistemology and methodology.

3.1.1.1 Philosophical Underpinnings

Philosophy of social science writers largely agree that the philosophy of social science cannot exist and develop on its own (Hollis 1994; Baert 2005). Essentially this means that other, often diverse disciplines such as history, mathematics and economics influence this philosophy in some manner and vice versa. As Hollis (1994, p. 2) writes:

> the philosophy of social science cannot breathe in a conceptual vacuum…[and its] boundaries are porous.

Consequently, the concepts and thought processes within the philosophy of social science, and indeed wider philosophy, can become blurred, reflecting the life world of the writer and philosopher.

It is against this backdrop that the researcher will describe and analyse the epistemological assumptions underpinning this thesis, centred on the workplace experiences of staff who have lived experience of severe and enduring mental health problems working in mental health services, drawing upon the main philosophical positions supporting this work. It will explore the key concepts,

consider competing philosophical positions, and articulate the researcher's own epistemological position regarding the research design. It will conclude with a summary of assumptions and the philosophical position used to underpin this research.

In order to provide context, it is important to first define the key terminology used, namely 'epistemology' and 'ontology', as philosophical concepts.

3.1.1.2 Epistemology

Epistemology has been a key interest of philosophers since Descartes highlighted it in the seventeenth century (Benton and Craib, 2001). Broadly, it can be defined as a branch of philosophy focusing on the theory of knowledge. Delanty and Strydom (2003) support this definition, tracing the word's origins from the Greek 'episteme', meaning 'knowledge', and 'logos', meaning theory; thus the 'theory of knowledge'.

Benton and Craib (2001, p. 233) expand this basic definition, describing it as:

> the philosophical enquiry into the nature and scope of human knowledge, concerned with distinguishing knowledge from belief, prejudice and so on.

Langdridge (2007, p. 4) supports this, however, stresses the human interaction within epistemology, depicting it as:

> concerned with knowledge and what we can say we know about the world, the relationship between the knower and the known.

Already it is possible to see that despite a general consensus regarding the definition of terms, the way different writers contextualise them within their philosophical approach varies.

This is further clouded by Delanty and Strydom's (2003) assertion that since the 1970s all key philosophical concepts within social science have undergone a considerable change in meaning, including epistemology. Claiming epistemology is a modern invention, identified and established in the eighteenth and nineteenth centuries, they challenge researchers to question whether the concept of epistemology in its traditional sense can be deemed adequate under contemporary conditions, particularly since they believe that "knowledge itself is contested and uncertain" (p.367).

It is therefore imperative that a researcher understands how epistemology underpins their study. This is particularly pertinent as Langdridge (2007, p. 2) asserts that a researcher's methodological approach will be determined by their epistemological stance, which is consequently likely to guide their methods of data collection and analysis. Furthermore, epistemology for Mantzoukas (2004, cited by Carter and Little, 2007), determines how a researcher communicates with their audience in addition to the conceptualization of the roles of the audience, the analyst, and the participants in the work. As Carter and Little (2007) conclude, with which the researcher wholeheartedly agrees, epistemology provides a potential connection between research practice and formal theories of knowledge.

3.1.1.3 Ontology

Another fundamental concept in philosophy is 'ontology'. Broadly, this can be defined as the theory of being, or as Benton and Craib

(2001, p. 10) write, "the theory of what exists in the world". Like 'epistemology', 'ontology' derives from the Greek language, literally translating as 'the theory of being as being'. In scientific inquiry terms, ontology specifically concerns "the nature and knowledge of social reality" (Delanty and Strydom, 2003, p. 6).

Epistemology and ontology are inextricably linked, and together they define a researcher's understanding of knowledge and how they gain that knowledge (Denzin and Lincoln, 2011; Howell, 2013; Baldwin, 2014).

3.1.1.4 Epistemological Position

There are two main traditional epistemological standpoints in philosophy, namely empiricist, which confines knowledge to facts and formal reasoning, that is, beliefs which observations can justify (Hollis, 1994), and rationalist, involving human interactions and experiences, which in summary is the belief that knowledge can be established through the use of human reason (Benton and Craib, 2001). The researcher has chosen not to debate on these somewhat opposing traditions, but instead focus on the question of epistemology and its implications for a case study methodology.

This thesis espouses an interpretivist epistemology using a social constructivist approach, which in its simplest terms contends that people construct their interpretations based on the world around them and how they interact with the people in their world (Baert et al., 2011). In essence, it posits the belief that reality is subjective and socially constructed, acknowledging the importance of individual perspectives and the existence of multiple, equally valid social realities (Blaikie, 2010; Burr, 2015). The emergence of knowledge, or meaning, is seen as a collaborative process between individuals, described as co-constructed and requiring

interpretation as opposed to direct observation. This perspective contrasts with the objectivity emphasised in positivist paradigms. In this view, a researcher's values are acknowledged as having an impact on the research process, prompting them to assess how their own values, beliefs and personalities have influenced the shared development of meaning (Blaikie, 2010; Baert et al., 2011). Accordingly, reflexivity of the researcher is of vital importance. (Burr, 2015; Maharaj, 2016).

Consequently, this supports the use of qualitative methods within this study to explore people's experiences and perspectives, namely in-depth interviews, and the examination of contextual case study documentation. It enables the exploration, analysis and interpretation of what participants say in their own words, as well as what other sources such as local and national policies say about the issue. This holistic approach helps to understand not only the individual perspectives but also how these perspectives interact with and are shaped by larger cultural, societal, and environmental influences. This approach enhances both the validity and reliability of the findings by triangulating information from multiple sources, ultimately contributing to a more robust and holistic understanding of the subject (Burr, 2015). By doing this, the researcher is able to gain a richer understanding of what is really going within the broader social context.

3.1.1.5 Ontological Position

As described, a researcher's ontological position is supported by their epistemological stance, and both are closely interconnected. This section will now introduce and briefly explore the key ontological perspectives.

According to Blaikie (2010, p. 93) there are six types of ontological assumptions, namely: shallow realist, conceptual realist, cautious realist, depth realist, idealist, and subtle realist.

The researcher, having reviewed these and considered them in line with the aforementioned social constructivist epistemology, has positioned this study within an idealist ontology, reflecting the philosophical stance of the researcher and the assumptions that they bring to the research (Crotty, 1998).

In modern philosophy, various philosophers such as George Berkeley, Immanuel Kant, Wilhelm Hegel, and Friedrich Nietzsche have developed and refined idealist ontology (Stein, 2019).

Described by Blaikie (2010, p. 93), an idealist ontology posits that:

- Reality consists of representations that are the creation of the human mind.
- Social reality is made up of shared interpretations that social actors produce and reproduce as they go about their everyday lives.
- Idealist ontologies take a variety of forms: one considers that there is a reality that exists independently of social constructed realities; another sees such an external reality placing constraints on, or providing, opportunities for reality constructing activities; and a third, constructions of reality are regarded as different (multiple) perspectives on an external world.

This is supported by Blaikie (2010, p. 95) who identifies an idealist ontology and a constructivist epistemology as a pair, asserting that

"it is not really possible or sensible to think of them as being independent".

3.1.1.6 Summary

In conclusion, by adopting an idealist ontology alongside appropriate methodological choices aligned with an interpretivist epistemology, namely social constructivism, this thesis seeks to contribute to a comprehensive understanding of complex social issues. It strives for an approach that considers subjective interpretations within a larger socio-political context and aims to contribute to a more nuanced understanding of social phenomena, particularly within the case study organisation.

As this thesis this is concerned with the workplace experiences of staff who have lived experience of severe and enduring mental health problems working within mental health services, the idealist ontological perspective is aligned to the social constructivist epistemology. It enables the voices of these staff and their managers to be heard and interpreted within the social and organisational context to which they belong. This thesis does not seek to find a truth, but to interpret the reality of the participants based upon their interaction with one another (Burr, 2015). Accordingly, methodological choices were made which were aligned with the research aims and questions. This chapter will now explore the major research paradigms, before justifying use of the chosen research methodology, namely the qualitative case study approach.

3.1.1.7 Major Research Paradigms

There are a number of interpretive perspectives available to researchers to examine the process of empirical enquiry. These stem from the two major research paradigms: quantitative and qualitative (Guba, 1990; Creswell, 2009; Angouri, 2010). A broad

overview of both these paradigms will now be offered.

In essence, quantitative methodology relates to matters that are measurable and objective. Creswell (1994, p. 1) defines quantitative research as:

> …an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analyzed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true.

However, qualitative methodology, while acknowledging that there might be some objective things we agree on in the world, many of these are determined by how we as individuals interpret the world, namely our subjective experience. Consequently, Creswell (1994, p. 2) distinguishes qualitative research as:

> …an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting.[5]

When considering the nature of the research questions outlined in Chapter 2, where the intention is to interpret and understand lived experience, the qualitative methodology has been deemed the most appropriate paradigm to use (Mason, 2005; Richards, 2015; Saldana, 2016). This is based on the fact that the study aims to

[5] Creswell (2009, p. 22) later clarified his interpretation of "natural setting" as typically that of data collected in the "participant's setting", namely where they live, work, or congregate.

identify the workplace experiences of clinical staff with lived experience of severe and enduring mental health problems and the extent to which their employer supports them. It intends to broaden and deepen our understanding of organisational behaviour and why things happen as they do within the workplace, particularly pertinent in an area [such as a mental health trust] where these issues are not fully understood (Hancock et al., 2007; Richards, 2015; Mbuagbaw et al., 2020).

Guba and Lincoln (1994, p. 108) clearly highlight the importance for all researchers of ensuring that the methods utilised fit the predetermined methodology and not vice-versa. The actions of those who choose to fit the methodology to predetermined methods are described by Chirkov (2016) as 'methodolatry', a concept borrowed from Emke (1996). This, she asserts:

> …jeopardises the quality of research, provides much less if any useful knowledge about a phenomenon, kills the creativity of a researcher and, finally, undermines the reputation of science because of the method driven studies' limited capability to solve problems that communities and societies are facing (Chirkov, 2016, p. 137).

Four of the major qualitative methodologies available to researchers were considered for the present study; grounded theory, ethnography, phenomenology, and case study. Grounded theory was discounted, as the research does not aim to generate theory. Similarly, ethnography was not considered appropriate, as the study does not wish to consider cultural aspects. Phenomenology was explored; however, it was deemed that the research required something more focused than simply the study of experience. Finally, it was concluded that the case study

approach fitted more closely with the aims of the research as it seeks to know more about the case study organisation chosen. Using the case study approach would also enable the researcher to use interviews and focus groups to capture people's experiences, and documentary analysis to explore the content of the organisation's workplace policies and strategies aimed at supporting its workforce.

In the present study the decision to use a case study approach was therefore guided by the research questions:

- How does a mental health trust support clinical staff with lived experience of mental health problems; and
- How do these staff experience work, in light of their mental health problems?

3.1.2 Understanding the Case Study Methodology

According to Thomas (2021), case study methodology continues to be increasingly popular as an approach amongst qualitative researchers. However, interpretation and understanding of the case study methodology varies throughout the social sciences (George, 2019). In addition to the critiques of the approach detailed below, there are also varying nuances within approaches, often dependent on the epistemological experience of the researcher (Stake, 2010). Yin, a supporter of the case study as a complete methodology, for example, defines case study research as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (2014, p. 16). However, Stake (1995, p. xi) argues that the true value of the case study is inherent in the "study of the particularity and complexity" of the case itself. In essence, the case study approach provides the researcher with the opportunity to explore a particular phenomenon in depth within its natural context

(Farquhar, 2012; Tight, 2017), essentially enabling the analysis of the "dynamics present within single settings" (Eisenhardt, 1989, p. 534). This differing definition, primarily based on the researcher's philosophical viewpoints, effectively highlights the shift from the Interpretivist tradition (Stake, 2010) to one with more Positivist leanings (Yin, 2014); a movement from one that focuses on the relationship between the researcher and the phenomenon to one where there is an estrangement between the researcher and the subject (Yazan, 2015), and where "established fact, or at least close to established fact as far as our research has enabled us to reach" (Crotty, 1998, p. 41) is sought after as part of the desire to build validity and rigour within the process (Cypress, 2017).

Van Wynsberghe and Khan (2007, p. 80) however, argue that the case study is neither a methodology, a method, nor a research design. They assert that the term is often used inappropriately as a "catch-all" for a broad range of methodologies and research methods and as a consequence loses its true meaning. Instead, through an analysis of the writings of Flyvbjerg (2001), Yin (2003), Stake (2005), and other qualitative researchers, they suggest that a more appropriate definition of the case study approach is that of a "transparadigmatic and transdisciplinary heuristic" (p. 90). More simplistically Luck et al. (2006, p. 103) describe it as a "bridge across the paradigms".

Tight (2017) highlights that one of the key benefits of the case study approach is that there are no specific requirements guiding case study research, thus enabling the design and data collection procedures to be tailored specifically to the research questions. This results in what Hamilton (2011, p. 1) describes as the freedom to "build up a rich picture of an entity, using different kinds of data collection". This affords researchers the opportunity to explore or

describe a phenomenon in context using a variety of data sources (Baxter, 2008), enabling the data to be analysed from a multi-dimensional perspective (Farquhar, 2012). Furthermore, this multi-dimensional capability offers the mechanism for the triangulation of data to ensure trustworthiness and authenticity, for as Hamilton (2011, p. 2) writes: "the use of multiple perspectives and different kinds of data collection is characteristic of high-quality case studies and lends weight to the validity of the findings". The value of utilising multiple methods and sources of evidence to ensure trustworthiness and authenticity is also advocated by Yin (2014) and Amin et al. (2020).

Stake (1995) identifies three different case study approaches, with the chosen methodology depending on the purpose of the inquiry. These can broadly be defined as intrinsic, used to learn about a specific case; instrumental, undertaken to gain a deeper understanding of issues beyond the case; and collective, which is the study of a number of cases in order to inquire into a particular phenomenon.

3.1.2.1 Critiques of Case Study Methodology

As one would expect of any methodology governed by theories and concepts of knowledge and understanding, there are a number of critiques against case studies as a whole. Some of these are specifically targeted at single case studies, as opposed to collective case studies. According to researchers such as Madill et al. (2000), George (2019), and Thomas (2021), it is therefore very important that the researcher be aware of these critiques to ensure consistency of meaning using this methodology.

Flyvbjerg (2006, p. 219) provides a useful introduction to the critique of case studies in a paper on qualitative inquiry. In this

essay he identifies and corrects what he believes to be five key misunderstandings/ critiques about case-study research, concluding that the case study is a valuable methodology within social sciences, which stands up to scrutiny and challenge. This is summarised in Table 5.

Table 5: Flyvbjerg's Corrections to the Critique of the Case Study Approach[6]

Proposed Critique	Flyvbjerg's Correction
1. Theoretical knowledge is more valuable than practical knowledge.	Predictive theories and universals cannot be found in the study of human affairs. Concrete, context-dependent knowledge is, therefore, more valuable than the vain search for predictive theories and universals.
2. One cannot generalise on the basis of an individual case; therefore, the case study cannot contribute to scientific development.	One can often generalise on the basis of a single case, and the case study may be central to scientific development via generalisation as supplement or alternative to other methods. But formal generalisation is overvalued as a source of scientific development, whereas "the force of example" is underestimated.
3. The case study is most useful for generating hypotheses, whereas other methods are more suitable for hypotheses testing and theory building.	The case study is useful for both generating and testing of hypotheses but is not limited to these research activities alone.
4. The case study contains a bias toward verification.	The case study contains no greater bias toward verification of the researcher's preconceived notions than other methods of inquiry. On the contrary, experience indicates that the case study contains a greater bias toward falsification of preconceived notions than toward verification.

[6] Adapted from Flyvbjerg (2006), pp. 219-221.

5. It is often difficult to summarise specific case studies.	It is correct that summarising case studies is often difficult, especially as concerns case process. It is less correct as regards case outcomes. The problems in summarising case studies, however, are due more often to the properties of the reality studied than to the case study as a research method. Often it is not desirable to summarise and generalise case studies. Good studies should be read as narratives in their entirety.

Flyvbjerg's response to the critiques of the case study approach is supported by a number of other researchers such as Van Wynsberghe and Khan (2007). Although Van Wynsberghe and Khan (2007) provide a discourse that backs all of Flyvberg's arguments, they are particularly vociferous in their support of his notion that the case study researcher is more likely to be biased towards falsification rather than confirmation of preconceived notions about the case. This is also the contention of Rueschemeyer (2003) who asserts that the case study approach uses to its advantage the direct and frequent interplay between theory and data compared to that of experimental or quantitative research. They reinforce this by adding:

> If case study research primarily represents an exploration of the phenomena for which evidence is being collected, then this necessitates researchers' immersing themselves in the context to such a degree that they have opportunities to also recognise flaws in their preconceived notions. (Van Wynsberghe and Khan, 2007, p. 86).

3.1.2.2 Responding to the Critiques of Single Case Studies

One additional critique aimed specifically at the single case study as a methodology is that it lacks breadth (Campbell and Stanley, 1963). Yet Flyvbjerg (2006, p. 26), whilst acknowledging its

limitations, underlines its trustworthiness as he writes:

> The advantage of large samples is breadth, while their problem is one of depth. For the case study, the situation is the reverse. Both approaches are necessary for a sound development of social science.

However, Flyvbjerg makes no account for a large-scale well-designed study that can provide both breadth and depth, for example a large Randomised Control Trial with 1500 participants on each arm, followed by 1,000 interviews. This, providing sufficient time is available, could provide breadth and depth, even if such a study was unlikely.

A second critique of the single case methodology by writers such as Hartley (1994, 2004) is that the case being studied within this methodology cannot be generalised, since it is not representative of similar cases. According to Hancock et al. (2007) and Tight (2017), such a response constitutes a misunderstanding of the case study methodology, whose aim is to describe that particular case in detail, not generalise; but whose ideas may be transferrable given the appropriate context. Readers can then decide for themselves, providing sufficient detailed information is given, if the situation described applies to their own local situation (Flyvbjerg, 2006).

One of the key advantages of the single case study approach is that it enables the utilisation of different data collection methods involving individuals at all levels of the organisation and in varying roles. Such flexibility facilitates a comprehensive study of the experiences of individuals within a single organisation whose working lives are governed and managed by the same overarching

employment policies and practices. Within the case study organisation, this includes staff with lived experience of mental health problems and the policy makers who help shape the organisational culture (Figure 1). Such a focus further enhances the identification and exploration of good practice based on both individual and collective experience within a single cultural entity. By focusing on a single organisation with a unique story to tell, whose commitment as an employer and service provider of choice in embedded within its core values, this study aims to offer a response to the key research questions: 'How does a mental health trust support clinical staff with lived experience of mental health

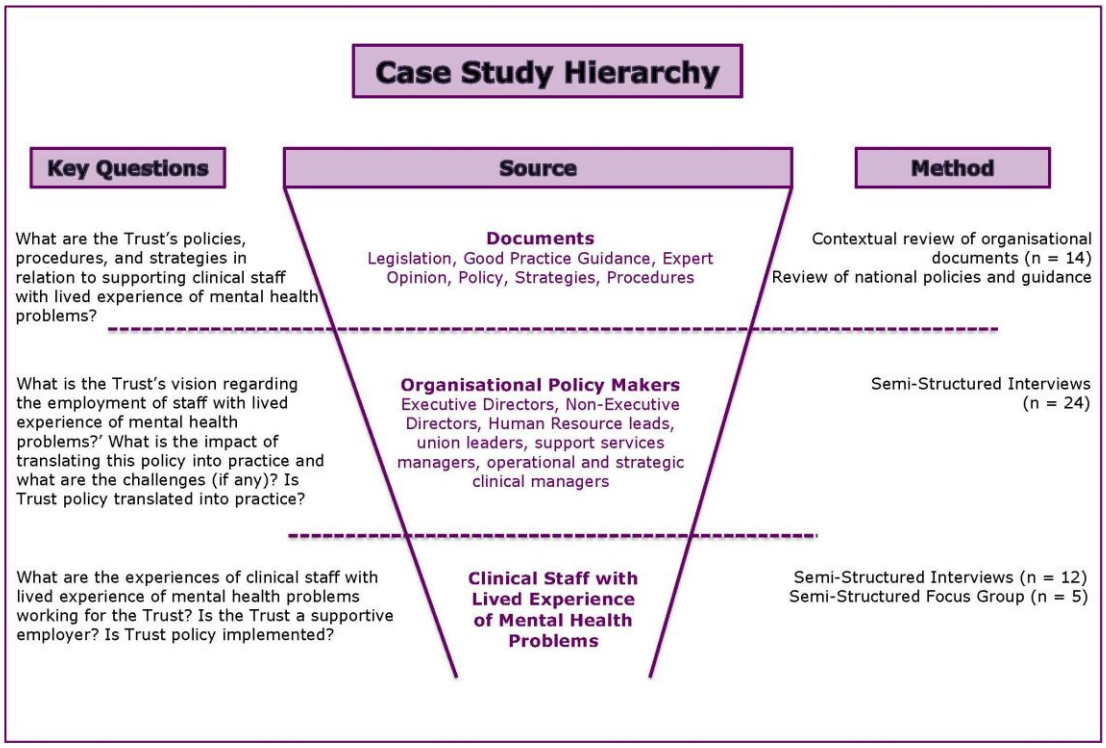


Figure 1: Case Study Hierarchy

problems; and how do these staff experience work, in light of their mental health problems?'.

Accordingly, the current study has utilised a single case study approach, which follows the aforementioned instrumental model proffered by Stake (1995). Using a single site as the focus of the

organisational case study, this methodology has enabled the researcher to undertake a systematic inquiry into the perceptions and experiences of staff with lived experience of mental health problems in relation to their working environment (Bromley, 1990; Powell, 2013) and is therefore a justifiable approach.

3.2 Study Design: Case Study

3.2.1 Study Setting

Glen Forest NHS Foundation Trust[7], which formed the focus for this case study, was chosen as it represented a large multi-professional mental healthcare provider that had projected a recovery-focused vision for both its staff and patients over a number of years. Of particular interest to the study is that a staff survey conducted in 2009 revealed that approximately 35% (n = 299) of the 855 staff who responded identified that they had lived experience of mental health problems, and 48% (n = 410) had experience of caring for someone who did (Glen Forest, 2010);[8] a figure considerably higher than the suggested figure of 23% for the general population (Singleton et al., 2001; McManus et al., 2009).

As such, this setting offered a suitable environment within which to explore the phenomena of interest, namely the lived experience of clinical staff with mental health problems. In order to understand the context in which the study is based, it is necessary to be

[7] 'Glen Forest NHS Foundation Trust' is a pseudonym

[8] Local documents are referred to within the succeeding chapters but are not formally referenced in order to safeguard the anonymity of the case study site and the participants. Furthermore, the name of the case study/sponsoring organisation, and any specific details attributable to it, including its logo, have been removed/redacted from the appendices to further protect the anonymity of the participants.

familiar with the case study organisation, including key aspects of its vision, values, and ethos.

3.2.1.1 Introduction to the Case Study Organisation

Glen Forest NHS Foundation Trust (the Trust) is one of the largest providers of integrated healthcare services in the country, serving a population of circa 1.1 million people from over 250 locations in a region within the UK, an area of over 2000 square kilometres (ONS, 2021). It has an annual budget of over £620 million and its staff support circa 190,000 patients each year.

Services provided include those for mental health, intellectual and developmental disabilities, drugs and alcohol dependency, offender healthcare, and community physical healthcare. Glen Forest also provides secure forensic mental health services in the County and beyond, employing in excess of 10,000 individuals in a variety of clinical and non-clinical roles. It has a national reputation for implementing recovery-based practice and was a pilot site for a national project to implement recovery. This included the appointment of a Trustwide recovery lead and the designation of recovery champions within clinical services.

As a public sector healthcare provider, the case study organisation is subject to UK legislation and government policy, therefore has a statutory responsibility to be inclusive in all its policies and practices, both as an employer and as a service provider. Consequently, one of the case study organisation's strategic priorities is to have a workforce that reflects the diverse communities it serves, as it infers that only through such an approach can the needs of its diverse communities be met (Trust Website 2015-2023). Glen Forest's equality, diversity and inclusion framework identifies people with mental health problems as a

protected group and specifies key actions and interventions that it will implement to improve outcomes for people within this cohort, both staff and service users. It is also a signatory of the Mindful Employer Charter and a Disability Confident Employer (previously Two Ticks). This further supports this Trust being a perfect candidate for scrutiny as a case study site.

3.2.2 Participants and Recruitment

3.2.2.1 Participants

3.2.2.1.1 Policy Makers

The application of current Human Resource/ Management practices and processes were explored through the medium of individual interviews to help ascertain, via staff experiences, how policy is put into practice and to identify the degree to which this is embedded across the diverse services and professional specialisms within the organisation. This necessitated interviews with staff in key roles within the organisation that have accountability for the development and implementation of Trust policies. 24 policy makers were included in the study.

3.2.2.1.2 Staff with Lived Experience

As this study is concerned with the case study organisation's performance as a supportive employer, the lived experience of clinical staff who have severe and enduring mental health problems and provide support to users of mental health services, are central to this study. This included Peer Support Workers (see Glossary of Terms). Interviewing staff with lived experience of mental health problems sought to answer both of the research questions, namely, 'How does a mental health trust support clinical staff with lived experience of mental health problems; and how do these staff experience work, in light of their mental health problems?'. 16 staff

with lived experience of mental health problems were included in the study, via individual interviews and/or participation in an exclusive Peer Support Worker focus group.

3.2.2.2 Recruitment Strategy

3.2.2.2.1 Recruitment Strategy: Policy Makers

The decision as to which policy makers to interview was based on detailed discussions by the research team, centred around the initial research question detailed in Chapter 2, i.e., how does a mental health trust support clinical staff with lived experience of mental health problems? Purposive sampling was used to identify potential participants. 19 of the 24 interviewees were approached based on their unique role within the organisation. These included Executive Directors, Non-Executive Directors, Human Resources leads, trade union leaders, support services managers, and both operational and strategic clinical managers, encompassing all three operational divisions, and corporate services (Figure 2). The remaining five interviewees were contacted based on discussions with HR and union colleagues who assisted by identifying senior managers that had experience of managing staff with lived experience of mental health problems in the workplace. 17 of the 24 policy makers interviewed identified as female, and seven as male.

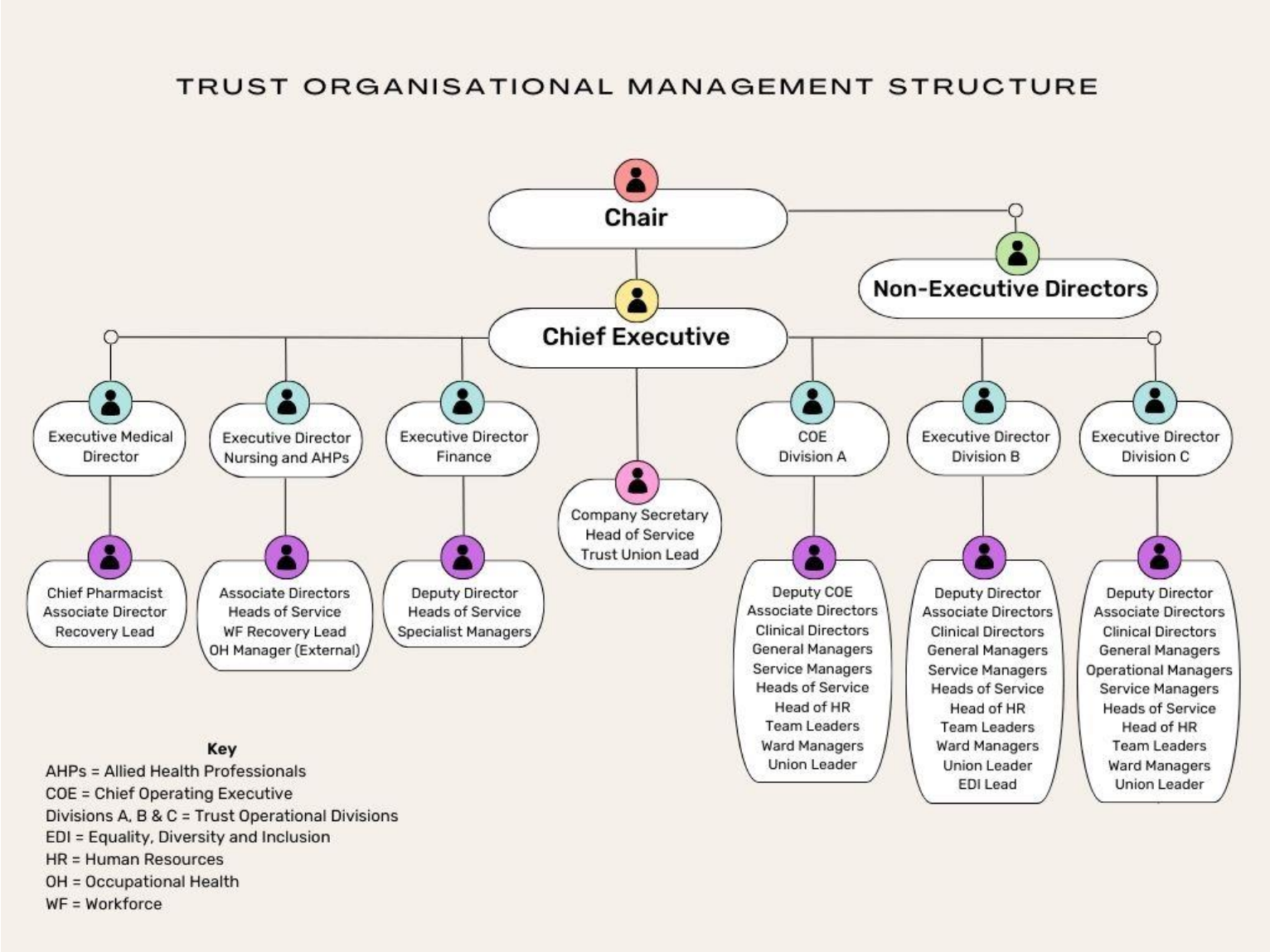


Figure 2: Trust Organisational Management Structure

All 24 individuals were approached via an e-mail from the researcher. This e-mail outlined the purpose and scope of the study, its aims and objectives, and invited them to consider being interviewed and to respond if they were willing to participate. A copy of the Participant Information Sheet (Appendix 1), the Interview Guide (Appendix 2), and the Consent Form (Appendix 3 or Appendix 4) they would be required to sign accompanied the e-mail. All invitees responded in the affirmative. A mutually convenient time was agreed with all interviewees and a private meeting space chosen based on the interviewee's preferences.

3.2.2.2.2 Recruitment Strategy: Staff with Lived Experience

The literature suggests that there are three main categories of mental health professionals with experience of mental health problems in the workplace; those who choose to be open about their lived experience of mental health problems; those who are selective to whom they disclose; and those who remain completely hidden in the workplace. The decision of individuals whether to disclose or not, and to what level, is based on a multitude of reasons and may or may not be consistent in an individual's career path from one organisation to the next (Jones, 1991; Fisher, 1994; Brandon, 1999a; Fiala, 2004; Burton, 2010; Adame, 2011; Wallace, 2012; Richards et al., 2016; Cohen, et al. 2016; Edan et al., 2021). In order to understand the experiences of all three categories of staff and allow for any variances outside these descriptors, two different methods of data collection were utilised: namely, individual interviews open to all clinical staff with lived experience, and a focus group only accessible to Recovery College Staff and Peer Support Workers .

Consequently, there are a number of comparative staff groups that the study seeks to examine, to determine both similarities and differences of experience. These are as follows:

a) Those who are open about their experience of mental health problems at work and those whose experience of mental health problems are known to a limited number of individuals:
    i. Staff who attend a work-based support group and/or are open about their experience of mental health problems in the workplace
    ii. Staff who attend a work-based support group but are only open about their experience of mental health problems to other group members and/or a select number of work colleagues
    iii. Staff who do not attend a work-based support group but whose experience of mental health problems is known only to the group lead.
b) Different professions across the organisation, to identify if particular professions have varying experiences of the polices and strategies in place and how they are implemented in practice
c) Different operational divisions, to determine the extent to which organisational policies are applied in practice across the organisation
d) Clinicians such as Peer Support Workers, for whom having lived experience is a condition of employment, and Peer Workers who use their lived experience of mental health problems in their work e.g., empathy, being open about personal mental health problems, sharing experiences etc., as well as those who do not.

As regards staff with lived experience of mental health problems, this study focused on the three principal and most accessible sources: the Living in Both Worlds staff support group, Peer Workers from Glen Forest's Recovery College, and Peer Support Workers.

3.2.2.2.2.1 Living in Both Worlds (LIBW)

The Living in Both Worlds (LIBW) Group was established in the case study organisation in 2009 by staff with lived experience of mental health problems for the benefit of such staff. This Group's main purpose is to provide an opportunity for staff with experience of mental health problems to meet together to: share and develop good practice to assist the organisation, influence policy and provide support and networking for each other. The Group is both approved and funded by the Trust. Membership of the Group remains confidential at all times and the Workforce Recovery Lead is the sole custodian of the electronic membership distribution list. This high degree of membership anonymity, one might suggest, is the reason why so many staff that demonstrate varying levels of disclosure about their experience of mental health problems have joined. At the time of this study the membership included over 120 staff, with some individuals opting not to attend meetings but still receive communications. Reasons given for not attending meetings include work commitments, confidentiality, management issues etc.

Due to the confidential nature of the LIBW Group membership as a whole, and the importance of engaging its members in this study, group members were invited to participate in this research via an e-mail from the group administrator, namely the Workforce Recovery Lead. Group members were specifically asked to consider participating in a confidential one to one interview with the

researcher. It was posited that the one-to-one nature of the interview process was likely to prove more appealing to those individuals who had not disclosed their experience of mental health problems at work and consequently would be less willing to discuss them in a group setting. Accordingly, the Participant Information Sheet (Appendix 5), outlining the project details and purpose of their involvement was attached to the invite e-mail.

Members were asked to send any expressions of interest to participate in the individual interviews directly to the Workforce Recovery Lead, who provided an opportunity for the individual to talk through their proposed involvement with them and/or the researcher if needed. It is believed that this method was of value to the research, encouraging staff that are closeted about their experience of mental health problems to participate, in addition to those who are either fully or more open.

Once an individual expressed their interest in participating in the study, they were sent a Consent Form (Appendix 6), with an additional copy of the Participant Information Sheet (Appendix 5). They were then given two weeks to decide if they would still like to be involved in the project before being contacted via their preferred contact method by the researcher to arrange a mutually agreeable meeting date, time and venue.

3.2.2.2.2.2 Recovery College Staff

Established in 2011, the Recovery College provides a number of courses, which aim to contribute in a variety of ways to the recovery and wellbeing of people with lived experience of mental health problems. In addition to coaching and supporting individuals on their own recovery journey, the College provides support and advice to Trust staff on using their lived experience of mental

health problems in their work and offers a bespoke four-week course on the subject. All of the teaching staff within the College openly identify as Peer Workers, that is someone who has lived experience of mental health problems and/or substance misuse.

College staff therefore hold a privileged position due to their personal experience and their unique contact with staff with lived experience of mental health problems within the educational environment. College staff were invited to participate in a one-to-one interview or a peer focus group with the researcher, via an e-mail from the Workforce Recovery Lead. The invite contained two Participant Information Sheets (Appendices 5 and 7), to help individuals decide whether or not to participate in the individual interview and/or the focus group. All other aspects of recruitment for this group followed the aforementioned process for that of LIBW members.

3.2.2.2.2.3 Peer Support Workers (PSWs)

Peer Support Workers are staff members who are specifically employed by the organisation due to their lived experience of mental health problems, either personally or as a carer of another. Furthermore, PSWs explicitly use this lived experience within their work to help others. The value of PSWs to patient recovery and indeed to that of the individual themselves is reported to be high, although the numbers within mental health organisations are still relatively small (Nestor and Galletly, 2008; Repper and Carter, 2010; Gilbert and Stickley, 2012, Watson and Repper, 2022). At the time of the recruitment for this study, Glen Forest had 42 PSWs within its services, however the Trust's Workforce Strategy (2013-19), in alignment with its Recovery Strategy (2016-21) made a commitment to increasing this to a minimum of two PSWs per clinical team by 2018. Despite there being no reference to Peer

Support in the 2022-2027 Workforce Strategy, it is noteworthy that as of August 2023 Glen Forest had circa 90 PSWs in post. The initial potential recruitment pool of 42 Peer Support Workers, along with the six Recovery College Staff provided sufficient volunteers to participate in a focus group of between 5-10 individuals for this study, a figure recommended by Hancock et al. (2007) in the National Institute for Health Research (as it was formerly known) guidance on qualitative research.

Including the experience of PSWs in this study was therefore paramount, as this is a staff group, who by the nature of their job role, are open about having lived experience of mental health problems. All Peer Support Workers were given the opportunity to either participate in an individual interview with the researcher, if part of the Living in Both Worlds Group (LIBW) or be part of a focus group. This, as with the interview invite to LIBW members, was sent to the PSWs via the Workforce Recovery Lead, who currently supports the PSW Service in the delivery of their role. The researcher conducted this focus group.

Recruitment of PSWs followed the process described above for members from the LIBW group and the Recovery College staff. However, a unique Participant Information Sheet (Appendix 7) and Consent Form (Appendix 8) were provided to Focus Group participants; these highlighted potential difficulties around maintaining confidentiality due to the presence of other PSWs in the focus group. None of the Peer Workers from the Recovery College opted to participate in the focus group (see Table 6).

Prior to commencing interviews and/or participation in the focus group, all individuals had the purpose of the study and its process clearly explained to them by the researcher. This included their

right to withdraw at any time. All participants, preceding any engagement in the study, were required to complete a Consent Form (Appendix 6 and/or Appendix 8). Issues of confidentiality, anonymity and data protection were addressed to reassure participants that any information they gave would be adequately protected at all times and would at no time identify them as an individual.

At no time were participants asked to disclose their mental health diagnosis or any associated treatments. Criteria for inclusion of people with lived experience of mental health problems was met by an affirmative response to the question, 'Are you currently, or have you in the past, used secondary mental healthcare services?'.

Of the 16 participants with lived experience of mental health problems interviewed, seven identified as male, and nine female. Participants included a psychiatrist, a psychologist, a clinical nurse specialist, two psychiatric nurses, a Cognitive Behaviour Therapy (CBT) Therapist, a peer worker, five PSWs and four service managers. One of the participants, a PSW, was part of the individual interviews and the PSW Focus Group (LE12/PSW2).

3.2.2.3 Summary

In this study, two different data collection methods were used to capture the experiences of Trust staff, namely individual interviews and a focus group. A recruitment strategy summary, indicating participant numbers can be seen in Table 6. Details of data collection methods and analysis approaches will now follow.

Table 6: Recruitment Strategy Summary - Table of Participants

Data Collection Method	Clinical Staff with Lived Experience (LIBW Group)	Recovery College Staff (Peer Workers)	Peer Support Workers	Policy Makers
Individual Interviews (n=36)	Received information: n=122 Made contact: n=10 Interviewed: n=10	Received information: n=6 Made contact: n=1 Interviewed: n=1	Received information: n=42 Made contact: n=1 Interviewed: n=1*	Approached: n=24 Responded: n=24 Interviewed: n=24
Focus Group (n=5)	Not offered (see 3.2.2.2.2.1)	Received information: n=6 Made contact: n=0 Interviewed: n=0	Received information: n=42 Made contact: n=8 Interviewed: n=5*	Approached: n=0 Interviewed: n=0

* PSW2 following the PSW focus group requested a 1 to 1 interview. PSW2 therefore has 2 identifiers to highlight their involvement in the PSW focus group and a 1 to 1 interview: PSW2/LE12.

3.3 Data Collection

In line with the aims and objectives of the study, as determined by the findings of the literature review, several data collection methods were utilised. These included individual interviews and focus group interviews, as well as the analysis of documents and other organisational data. Descriptive and reflective field notes were maintained throughout the study to support the data by noting thoughts, observations and reflections, as well as providing context and information deemed pertinent to the research (see 3.3.3).

Initially, this study design included documentary analysis as a supplementary method, however it immediately became clear that there was no explicit reference to the needs of staff with complex mental health problems within the organisational literature. Consequently, Glen Forest's policies, procedures and strategies were used for contextual purposes only, as opposed to being formally analysed.

This chapter will now discuss each of the data collection methods used in turn.

3.3.1 Contextual Case Study Documentation

In order to fully understand the intent, rhetoric and vision of the organisation as an employer of staff with lived experience of mental health problems, it was necessary to firstly analyse the case study organisation's key policies, procedures, strategies, and practices in relation to staff health and wellbeing.

Of particular significance to this study were those policies, strategies and guides that focused on promoting staff wellbeing as

well as the available support mechanisms for staff with mental health problems, which included workplace adjustments and return to work schemes. This involved only 14 documents and included the Workforce Strategy; Recovery Strategy; Employing People with Disabilities Policy; Sickness Absence Policy, and the Staff Supervision Procedure. These were reviewed in conjunction with the external policy, guidance and legislative framework described in Chapter 2, to determine and contextualise the identified Trust's performance as an employer of choice for those with experience of mental health problems. However, as highlighted previously, no mention was made in these organisational documents to the specific needs of staff with lived experience of mental health problems.

Anonymised employment data in relation to grievances, harassment and discrimination claims by and against individuals with declared mental health conditions were not available as the current national Electronic Staff Record system is not presently set up to provide this level of detail. Likewise, sickness absence rates, disclosure rates and retention rates could not be examined, which it is suggested may have helped to identify the level to which the culture of the organisation was deemed supportive or not, and its success in achieving its ambition to create an environment where people are included, have a sense of belonging, and can reach their full potential.

It was important that a contextual review of the organisational literature was conducted prior to the individual interviews and the focus group to enable this knowledge to be used to inform the development of the interview guides (Appendices 2 and 9).

3.3.2 Qualitative Semi-Structured Interviews

Semi-structured interviews were chosen, as the researcher, based on the research questions, had identified key themes that aimed to capture the experiences of both policy makers and staff with lived experience. The semi-structured approach enabled the researcher to hear the participants' views and experiences but remain on topic and not digress from the themes identified in the research questions (Roulston and Choi, 2018; Low et al., 2019; Islam and Aldaihani, 2022). This was supported by pre-piloted interview guides (Appendices 2 and 9), tested on staff and managers from the Trust's disability improvement group. These guides allowed the researcher to introduce the research topic and provide a few general questions to elicit discussion. This was supplemented by a number of additional questions designed to probe, should key areas not come up as part of the conversation (Low et al., 2019; Robinson, 2023).

With participants' permission (Appendices 3, 4, 6 and 8), each interview and focus group was audio recorded to enable accurate transcription of the discussions and ensure data quality. This was rechecked prior to each interview commencing. The researcher then uploaded each audio recording to a secure server, which they transcribed verbatim. Utterances such as "erms" and "hms", filler phrases, stutters, false starts, and involuntary vocalisations such as laughing, coughing, or phones ringing, were included in line with the chosen data collection methods (Seale and Silverman, 1997; MacLean et al., 2004). Transcription was completed as soon as possible after the event to ensure that other indicators, such as non-verbal communication, were appropriately noted and described within the corresponding field notes (see 3.3.3). The researcher then listened back to the audio recordings, checked the transcripts

for accuracy and anonymised them. The academic supervisors then checked these for accuracy and quality assurance purposes.

3.3.2.1 Policy Makers

Interviews with policy makers commenced by exploring issues such as their role and their knowledge of the Trust's vision in relation to the employment of staff with experience of mental health problems. They then progressed into elucidating their level of understanding of the support needs of staff with mental health problems in the workplace, their views on the extent to which the organisation was achieving its vision as an employer, and any challenges they had encountered when translating this policy area into practice. The interview guide used is available as Appendix 2.

3.3.2.2 Staff with Lived Experience

The individual interviews with members of the LIBW Group/ the Recovery College Staff and the PSW Focus Group were semi-structured, using open questions aimed at answering the key research questions. Accordingly, the questions focused on participants' experiences of mental health problems, their relevance and utility in their work, their experiences of support or otherwise, and where appropriate, an exploration of what could be done to better support their needs and those of others. These were supported by the pre-prepared interview guide (Appendix 9), which enabled the main research topic to be addressed. It also provided the participants and the researcher with the opportunity to explore additional topics that arose in more detail.

Specific questioning of individuals focused on personal experiences within the workplace, including: identifying if and at what point in their employment they had disclosed that they had a mental health problem to management and/or work colleagues; barriers to

disclosure; age of diagnosis in order to determine if age had an impact on experience and if diagnosis was pre or post-employment in mental health practice; examples of any barriers encountered, potentially exploring key issues such as stigma and discrimination, including multiple discrimination; experiences of supportive policies and practices, such as implementation of reasonable adjustments, disability leave, employee assistance etc.; self-management techniques invoked; what formal and informal support processes they used; perceptions of organisational culture/commitment towards a positive working environment, notably in relation to issues such as stress, anxiety and burnout; contribution of lived experience on clinical practice; perceptions of self; and perceived attitudes of others to colleagues with lived experience of mental health problems in the workplace. Questions posed are located in the aforementioned interview guide labelled Appendix 9.

3.3.2.2.1 Peer Support Worker Focus Group

As recommended by Hancock et al. (2007), eight Peer Support Workers were invited to participate in a focus group. Three of the PSWs were unable to attend on the day due to illness, however the absence of the three additional peers did not detract from the intense and inclusive content of the discussion. This smaller number enabled participants to interact with each other and engage in a dialogue, where it is believed new meaning was created. The power of dialogue also provides some reassurance as to how qualitative researchers understand differing approaches or cultures for which we have no knowledge. Dialogue is an effective approach for ensuring space and consideration is given to the divergent experiences of the opposing parties, enabling one to "look for not only what is 'said', but what is said 'between the lines" (Laverty, 2003, p. 19), and what is not said due to perceived issues of stigma, repercussions etc. Dialogue was particularly

favoured by Marxist followers such as Brazilian educationalist Paulo Freire (1921-1997), who not only believed that the creation of new meaning was possible through dialogue, but also liberation of the individual itself in the form of freedom from oppression (Freire, 2005, p. 65). This is particularly relevant within the area of the study, as there still exists an underlying culture within mental health services whereby it is unacceptable as a clinician to admit to using services oneself.

3.3.3 Field Notes

Taking field notes is a fundamental aspect of documenting and analysing data in qualitative research as it helps limit bias and ensures that the data collected is rich, meaningful and contextualised (Maharaj, 2016; Small and Calarco, 2022).

According to Bogdan and Biklen (1998), field notes typically encompass two main types of writing: descriptive and reflective. Descriptive notes help to document the specific details of what was experienced during the fieldwork, providing a clear record of events as they happen. Reflective notes allow researchers to analyse their own biases, assumptions and feelings that may have influenced their observations and/or decisions during the research and can help establish trustworthiness in the interpretation of the data (Bogdan and Biklen, 1998; Maharaj, 2016; Nowell et al., 2017). By combining both types of notes, researchers can create a comprehensive narrative that not only supports the data but also adds depth and meaning to the findings. This holistic approach to notetaking can enhance the credibility and integrity of the study by offering transparency into how conclusions were reached based on firsthand experience in the field (Nowell et al., 2017; Small and Calarco, 2022).

Within this study both descriptive and reflective field notes were used. Descriptive notes were adopted during the interviews and focus groups to note key observations, such as the physical environment, non-verbal communications such as body language, as well as log any surprising statements. Reflective notes were primarily used before and after the interviews/focus group to allow the researcher to recognise any potential bias based on their knowledge of the interviewees, consider reactions to participant statements, encourage critical thinking, reflect on their position within the study, enhance self-awareness, and identify areas for further exploration. Examples of both descriptive and reflective notes taken from this study can be found in Appendices 10 and 11.

3.3.4 Summary

Utilising these methods, namely semi-structured interviews, a semi-structured focus group and contextual policy analysis, supported by field notes, allowed the triangulation of data (Figure 3). This helped authenticate the study and provide a fuller perspective; one that clarified meaning and considered the diversity of perceptions. As Stake (2010) and Amin et al. (2020) report, triangulation may help the researcher identify different realities.

Research Strategy Summary

- **Methodology**: Organisational Case Study
- **Methods**:
  - ***Semi-Structured Interviews (n = 36)***:
    - Staff with lived experience of mental health problems, including members of the Living in Both Worlds Group (n = 12)
    - Executive Directors, Non-Executive Directors, Human Resources leads, union leaders, support services managers, operational and strategic clinical managers (n = 24)
  - ***Semi-Structured Focus Groups (n = 5)***:
    - Peer Support Workers (n = 5)

Figure 3: Research Strategy Summary

3.4 Recording and Managing the Data

Participants were initially identified with a code and later with a pseudonym. This practice was implemented to protect the participants' identities and maintain their privacy throughout the research process. It also helped build trust with the participants, as many of them felt more comfortable sharing their experiences as they knew their identities were protected. Furthermore, this aligns with ethical guidelines and ensuring that participants' safety and confidentiality are prioritised throughout the research process. By using codes and pseudonyms, only the researchers involved in the study had knowledge of the participant information, which were kept secure and confidential. This practice helps to prevent unauthorised access or disclosure of the participants' personal information.

All research data were managed in accordance with the Data Protection Act (2018) and associated University of Nottingham policies, as outlined in the University of Nottingham Code of Research Conduct and Research Ethics (University of Nottingham, 2023). Data collected as part of this study were held by the

researcher for safe storage and analysis using secure methods. The processing of the personal data was minimised by use of a unique study ID number only, on all study documents and electronic databases. This data were only accessible to the researcher and research supervisors.

3.4.1 Electronic Data

All electronic data were kept on a secure server in a folder which was password protected.

3.4.2 Paper Data

All printed materials, such as consent forms and the researcher's anonymised field notes, were stored in a secure, locked filing cabinet in a single occupant office that was locked, with additional security keypad features.

3.5 Data Analysis

This section on data analysis is important as it adds to the quality of the study by giving the reader a detailed account of the processes used and the actions of the researcher. In doing so, it contributes to the research decision trail, which Koch (2006) and Amin et al. (2020) argue helps establish the trustworthiness and authenticity of the study.

Examination of the data was undertaken using content analysis. Within the qualitative paradigm content analysis can be defined as:

> …a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon, 2005, p. 1278).

Content analysis was chosen as the method of data analysis as it

can be used to analyse written, verbal or visual communication messages (Cole, 1988; Krippendorff, 2018; Kleinheksel et al., 2020). As a method of analysis, it offers a systematic means in which to describe and measure phenomena, and analyse documents (Elo and Kyngas, 2008). Furthermore, as Krippendorff (2018, p. 18) asserts content analysis "provides new insights, increases a researcher's understanding of particular phenomena, or informs practical actions". He continues to describe it as one which is flexible in that it is able to cope with large amounts of data or small amounts of text; one that, as quoted by Hsieh and Shannon (2005) above, can be used to identify themes or patterns (Krippendorff, 2018).

Using the "open coding" approach advocated by Hsieh and Shannon (2005, p. 1280) and Richards (2015, p. 89), the researcher in the present study read through each line of text taken from the focus group and interview transcripts and the organisational health and wellbeing documents and condensed this into general themes using a "broad brush" strokes approach (Richards, 2015, p. 116). Each of the transcripts and organisational documents were then re-read, using a more focused approach, and listing descriptions that summarised all aspects of the content in the margins. The headings were then transferred from the margins to summary coding sheets (Elo and Kyngas 2008; Richards, 2015), condensed into themes based on their interpretation of what was being said, and finally categorised into sub themes (Graneheim and Lundman, 2004; Elo and Kyngas, 2008; Braun and Clarke, 2014). Consequently, the themes identified were based on an interpretation of the data emerging from individuals' stories as opposed to pre-set categories, as advocated by Braun and Clarke (2006, 2013, 2014, 2019). Examples using data from this study are described in Table 7. These can be categorised as the first

stage of theme development; part one of the tripartite data analysis process in this study, based on enhanced levels of refinement utilised. Braun and Clarke (2019, pp. 593-594), describe these as "data domains or 'bucket' [themes]"; an initial analysis stage that "doesn't [yet] tell a thematic story".

Table 7: Stage 1- Examples of General Themes, Content Descriptions, Interpreted Themes and Sub Themes

General Theme	Content Descriptions	Interpreted Themes	Sub themes
• Work related stressors	• Conflict at work (verbal and nearly physical), seen as outsider • Responded with aggression and distrust of others	• Stress	• Work related stress • Personal stress- due to life events • Impact of stress on self and work
• Stigma/ Self-stigma	• Fear for job if fully open about mental health problems • Support varies by team • Staff should disclose more to patients but have to gauge it based on the patient • Has not disclosed about self-harm but should as good	• Disclosure	• Selective disclosure • Role model (for other staff) • Staff disclosure to patients debate • Public disclosure

	story		
• Reasonable adjustments for staff with disabilities, including mental health problems	• Disability leave • Special leave to attend treatments, counselling etc. • Adjustments to sickness targets • Adjusted working hours • Change of job role	• Management/ Organisational Support	• Line Manager Support • Organisational Policies and Procedures • Organisational Culture • Impact on wider team
• Impact of mental health problems on clinical practice	• Staff with mental health problems give positive contributions re their lived experience, however caution should be exercised • Staff with mental health problems providing clinical care is normal practice • Worked with people with mental health problems who have not met some of standards and	• Personal view of staff with mental health problems providing clinical care- impact on practice	• Boundaries • Paternalism of the healthcare system • Empathy • Shared understanding • Supervisor role • Personalisation agenda • Performance

	performance • If you have real empathy with someone there is a boundary risk between professional lived experience and being a patient		

Interpretations of the data were constantly cross-checked by the researcher against the original transcripts, to ensure faithfulness to the experiences shared by research participants. This strategy to maintain authenticity is advocated by Lincoln and Guba (2000).

Using a thematic approach within this study to analyse the data collected enabled the researcher to:

- Identify perceptions and experiences of staff with lived experience of mental health problems in relation to their working environment
- Compare and contrast staff experiences of support for mental health and wellbeing throughout the organisation
- Identify and explore good practice in employment based on participants' experiences.

The qualitative data analysis software 'NVivo 11' (Lumivero, 2015) was used to assist in the organisation and management of the data collected from the interviews. The application itself enabled the storage and streamlining of key data such as interview recordings, field notes and articles for classification and further analysis, subsequently helping to confirm the themes emerging from the manual coding process described above; for as Richards (2015, p.

111) writes: "… auto-coding is no substitute for your interpretation".

3.5.1 Thematic Coding: Interviews and Focus Group

Further analysis of the data and the corresponding "'bucket' [themes]" (Braun and Clarke, 2019, pp. 593-594), resulted in more refined themes (Table 8) emerging from the coded data taken from the interviews and the focus group with staff with lived experience of mental health problems, and the interviews with policy makers:

Table 8: Stage 2- Key Themes from Interviews and Focus Group

Interviews with policy makers	**Interviews with staff with lived experience of mental health problems**	**Peer Support Worker Focus Group (Staff employed due to lived experience of mental health problems)**
1. Professional Role as a Manager	1. Work-Related Stressors	1. Work-Related Stressors
2. Management/ Organisational Support	2. Management/ Organisational Support	2. Management/ Organisational Support
3. Experiences of staff with mental health problems working for the Trust: tokenism and challenges	3. Professional Identity	3. Professional Identity
4. Own view of staff with mental health problems providing clinical care- and the impact on practice- value of lived experience and boundaries	4. Disclosure and Boundaries	4. Disclosure and Boundaries
5. Societal Stigma regarding clinicians with experience of mental health problems providing	5. Value of Lived Experience	5. Value of Lived Experience

care		
6. Organisational Goals and Aspirations	6. Societal Stigma	6. Societal Stigma

These themes were further refined and developed, producing three definitive over-arching vertical themes, each of which are the focus of a distinct findings chapter: Fulfilling the Organisational Narrative: Practicing What We Preach? (Chapter 4), A Balancing Act: How Staff with Lived Experience Negotiate their Identity (Chapter 5) and Wielding the Double-Edged Sword of Power and Powerlessness (Chapter 6), before being positioned to show their inter-relationships in the form of cross cutting arguments; thereby showcasing a deepened level of interpretation and understanding. This third and final stage of refinement (see Figure 5, p. 258). is the key focus of Chapter 7: Discussion and Conclusions.

3.6 Ethical Considerations

The researcher is aware of the sensitivity of the subject matter within this study and the confidential nature of the sources. Due to this sensitivity, ethical approval was sought and granted by the Health Research Authority NRES Research Ethics Committee London-Surrey Borders (Appendix 12) and the study sponsor's Research and Development Department (Appendix 13) prior to commencing data collection for this study. The Associate Director for Human Resources from Glen Forest Healthcare NHS Foundation Trust acted as the gatekeeper of all employment data accessed within the case study organisation to ensure the strictest compliance with data protection regulations.

As a senior manager employed by the case study organisation, it was important that the researcher continuously fully considered their structural positioning, as this had the potential to both

support and impede the research outcomes. Aligned to this were issues of power, which the case study approach does not address, particularly pertinent within the mental health arena. Guidance and advice from academic supervisors ensured that these issues were fully monitored and addressed within the research practice. This is explored further in Chapter 7.7.3.

All research practices adhered to the University of Nottingham's 'Code of Research Conduct and Research Ethics' (2023), as adopted by the University of Nottingham Faculty of Medicine and Health Sciences. However, the four moral principles, adopted by the National Institute for Health and Care Excellence (NICE), which underpin clinical and public health practice in the UK (Table 9), are generally accepted to be the most accessible guides within medical ethics (Cookson and Dolan, 2000; Beauchamp and Childress, 2001; NICE, 2008; BMJ 2022). Consequently, these four principles form the basis of the ethical considerations within this research.

Table 9: Ethical Principles and How they were Addressed in the Study[9]

Moral Principle	Description	Method of Address
1. Respect for Autonomy	To respect the decision-making capacities of autonomous persons, enabling individuals to make reasoned informed choices.	• Recruitment of staff with lived experience of mental health problems is voluntary. • All interested individuals were provided with an information sheet outlining the study and its aims. • All participants were asked to read and sign a consent form, which clearly highlighted their right to withdraw from the study at any time.
2. Non-Maleficence	To avoid causing harm. Where unavoidable, harm should not be disproportionate to the benefits of the treatment.	• Participants were at no time asked to disclose personal medical information including any mental health diagnoses or associated treatments. • It was recognised that questioning may have been potentially distressing to some participants therefore psychological/ therapeutic support was made available to all. This was accessible both during and after the interview via the 'Let's Talk Wellbeing' Service and/or the Staff Counselling Service. The latter were on-site at each of the interview venues.

9 Adapted from Beauchamp and Childress (2001, p. 12).

3. Beneficence	To do good. Balance benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.	• No views and opinions of patients were sought at any time, only those of staff members who volunteered to be part of the study. • The University of Nottingham and the case study organisation's safeguarding policies and procedures were followed at all times. These were important to have in place should a participant become unwell, or if any concerns arose from a disclosure within the interviews or the focus group. Consequently, a senior clinician from the Trust was available in each building where the interviews and focus groups were taking place to support if and when required. Furthermore, safeguarding mechanisms were in place to report any disclosures that raised concerns. This was stated in the Participant Information Sheets (Appendices 1, 5 and 7) so that all participants were aware of this obligation.
4. Justice	To respect justice. Benefits, risks and costs should be distributed fairly, and the law should be adhered to at all times. The actions of healthcare professionals should be justifiable at all times.	• Personal privacy was treated as paramount throughout the study. • Information provided by participants was stored securely at all times as prescribed by the law using methods that would not allow them to be individually identified. • The name of the case study/ sponsoring organisation, and any specific details attributable to it, including its logo, were removed/ redacted from the appendices to further protect the anonymity of the participants.

The previous chapter identified that people are afraid of the consequences of employers knowing about their experience of mental health problems and are uncertain of the personal

consequences of talking openly about their experiences, both within and outside the workplace. This can lead to an ongoing paranoia that others are aware of this information and may use it against the individual.

Accordingly, all aspects of this research were handled with the utmost sensitivity and respect. Due to the delicate nature of the subject matter, recruitment of staff with lived experience of mental health problems to this study was voluntary, with personal privacy treated as paramount. Mindful of this, individual interviews with staff with lived experience of mental health problems was opted as the main data collection approach for this cohort to offer privacy via the one-to-one setting. The choice of meeting venue was determined by each individual, based on where they felt most comfortable; sometimes this was in their or the researcher's private office, at other times a neutral private venue. The focus group approach was only utilised with Peer Support Workers as a means through which to explore both individual and collective experiences, as this was a group who, by the nature of their role, were already very aware of each other's personal experiences of the workplace. Nonetheless it was acknowledged that such questioning may have been potentially distressing for some participants, as could the views and opinions of others within the focus group. Psychological support was therefore made available, as required, via the organisation's 'Let's Talk Wellbeing Service' and/or the Staff Counselling Service. This was accessible both during and after the interview. At no point did this study seek the views and opinions of patients, only practicing staff members.

3.7 Personal Reflections and Reflexivity

Throughout data collection, the researcher kept reflective field notes to help them consider their own position within the study, to observe any preconceived assumptions or unintended bias and to note areas for further exploration, in line with the philosophical underpinnings of the chosen research approach. This enabled them to question their own processes. Such an example can be demonstrated in relation to interviewing a staff member who the researcher learned prior to the interview had only recovered from a psychotic episode a month earlier. The researcher's assumption was that they would be quite fragile and would require a great deal of sensitivity and care in the interview. Post interview reflections helped the researcher to identify that their initial assumption had been challenged. This was someone whose lived experience of mental health problems had given them the knowledge and experience to know when they were well enough to engage in such activities as interviews, and the strength to terminate them should they feel unwell or unsafe. Furthermore, the researcher learned that the individual had taken the initiative to put in place their own support mechanisms in the form of her manager working in a café not 30 feet away from the interview room (Appendix 11.1).

The reflective field notes and the descriptive field notes are a valuable resource, and consequently they were utilised to inform the analysis and interpretation of the data collected. For this same reason, analysis of data obtained from interviews and the focus group was carried out throughout the study to enable learning to be embedded within the research process (Appendices 10 and 11).

Additional reflections on the study methodology and methods are provided in Chapter 7.7 of this thesis.

3.8 Conclusion

A case study approach was the methodology chosen within the study, guided by the outcomes of the literature review. The review identified that such a study had never been carried out. Consequently, a gap was identified, compounded by the fact that little data exist in relation to the experience of people with mental health problems working for the NHS, particularly those who work for a mental health provider and who themselves provide mental health interventions. Utilising a case study methodology enabled an examination of the lived experiences of staff with mental health problems, within the constructs of the mental health provider organisation in which they work; to understand the experiences of individuals within a single organisation whose working lives are governed and managed by the same overarching employment policies and strategies.

Semi-structured interviews and a focus group were utilised to address the research questions identified. This allowed triangulation between the intent of the policies and strategies, the experience of those staff with lived experience of mental health problems of the workplace, and the understanding and experiences of policy makers. This enabled the researcher to provide an answer to both of the research questions posed, namely 'How does a mental health trust support clinical staff with lived experience of mental health problems; and how do these staff experience work, in light of their mental health problems?'.

The methods used for analysis aimed to maximise the trustworthiness and authenticity of the findings, discussed next in Chapters 4, 5 and 6.

The following three chapters set out the findings of the interviews with staff from the case study organisation. Chapter 4 will focus on policy makers, namely senior managers and other staff with key policy roles within the organisation; while the subsequent two chapters concentrate on staff with lived experience of severe and enduring mental health problems (lived experience), who undertake diverse roles within the case study organisation. It is anticipated that comparing the findings of the policy makers with the workplace experiences of staff with lived experience, will help illuminate how the Trust's ideology aligns with the experiences of its staff.

Chapter 4: Findings: Narrative Versus Experience- Policy Makers' Perspectives

4.0 Introduction

This first data chapter highlights the findings of individual interviews with 24 policy makers. The term policy makers was chosen as a descriptor for this cohort as each of the participants were senior staff, who as a result of their leadership and management responsibilities had inferred power to shape and influence the organisation's ideology, culture and therefore, policy. Furthermore, use of the collective term 'policy makers' protects the anonymity of this group of participants, whose privacy it was essential to preserve due to the ethically sensitive nature of this study. Participants included members of the organisation's Executive Team, Non-Executive Directors, Human Resources leads, internal union leaders, support services managers, and both operational and strategic clinical managers, encompassing all three operational divisions, and corporate services (Figure 2). Through an analysis of the collective views of these policy makers, this chapter provides management and leadership insight into the organisational context in which staff with lived experience work. Additionally, it offers the opportunity to consider how these leaders personally view and experience the organisational narrative and what their role is in shaping it, the challenges they experience and so forth. This will provide context for Chapters 5 and 6, which feature the accounts of staff with lived experience of mental health problems and, in response to the research questions, the extent to which Glen Forest supports them in the workplace and how these staff experience the workplace in light of their mental health problems.

4.1 An Organisational Perspective

Analysis of the interview data revealed a single overarching theme in relation to policy makers. This could be conveyed in terms of the relationship between the organisational narrative and the way staff experience it. Within this theme lie a number of sub-themes, which are summarised in Table 8 and will be addressed as subsections under the main thematic heading. Whilst all participants suggested from the outset that the organisation was a supportive place for staff with lived experience of mental health problems to work, deeper exploration of their views intimated that this was not the case for the majority. Analysis indicates that while only one of the policy makers advocated that the organisation's narrative almost completely matched staff experiences, all of the others contradicted their initial assertions and identified areas where the organisation had fallen short, highlighting gaps and suggesting things that the organisation could and should have done. Of these, over three-quarters shared extremely critical opinions; arguably some of which were embroiled in national politics and government policy. In conclusion, the findings from over three quarters of the participants suggested a disconnect between the Trust's ideology and the experience of its staff with lived experience; an organisational paradigm where the organisational narrative did not appear to match the experience of its staff.

4.2 The Altruistic Employer

In order to provide context for their views, and their point of reference, it is firstly important to understand what helped motivate the policy makers who participated in the study to pursue a career within healthcare. All participants, with the exception of one, stated that they entered the profession to help others and give something back; six of whom disclosed that they also felt

compelled to work in the healthcare sector as a consequence of their own lived experience of mental health problems. This alludes to a group of participants who consciously believed that they intrinsically cared about others and wanted what is best for them, including the staff they managed.

As Louise, an HR professional, commented:

> I wanted to work in a role where it… was providing a service back into a community and back into a you know, caring, in a caring environment really and I think that's why I started off with the notion of being a nurse 'cause that's where the obvious joy is to people who want to work in caring professions… I've always wanted to work in caring (Louise, PM18).

Billy, a ward manager reinforced the notion of his desire to care for others and make a difference to their lives:

> I worked in a 1500-bedded hospital, and you thought to yourself 'you know you'd go in and you'd think to yourself you're making people's life a wee bit better' (Billy, PM17).

Isla, a General Manager and self-identified nurse, endorsed this sense of altruism, of doing something to help fellow human beings because you can:

> I'm a nurse, and erm basically as a nurse you, in my day [laughs] when I first started nursing the patient, you went into it not for the money, not for anything else but actually because you wanted to help somebody (Isla, PM8).

Sue shared how her both her lived experience and upbringing affected her career choice:

> I started as a general nurse; I did my mental health placement and had my first breakdown whilst I was training to be a general nurse and as a result of that went straight into mental health nursing. Erm I, I was brought up amongst a whole crowd of foster children all of whom had different health problems, mental health problems, emotional difficulties, developmental difficulties and… that was all explained in terms of psychological [clears throat] reasons, which probably meant that… all of erm my brothers and sisters have gone into some kind of caring profession (Sue, PM21).

Reasons for entering the healthcare profession extended beyond initial attraction to include what influenced people to stay. Donald, a Non-Executive Director, highlighted what kept him working for the NHS after so many years:

> It becomes infectious the NHS; it sort of sits in your blood doesn't it?... it's part of my DNA now. […] The delight of actually seeing that impact on individuals is just phenomenal (Donald, PM20).

Donald recounted an example of why he comes to work. He shared the story of a visit to one of Glen Forest's Involvement Centres where a service user told him that he'd saved their partner's life. As a Non-Executive Director, he was surprised and shocked to hear this revelation and queried it, to which the individual responded:

> You went onto ward X, you saw my partner, you were walking through the ward with somebody important, and my partner looked at you and thought that person's obviously very important, and as you were walking through they thought to themselves "you know I'm nobody and, as soon as I get out of here I'm going to kill myself as nobody cares"… and you stopped and you said to the other person "I'm sorry there is somebody over there I want to go and talk to they're important", and you went over to them and just talked to them for 2 minutes… [As a result, my partner thought to himself] "I am important, and not only am I important I'm more important than the important person he was with because he left them and he came to talk to me, so you know, I'm not going to kill myself because I am important" (Donald, PM20).

The remaining interviewees stated that they simply came into the NHS as it "was recruiting [whereas] local government wasn't. It was a bit of an accident to be honest" (Christine, PM23).

4.2.1 The Value of Staff with Lived Experience

All of the interviewees, regardless of professional background, shared a common belief that staff with lived experience providing clinical care to patients added value to the organisation. There was an overwhelming agreement that it was not only a good thing to do, but also the right thing to do. However, participants acknowledged that working as a mental health clinician, with lived experience of mental health problems worked well for some individuals, but not for others, due to a multitude of reasons. The risk, some said, was worth it.

> I think when they've had lived experience of depression, anxiety or any enduring mental health, it actually gives them and, I don't mean sympathy, I mean real empathy. […] It's that level of, having that level of compassion, that actually you've been through it, you've experienced it, you've lived that, and it gives you erm an …that added dimension of compassion towards that other person (Isla, PM8).

Lorra, an Executive Director and practicing mental health nurse, agreed with this, highlighting that staff with lived experience possess an additional competency:

> If I think about erm staff working on an acute ward erm… with patients with secondary mental health problems and the difference between a member of staff without a secondary mental health problem ever or with one, the person with one will know much more about what that person's experience will be like… erm and be able to think more insightfully about how their care might be delivered and think about them probably in a more holistic way (Lorra, PM9).

The perspective of Jayne, a Medical Director and a practicing psychiatrist, came from her personal experience when a trainee psychiatrist.

> The trainer that I worked for who had bipolar and if anything that probably set a lot of my attitudes going forward, because she was the best trainer I ever worked for. She was fantastic psychiatrist and I admired her hugely and if anything her lived experience had definitely fed into her understanding and management of others (Jayne, PM6).

When asked how that impacted on her and her colleagues she added:

> It was something she just managed, and the team would be very supportive of it, so I think her entire team was well sighted on all of her early warning signs so- everybody would know, 'right we're a bit worried, we'll, we'll shift things around, we'll make sure that clinics are a bit shorter'. So, the whole team took on a sort of caring role at the same time. (Jayne, PM6)

Furthermore Marie, an HR Manager with considerable experience in employee relations matters within the organisation, asserted:

> My personal experience and the, the feedback that I've had in terms of… others delivering that care and on the receiving end of that care… has been that that is an absolutely positive thing to do and to have, is healthy within a workplace both for staff and for patients, carers, and service users… I sit overwhelmingly in the camp of that is the right thing to do […] and the reasons for that are… that… for all the times I see it go wrong, I probably see tenfold it go right. So, for me that's a calculated risk, if that makes sense?… because actually I think the positive contribution that it makes is far greater and you just have to deal with the times when it doesn't go well, as it happens (Marie, PM14).

4.2.2 Organisational Narrative

The general consensus was that with the right managerial support, staff with lived experience of mental health problems can and do flourish in the workplace. This was illustrated by the majority of interviewees highlighting how the Trust's previous Chief Executive,

who openly shared his lived experience of mental health problems, served to do this through role modelling:

> I know [x] the previous erm chief exec, he had bipolar and er he openly admitted to anybody that he suffered or had lived experience of bi, bipolar […], he was open, transparent, he took questions on it, he gave examples of his own lived experience erm… So… […] he gives people something to aspire to you know… just because you have er lived experience of mental health issues and problems, it won't stop, it shouldn't stop you from doing what you want to do erm and that's, that's how he came across to me that you know, he would strive and go for whatever you know, just because he'd got erm… bipolar wouldn't stop him from doing anything he wanted to do (Grace, PM12).

Policy makers were able to identify a plethora of organisational policies, procedures and practices available to support staff, and highlighted areas of good practice as demonstrated by themselves and others. The adage that policies were only as good as the manager who applied them, was referenced by several of the participants, in the knowledge that staff experience varied depending on their manager. It was emphasised that there was no consistency within the organisation and some managers lacked the necessary skills to support their staff; something that frustrated a number of the interviewees, especially when it was noted that these managers were trained mental health professionals with significant experience of supporting patients effectively.

4.2.3 Organisational Policy

All of the interviewees were able to list a number of supportive policies and services within the organisation to assist colleagues

with lived experience of mental health problems. Over two-thirds of the policy makers provided examples of how their teams had used them, with the remainder knowing of their existence but not the extent to which they were used, or indeed if they were applied effectively. The latter were all very senior managers, namely Executive Directors and Non-Executives, which may offer some explanation as to why they lacked this knowledge due to being farther removed from the operational level. However, what was noteworthy was the realisation of this knowledge gap by the case study organisation's Board members and their acknowledged need to do something about it. As Christine, an Executive Director stated at the end of the interview:

> It's been an interesting hour... And some of the questions has made me think "I don't know that, and I ought to know that", so there's some homework for me after today, in, in terms of actually "what, what should I have said? What haven't I said, which I need to do something about?" (Christine, PM23).

Ben (PM4), a non-clinical support manager in one of Glen Forest's clinical divisions, listed a number of supportive policies and services available for use within the organisation. This included the Sickness Absence Policy, reasonable adjustments, Workforce Individual Support Plans (WISPs), an Occupational Health Service, Staff Counselling, access to Disability Leave, job redesign, flexible working, and a peer support group for staff with lived experience called 'Living in Both Worlds', or as some of its members described it, 'Wearing Two Hats'. Ben also mentioned the Trust's Workplace Wellbeing Plan developed for all staff to use, not only those with disabilities. Of interest to the research was that Ben also held a trustee role for the national mental health charity MIND, and

volunteered his extra-curricular endorsement to Glen Forest's standpoint:

> The Trust's approach is one that looks to be […] supportive and MIND would be supportive of the Trust's approach. MIND as a leading mental health organisation clearly is supportive of enabling people with mental health problems, people with experience of mental health as MIND frame it, erm to maintain themselves in employment at whatever level, and as I say I think the Trust and MIND would be aligned in that, that regard (Ben, PM4).

The existence of a plethora of tools available within the organisation to help managers support staff with lived experience was also offered by Joy, the manager of Glen Forest's Occupational Health Service, which was an external service. In addition to her own service, Joy's references included the Flexible Working Policy, the Health and Wellbeing Policy, Disability Leave, and the Bullying and Harassment Policy. However, her main focus was the Sickness Absence Policy as she was most familiar with this:

> In terms of mental health, I think one of the things that I think the Trust is very good at doing is erm for example within their, within the sickness absence policy- they try to take account of long-term health conditions in terms of setting sickness absence targets etc., etc. and managers do have that flexibility to set the targets and do that. […] The good will is there for the Trust to do that and I think they do try. Other organisations don't have that degree of flexibility within their sickness absence policies, so I think that's very good (Joy, PM7).

She added:

> My experience is that where people have for example a mental health problem and have difficulty doing their own job long-term, I think the Trust is very good at seeking secondment opportunities for people and I don't see that in other organisations. I see the staff… the Trust to be very supportive in enabling people to come back to work in to another area initially to ease their transition back in to work and I feel quite comfortable about suggesting that might be an option that the manager may wish to consider to enable the person to ease back in to work without the full stressors if you like of their normal day to day job, you know, working with patients that can often be erm challenging erm. […] I also see that the Trust is, will acknowledge often that people aren't unable to go back to their substantive post because of a long-term mental health problem and I see that the Trust does seek to find alternative work for them when they are at risk in terms of their job and I have seen that erm on several occasions (Joy, PM7).

However, it is important to note that the reason why Joy suggested that she referenced the sickness absence policy so much, particularly in relation to long-term health conditions was because "often people aren't aware of that policy."

Having listed the majority of the policies and support services identified above, Isla, a clinical manager with responsibility for a large number of services, concluded:

> My belief is that the Trust approach is, as a mental health trust, is that… and I've, actually seen it actually […] it is a

> compassionate organisation. Erm my belief is that they do not support stigma, stigmatising people; they, the people with mental health issues have a voice and there's that, there's the whole recovery plan and recovery college and, it's a very important part of the organisation that, that nobody erm… isn't listened to it if they've got mental health issues or not […] (Isla, PM8).

4.2.4 Practice and Praxis

Ensuring that the organisation's narrative was embedded into practice was important to all of the participants, as was benefitting from lessons learned. Having identified the views of policy makers as to the Trust's ideology and the supportive policies and practices in place, this chapter will now focus on an analysis of their views as to how this narrative is translated into the day-to-day experiences of staff with lived experience in the organisation. As recognised earlier, all of the policy makers were able to provide examples of how they deemed the Trust to be a supportive workplace for staff with lived experience. These examples of 'what good looks like' were based on interventions that the policy makers themselves had been involved in or witnessed through the managers they managed.

4.2.4.1 What Good Looks Like: Practicing What We Preach

All of the policy makers offered examples of good practice, based on the support that they and/or their colleagues had given staff with lived experience. In the main, these examples reflected the organisational ideology espoused about providing a supportive work environment for these staff, one in which they could succeed.

Kate's experience (PM13) of talking to staff members with mental health problems signalled that they generally felt well supported,

they felt it was positive and that there was a good culture of openness. She believed that society was changing and that mental health problems were now seen as more acceptable and that the Trust had been a "leading light in that", adding that the Trust's approach "empowers staff" with mental health problems. When asked what she meant by this last phrase, she responded that all of the helpful behaviours espoused by the Trust, when put into practice "makes people feel much better and gives you, [as a manager] the satisfaction that you are making a difference to people's lives, that you're on the right track". Kate provided an example of how her support for a member of staff with lived experience kept her well enough to work, which in turn benefited the service.

> [A staff member] came to us erm via an 'at risk' process […] with a terrible sickness record… huge amounts of long-term sickness over quite a number of years. Fundamentally it was mental health that was the issue, but she'd not really been able to properly fully acknowledge that and speak about that openly to her previous managers and get some proper support. I think she developed a really good relationship with her line manager erm and via that relationship was able to actually I think disclose what was going on and therefore get much more appropriate support I think to continue at work than she's had before. So, we've seen just a massive… she's been with us now for about 3 and a half years… a massive change, hardly any sickness. She's still having some sickness actually… and she's still struggling sometimes but actually much more able to remain at work. What she does is recognise much earlier on and get support, maybe take a bit of time off much earlier on which means that it never gets as bad as it has been before and she's generally back in work

> much more quickly and we get the most fantastic feedback about her. She is loved by the GPs [laughs] she's loved by her colleagues…you know; she's an absolutely superb worker. So that investment I think in actually getting it right and working with her to get a plan that means that she can continue to use her skills in work has been great you know, really worthwhile (Kate, PM13).

Kate also cited an example of a staff member she managed who had schizophrenia. The team was very supportive to the individual, however things happened in the staff member's personal life that impacted on her at work and made things difficult for the team. She recounted how the staff member would be found crouching under the office table wailing and refusing to go home. The other team members did not want to leave her when she was like this, which meant that they could not go on their clinical visits. Kate said that she was honest with her and at times told her that she was not well enough to be at work and needed to better look after herself, which she accepted. Kate recounted that on numerous occasions she had to make the decision to send her home, in the knowledge that her going home would not be easy to manage either, as work was easier for her than facing being at home. Using the organisational tools available and her own experience as a manager, Kate ensured that the staff member had a named HR person who provided support, had a specific support person within the team, met regularly with her, ensured that she had the right medical support, and that she was going to be safe at home. The individual remained at work for a number of years but then went on to further education. Kate stated that she was clear what her responsibilities were as regards supporting staff, as per the organisational policy:

> [My role would be to] ensure that there was a plan in place that they felt was reasonable in terms of meeting their… their needs. So, I think if they had a long-term problem, whereby we as an employer needed to make some adjustments in terms of them being able to remain at work, then we would agree that. I think in terms of the Equality Act you know, we need to formally identify that as such and identify a plan in terms of you know, how we were going to offer support and then regularly review that. […] It should be part of the supervision anyway in terms of just checking in each month, are you ok? Any issues? You'd do that with anybody anyway. But then also making sure you've got more formal reviews, just thinking about things like Access to Work you know, thinking about [sniffs] any additional supports like counselling, that kind of thing. Any other issues that might have come up erm I don't know in relation to the nature of the work someone's doing, their role, their colleagues. I think it's just you know, making sure that you are regularly reviewing any plans that you've put in place, adjusting them when you need to (Kate, PM13).

Billy's response also matched the organisational ethos that all staff, including those with lived experience, should be afforded the same opportunities to succeed in their career. He added:

> […] they're gonna bring some issues for you that you have to manage but eh you go into that with your eyes open 'cause eh to me it should be the person that you're dealing with, it's not their issue. And if people have got the qualifications and the right skill sets and their, their references and everything that would indicate to them that they're spot on…you know but every so often they experience these problems you know,

> for two months a year, three months a year, so what? Nine months a year you're getting a really good functioning person and my aim would be that for that three months of the year… I'd be supporting him to make sure that that nine months became a year (Billy, PM17).

He continued:

> I've always pretty much been a staff person […] I've also like worked on the principle if your staff are happy at work and feel as if somebody is actually looking after their interests and you're there to get the best out of them, they'll give you more and the more you give people, the more they'll give you back and therefore so they're offering a better service. And I think with people you've got to accept everything that comes with this person. […] I would take you for what you can give me on that day, and I won't judge you on something that you've not done, I'll judge you on something that you've done well (Billy, PM17).

Grace, one of the organisation's union leaders, highlighted that the trade unions have a role to play in ensuring that the organisation is accountable for embedding its ideology in practice, something she acknowledged is welcomed by the Trust:

> It's about making sure that we are as an organisation are true to ourselves and true to what our positive values are (Grace, PM12).

Confident in Glen Forest's practice of supporting staff with lived experience, Grace said that she would encourage any of her family members with mental health problems, who wanted a job in the

Trust to disclose their mental health problems on their application, as they would get the necessary support. Grace exemplified this with an example of a manager she worked alongside to support one of her union members.

> She saw it from his point of view, and I think that […] it's an excellent place to be for anybody to actually see it through his eyes and feel it through his feelings and I, and I know she took that on board. Absolute empathy […] their working relationship erm improved no end and he wasn't off sick for eighteen months and I'm really pleased about that, and he was fit and well (Grace, PM12).

Having identified policy makers' initial positive views of the organisational narrative, their affirmative personal views of staff with lived experience and examples of good practice they have either experienced or witnessed, this chapter will now explore the contradictions highlighted during their interviews. First, the areas that interviewees identified where the Trust had fallen short and where improvement was needed will be explored. This will be followed by the highly critical views shared by a large number of the policy makers. The chapter will then conclude with a perspective as to whether the organisation's policy makers believed that the Trust's narrative matched the experiences of staff with lived experience.

4.3 Falling Short

Analysis suggested that only one policy maker's argument that the organisation's narrative almost completely matched their understanding of staff experiences was resolute. When the data from the others were analysed further it was clear that they later

contradicted their initial assertions. Based on their organisational positioning and management experiences, they articulated examples of when things had not gone particularly well and had fallen short of their expectations. In such instances, they, on occasion, suggested things that the organisation could and should have done to improve things for the future to ensure the narrative matched staff experience. Analysis of the data suggested three key sub-themes: equity of experience; leadership, vision, and values; and 'wicked' management challenges. It should be noted that some of these sub-themes will be explored further in section 4.4 when 'failings' are discussed due to overlaps between some of the themes, namely where policy makers have perceived them to be more akin to failings than falling short.

4.3.1 Equity of Experience

The majority of the interviewees stated that their perception of the Trust's support for staff with lived experience of mental health problems was that it was mixed. Some areas were acknowledged as supportive, whereas others were not. Such fragmentation was identified by most of the participants as largely being based on who the individual's line manager was, while others suggested that some elements were out of the Trust's control and/or to be expected in such a large and complex organisation. Regardless of causation, a large number of policy makers deemed that the organisation, based on the fact that it is a mental health trust, should be doing better and setting an example.

4.3.1.1 Fragmentation

Nearly all of the policy makers identified areas of both good and bad practice within the organisation as regards support for staff with lived experience. Lorra, a clinical leader, asserted that the experiences of staff with lived experience varied:

> I think that there will be a lot of people working for the organisation who, who have problems and we don't know… I think there will be a number of people who wouldn't tell us… still. Erm, I think that there'll be people who potentially told us and wish they hadn't. […] I think there'll be staff who have told people and haven't felt supported, I think there'll be people who have told […] their manager and have felt fantastically supported or just enough supported (Lorra, PM9).

Similarly, Molly was not surprised that a number of staff with lived experience felt unable to discuss their mental health problems with their manager, despite the fact that the Trust has encouraged all staff to have a wellbeing plan. These, she believed were good but are not the solution.

> When I was talking to a group of people about wellbeing plans, they were saying "I'm not going to share with my manager that I struggle on these occasions to do this, because when we go through reorganisation or I'm next off sick it'll be used against me." [...] I think it makes them very cautious and very anxious about sharing their lived experience (Molly, PM24).

Despite giving examples of where staff with lived experience were supported, Molly concluded:

> I think there is a long way to go for me to be able to sit here and say that the Trust is supportive of people [staff] with mental health problems (Molly, PM24).

Marie, a Senior HR Manager, agreed that there were a number of staff with lived experience who felt proud to work for an organisation that they believed was supportive of them, which understood their struggles and was committed to reducing stigma. Such people, she suggested, had a supportive manager and a wellness plan in place, which helped them identify triggers, feel safe, and enabled them to see their Community Psychiatric Nurse (CPN) if needed. However, she had examples of where staff had told her that they had not felt supported and were unable to disclose their lived experience to their managers as they did not feel safe to do so, where there was a culture of secrecy. Nonetheless, PM14 concluded that there were many reasons why such staff felt unsupported and not all of it could be resolved by the organisation; some of which were dependent on the staff members themselves:

> [Some staff] working in a mental health trust do not have regard for themselves as a patient and have a real sort of personal and professional tension around that. […] Some of those can be more controlled and influenced by the organisation and what it does and some of those sit outside in terms of society in general, people's professional pathways, how they believe stigma may or may not be attached to that, how they feel and how they believe it might affect their careers (Marie, PM14).

4.3.1.2 Better Staff Support

The majority of policy makers emphasised that improved access to a range of support for staff with lived experience was vital within the organisation. This included mainstream services such as Cognitive Behaviour Therapy (CBT) and counselling, as well as specialist psychiatric support. Notably, four of the interviewees

expanded their opinion by suggesting that early intervention support was required to help prevent some staff with lived experience from spiralling in the first place.

4.3.1.2.1 Early Intervention

Being more proactive and actively putting things in place earlier to support staff with lived experience was identified by over half of respondents as a key element of improving equity of experience. As Jayne, a senior medic, stated:

> If the system worked you'd be back to that element of early prevention that we'd have a system that trained and supported people in terms of their mental health regardless […] Managers and co-workers actually being aware of what is happening with other colleagues and feeling a responsibility that actually if you can see somebody else is struggling or falling apart you don't just stand back, that there's a shared way of working together to support each other… It's all the things that we would talk to patients about, in terms of managing them, early prevention, warning signs, everything else but we don't apply… to ourselves. Somehow all mental health staff are all supposed to be superhuman and able to cope with anything and just continue (Jayne, PM6).

Isobel, a social worker, argued that ensuring the employment of staff with lived experience was secure from the outset was of pivotal importance. The potential for loss of job could lead to a continuum of loss of status; and the consequential loss of income may result in forfeiture of their home, in turn resulting in loss of family, and potentially custody of their children if in a period of crises.

> …we should be thinking about protecting somebody's employment from the moment they become unwell, not the moment they start to get better. We should be thinking about how we maintain your employment from that moment as opposed to six weeks later when you're ready to be discharged from hospital…because that's often at that point when it's too late (Isobel, PM11).

The key concern expressed by James (PM3) and Joy (PM7) was the organisation's need to better support staff that develop mental health problems during their period of employment. Both believed that the Trust was good at employing people with a history of mental health problems, but not staff who developed them while in service. PM3 claimed:

> We are one of the biggest providers of mental health services in the country and yet […] we're much, much less good at actually catering for the needs of people who become ill during service […] There seems to be a belief erm that if you are profoundly depressed you still should have insight into your condition. […] If they had insight into their condition they'd go straight away and get help, wouldn't they? (James, PM3).

While the view of James (PM3) was more general, Joy (PM7) had some specific areas of concern and identified a key area for intervention that warranted the organisation's attention. This related to staff that had acquired mental health problems, primarily Post Traumatic Stress Disorder (PTSD), as a long-term consequence of being injured at work following assault by a patient. Referring to the experiences of staff with PTSD she had clinically supported, she identified that the uncertainty around

internal and Police-led investigations, although essential, often caused a lot of unnecessary distress due to the lack of communication provided to the individual. She highlighted:

> There may be mechanisms that could be put in place, if you like to […] facilitate that for staff so that that degree of uncertainty about "how long is it going to take?" "What will the effect be on me?" "What will the effect be on my job?" All those answers can be there for the individual (Joy, PM7).

She added:

> […] the difficulties in getting those individuals or supporting those individuals back to work erm does very much rely on the support that is given by the manager and the processes that are put in place for that person to get back to work. And often it's successful; often it's less successful (Joy, PM7).

4.3.1.2.2 Access to Support

Marie (PM14) acknowledged that the organisation did not make it easy for staff to find the support they needed within the organisation. While she accepted that some staff, due to the nature of their role, were able to ask colleagues to signpost them, this was not universally accessible. Christine also recognised this gap, and as a senior leader, professed:

> I don't think we are as good as we should be or could be… [we need to be] making things a bit more readily available, a bit more signposted, a, bit more a- accessible (Christine, PM23).

Isla (PM8), a clinical lead, alluded to the lack of organisational support available when she described a member of her team who had severe depression/anxiety. She explained that the staff member often felt unable to fulfil her role and at times had expressed that she "can't wait to die". The individual told her that she did not believe that the secondary mental health services that she had accessed were of benefit to her due to her being a nurse, as they had failed to "get to the crux of the matter". Isla had referred her for Cognitive Behavioural Therapy (CBT), but the staff member had been waiting for months to receive this as there were long waiting lists; there is no fast-tracking service available to Trust staff in distress. However, improved access to "a more comprehensive, more flexible and easier access service for staff in distress", is something Isla knows the Trust is exploring.

4.3.1.2.3 Improved Access to Specialist Services

Four of the participants highlighted that the process for procuring access to secondary mental health services for Trust staff needed reform. Reflecting on current policy, Christine recounted a recent experience she had had around securing an external placement for a staff member. She described it as:

> …a rather difficult on-call issue about the state of that [where] it just seemed to be custom and practice and gentlemen's agreements as opposed to erm agreed written protocols in, in that, in that respect (Christine, PM23).

This opinion was reinforced by Carol (PM16) who stated that a more formal pathway from staff counselling to secondary services was needed to support staff. For Molly, however, it is about much more than access to secondary services. It is about how staff that

have accessed these services are supported when they return to work. She revealed:

> I think it's hard when you think about [X] Services who might come to me and say that they've had a period of time off and they're really struggling with their mental health and they've been using secondary services and they've come back to work and nobody knows how to talk to them, nobody knows how to ask them any questions, nobody knows if it's ok to talk about it and the, the individuals then feel very lonely and isolated and… then ashamed I think of the experience they've had rather than you know, thinking "well this something that I can work my way through and I need some support to do it" (Molly, PM24).

When reciting support mechanisms for staff with lived experience, Marie (PM14) mentioned the Recovery College "that staff can access". Noteworthy is that almost two-thirds of respondents mentioned the Trust's Recovery College, however almost half of those believed that the College was only open to patients. One of the respondents (Sue, PM21) who had leadership responsibility for the College confirmed that it was indeed open to staff, however highlighted that few staff use it, as many of the same training courses can be accessed at a higher level via the Trust's Learning and Development Department.

Regardless of what was being planned for the future, policy makers agreed that better access to a range of support services was essential to meet the needs of staff with lived experience, helping to keep them at work, remain well, and feel supported when at work.

4.3.1.3 Policy and Process

Unequivocally, one of the largest concerns the interviewees identified related to existing policies and their application. Better managerial support, better quality and execution of policy, and better guidance for staff with lived experience, were all identified as necessary improvements by the policy makers.

4.3.1.3.1 Better Management Support

Enhanced support for managers was specified as an essential requirement by over three quarters of the interviewees. This was mainly expressed in terms of the need for management training to provide both new and experienced managers with the knowledge and skills necessary to support staff with lived experience in the workplace. However, two of the respondents highlighted that management training was not the issue: for one, the greatest need was giving managers the autonomy, responsibility and time to manage; and for the other, a whole organisational change programme was required.

James described the organisation as being fantastic at leadership training, but not at management training. He continued:

> …you can't put people into positions of authority and expect them to cope and to manage unless you have trained them for that. […] We promote to their level of incompetence simply because we don't bother to train them, yet we expect them to do it and yet if we trained people to have different attitudes […] then we'd do so much better overall (James, PM3).

Both Tina (PM5) and Isla (PM8) identified that they themselves, despite being "experienced" operational managers, also needed more training on supporting staff with lived experience.

> One of the things that erm I would like to see would be […] about developing almost a session [cough] that would look at erm how we manage staff from erm… from a equality and diversity standpoint, for staff that we have with mental ill health- I, I think, something like that would be very […] helpful for managers to have […] specifically developed around how we manage people with mental health issues […], it's not about being taught it's about […] that learning and having somebody that's managed somebody with mental health issues (Isla, PM8).

Joy, an occupational health specialist, confirmed the need for such management training:

> Often managers erm don't understand mental health conditions so they don't understand how this may impact on somebody's day to day activities for example. […] It may take them slightly longer to do a particular task because of their concentration or because of their memory and they expect that when somebody's back at that they'll be work, working one hundred per cent of their capacity. Well, we don't all work at one hundred per cent of our capacity erm very rarely [laugh] (Joy, PM7).

Joy added that this also applied to some clinical managers who worked in the provision of acute mental health services, who may be less able to understand the more minor mental health

conditions, such as mild to moderate depression as they are used to managing the more severe mental health conditions.

However, Lorra (PM9) stated that she hoped that it was more about managers not always being skilled at knowing what to do if people, regardless of their mental health problems, brought concerns to them, as opposed to not knowing enough about mental health. Furthermore, Lorra speculated that it may also be something more fundamental, such as managers not recognising that it is happening, or not having enough time or insight due to being too busy managing their own personal stressors. Christine (PM23) agreed with this, asserting her belief that it is more about "not very good managers" than an inability to understand staff's mental health problems.

Louise, however, suggested that it can often be difficult for managers to negotiate the dual role they have of confidant and potentially the person who has to manage and discipline. Consequently, she believed that it had nothing to do with mental health problems per se, simply that some of the clinical managers are much more comfortable using their discretion with patients than with their staff. She stated:

> [Some managers] fear an allegation of 'you're treating me differently', 'you're harassing me', or 'you're treating that person differently to the rest of us'. And it all boils down to a fear of being disliked and fear of making the unpopular decisions, and I see it most in our ward managers when they try and manage the sickness absence of their staff. And on one hand we encourage […] forming a bond with their staff to the degree that they understand them, can pick up when things aren't right, you know, being supportive, friendly,

> caring… and then on the next hand erm there are times when they have to make unpopular decisions and some of them struggle with making unpopular decisions and communicating that… and […] it's down to us, as in the Trust, to make sure they're supported, trained, comfortable… with the fact that sometimes you do have to make uncomfortable decisions (Louise, PM18).

Isobel agreed, highlighting her belief that often managers are fearful of being seen to be discriminating when they're "actually showing someone respect by being open and upfront with them". Isobel added that it is not necessarily mental health we have a problem with; it is our vulnerability which some see as a weakness.

She added:

> If you believe that an organisation will see vulnerability as a weakness, you're not going to express it (Isobel, PM11).

For Isobel, management support needed to go beyond improved access to services; an organisational change programme to enable and nurture an open, honest and transparent two-way relationship between managers and their reports was required. One where both parties could share the good things, but also those that frightened or concerned them. For Isobel, this was particularly important for staff with lived experience working in a mental health trust, which she explained:

> We work with some very, very complex individuals and their families and we need to recognise that that has an impact on all of us and whether or not that has a disproportionate impact… You have to recognise that sometimes the way we

> talk about service users in that… patient/worker relationship might also affect somebody who's struggling with… their own disclosure of mental health problems (Isobel, PM11).

Billy, a serving ward manager, corroborated the need for a more open, honest and transparent manager and staff relationship as opposed to management training. He expressed a belief that staff with lived experience benefited more from a supportive and attentive manager than something like attending a staff support group:

> I think it's up to me to eh know what they need through their working day. They might need to go out for an extra fag and they're saying, "oh we're short of staff". You're never short of staff if somebody's sitting in an office …you [managers] need to come out, you make yourself available, you make these people know that you're there to help them (Billy, PM17).

Accordingly, Billy suggested that the Trust had to do more to permit and support managers to manage:

> People need to be aware that sometimes my priorities will not be to get my supervision info in on time. My priorities will be for that time […] "well I've actually got a man here with some serious, serious issues and what I'm trying to do is maintain him at work" […] but I think there's just not enough consideration sometimes put into the fact that actually you need to be letting me have time with my staff. You need to be letting me invest in my staff in different ways do you know what I mean? (Billy, PM17).

Louise agreed, suggesting that managers need to be empowered and comfortable with some of the things they do, and hoped that they were getting the support they needed from the HR Teams. She did, however, add that sometimes tensions between HR and managers do arise:

> 'Cause sometimes when there's difficult decisions to be made, some managers will back away from the difficult decisions and let the HR person make the difficult decision for them… And that's not what they're there to do. And then there becomes a tension about what is the role of the HR adviser? What is the role of the manager? (Louise, PM18).

It is notable that four of the policy makers highlighted how important it was for managers to be able to be open about and learn from their experiences, including where things went wrong. Referring to both staff and patients, Donald stated:

> We do hurt people in the NHS; it's the nature of what we do. We don't understand everything […] mental health is a classic example of that: if we all understood mental health then, you know, what the hell, we wouldn't have a trust at all would we? So, we make mistakes as we're helping people and […] if we pretend we're perfect and they can see we've not been that's not helping their mental health at all, is it? It just makes them realise that we're liars or we're kind of… not really caring for them and therefore why should they trust us when we say that we are? (Donald, PM20).

According to Louise (PM18), learning from one's experiences is a natural attribute of a good and effective manager. This, in conjunction with the reflections of the other policy makers,

suggests a greater focus on possessing good leadership and management skills, as opposed to recognising the value of staff with lived experience in mental health services.

4.3.1.3.2 Updated Policies and Guidance

Almost half of the interviewees expressed a view that an overhaul of policies was needed in some form. Suggestions ranged from developing new and inclusive polices that better supported the needs of staff with lived experience, to updating existing policies, as well as better communication of what policies are in place, and improved version control.

Although policies were mainly referred to as a collective group in the form of "HR policies", respondents specifically focused on policy reform with reference to the sickness absence policy. Tina (PM5), Isla (PM8) and John (PM1) believed that this policy was too general and offered minimal guidance on supporting staff with lived experience, whereas Louise (PM18) simply suggested that it was out of date and that she did not think that people referred to it in the way that it was originally intended. However, Jack was more expressive, suggesting that this policy was not flexible enough for managing staff with lived experience:

> You've got to adjust your policies and you've got to have adaptable policies in order to enable that person, because you specifically have said "we want you." […] The system has to be able to accommodate that some illnesses and some challenges that people live with can have recurrent situations, that may have longer time frames than the sickness policy ten days or two episodes… (Jack, PM22).

Molly (PM24) took it a stage further and said that she was concerned that these policies were written by people who really did not understand the needs of the staff at which they were aimed. She critiqued the language used, suggesting that it could be written in a more supportive and "kinder" way; something that could be resolved by working in collaboration with colleagues with lived experience. Billy (PM17) described the sickness policy as "atrocious".

Christine confirmed this with her assertion that Trust policies such as this fall short of the Board's vision for the organisation as an employer of choice for all, inclusive of staff with lived experience. She suggested that:

> they are old fashioned, bureaucratic and haven't been designed necessarily with everybody's best interests at heart (Christine, PM23).

She added:

> I don't think they're very good, and that's something I'm on a mission to change. (Christine, PM23).

Carol (PM16) suggested that a specific policy with guidance be developed to support managers to better meet the needs of staff with lived experience. This she intimated would provide a formal support framework, in line with other HR policies, to ensure that staff with mental health problems received the support they needed at work; adding that such a policy would equip managers with the necessary tools to make this happen. This she hoped would negate some of the experiences that staff had reported to her. She offered the example of a staff member whose mental

health problems had been "used as the scapegoat." The employee was off with work-related stress, but the manager challenged this diagnosis based on their knowledge that individual had suffered from depression in the past: "well it's your depression, what's really going on."

4.3.1.3.2.1 Application of Policies

According to Ben (PM4), a policy "is only as good as the people who apply it." He recounted examples of managers who used them appropriately, and highlighted others who he did not believe utilised them in the way that the author(s) intended, which was "to support staff, not beat staff up." Marie agreed:

> We could have the platinum policy but the way it's deployed might not be platinum so what's the good, what's the point in having a platinum policy. It's the deployment of it that we've got to get right and focus on (Marie, PM14).

James believed that the organisation's goal, through its well-intentioned policies and procedures, was to "treat people fairly and equitably and with kindness and consideration", but that this did not always work in practice and often broke down around middle manager level. This he explained was often due to workplace tensions:

> I think the job is very hard and sometimes it's about time and pressure of work and having somebody who doesn't necessarily conform to the, the accepted norms and […] is really quite challenging and it means that we've got to do extra work in order to make that happen and sometimes the pressure of the job is just **so great** on people that they don't believe they have what is seen as being the additional time

> necessary in order to deal with that situation effectively, so they tend to erm push people out and push them to the side if they can (James, PM3).

Molly's biggest concern was how the sickness absence policy was applied by managers and suggested that if the staff member who was off sick was the Chief Executive the person discussing it with them would likely be more supportive and kinder that if it was a cleaner, something that she alluded to as being discrimination that goes on in this organisation:

> If you're at a certain level […] it's acceptable for you to be stressed and anxious […] you've got very big important jobs so they're bound to impact on your health and wellbeing but you know if you're a domestic or a porter, how can you possibly be experiencing those things…? (Molly, PM24).

However, she suggested that one possible explanation for this inequity of application was due to the gap between what managers feel they want to do and believe they are allowed to do. The result, she asserted, is that managers don't do anything for fear of doing the wrong thing:

> I don't think managers know that they […] have that flexibility within their gift. (Molly, PM24)

Billy also expressed concern about what he believed was expected of him as a manager when applying the sickness absence policy. He believed the Trust's expectation of him was to get the staff member back in work as soon as possible, regardless of whether that was the right thing to do. This he described as the "short

view" of bringing a staff member back to work a week earlier as opposed to the "long-term gain":

> I'd rather have somebody with me for eight months than come back a month and have three months off, so I think you've just got to look at the long-term (Billy, PM17).

For Marie however, the issue that concerned her was unfair application of the policy based on mental health as opposed to physical health absence:

> So, someone off with a long-term mental health condition… was… not getting much contact from the organisation, was not being supported while they were off work, engagement was poor. I question if they'd have been having long-term treatment and chemotherapy for cancer, would that have been the case? No, I don't think it would. I think there'd have been flowers, cards, and a lot more engagement (Marie, PM14).

4.3.1.3.2.2 Accessibility of Policies, Procedures and Guidance

Inaccessibility of policies, procedures and guidance was identified as an important issue for five of the respondents. Molly (PM24) highlighted her concern that some of the supportive policies, procedures and guidance were not always easy to locate and caused frustration and apathy, something she described as "so wrong." Some, she asserted, were simply not located where you expected to find them, whereas others, particularly what she described as "the ones that would be deemed as being more supportive", in relation to reasonable adjustments and flexible working were "buried in another policy somewhere." Such

frustration was shared by Tina (PM5), who identified that she used the manager's toolkit produced by the mental health charity MIND, as she was unable to locate the Trust one. She added her belief that many of the other managers she worked with would be unaware that the Trust even had a Disability Leave Policy, something she only had become aware of recently when it was raised by an HR colleague, supporting her with a staff sickness case.

For Fraser (PM15), however, the two key issues that annoyed him as a manager were version control and policy notification. He believed version control was important to ensure that "everybody's on the same page and referring to the same document", something that he referred to earlier in his interview as being extremely important as "we do live in a society that is increasingly litigious."

Furthermore, he asserted his belief that the Trust does not always launch policies and procedures in the right way. These, he advised, tended to be promoted to managers, not the wider workforce who were affected by some of them. He provided an example of a key policy on bullying and harassment, which although he acknowledged had been amended, believed that the changes had not been communicated to staff.

4.3.1.3.3 Better Guidance for Staff with Lived Experience

Almost half of the policy makers identified a need for enhanced guidance for staff with lived experience. This focused on two key areas: signposting to information and support systems; and specific guidance on expected organisational behaviours, particularly around disclosure and boundaries.

4.3.1.3.3.1 Signposting

Molly's earlier concern (PM24) that important information was not always easy for managers to access naturally extended to staff with lived experience. This view was supported by Joy (PM7), an occupational health manager, who advised that there was a need for HR to make this information available to managers so that they could share this with new staff starting work in the organisation, thereby enabling them "to function in the workplace." This included information on how to access key policies, such as sickness absence, disability leave and reasonable adjustments. Joy added that a number of staff she sees in her professional role are unaware of the Trust's Sickness Absence Policy, which specifically mentions disabilities and other long-term conditions.

For Jack however much more is needed to support staff with lived experience than policies and management communications. He asserted that the Trust had a responsibility to ensure that training or some other resources be made available to help and guide staff with lived experience, so that they do not set themselves up to be discriminated against, such as knowing how to deal with a concern locally as opposed to reporting it to HR. Accordingly he suggested that a staff handbook, with space for a wellbeing plan, be developed and provided to all staff not just new starters. Staff could take it to their management and/or clinical supervision sessions, thereby making it an integral part of their job and not an extra piece of work. Such a resource he believed, if made into "a product" would be valued by staff and also make them feel valued, symbolising a commitment to an open culture within the Trust:

> [It would be] a thing that's consolidated and everything's there. "Did you know that you can ask 'would it be possible to use the disability leave?' These are the criteria…" […] "Did

> you know that this is available? […] because under the protected characteristics you can't discriminate against in terms of health- that's physical health and mental health." So naturally they have a whole network that's available in terms of talking to you if there's an issue that's pertinent (Jack, PM22).

4.3.1.3.3.2 Expected Behaviours

Ensuring that staff with lived experience were aware of organisational expectations in terms of disclosure and boundaries was highlighted by half of the interviewees as being an area that needed to be addressed. However, policy maker opinions were divided as to where the ultimate responsibility for ensuring boundaries lay. A few suggested that the Trust had primary ownership, while the majority believed that it was a shared responsibility. Noteworthy however is that three-quarters of respondents who said it was a shared responsibility specified that it was the duty of the organisation to stipulate the expected behaviours and ensure that they were enforced.

For Jack (PM22), the responsibility lay with the managers in ensuring that expectations were clear, and that instruction was provided via training and management support. This was supported by Kay (PM2) who highlighted the need for staff with lived experience to be constantly reminded what the boundaries they are expected to maintain, ensuring that they:

> fully understand what it is that they can and should say and what it is that it would be not right to say because of what the consequences would be [from the]… patient point of view (Kay, PM2).

Sue (PM21) highlighted the need for a strategic approach, whereby all clinical staff received information on boundaries and disclosure during their induction, similar to that included in the Peer Support Worker training programme. This she suggested should be followed up quickly with a basic e-learning programme stipulating "what you can and can't say to whom", followed by more in-depth training around the use of "lived and life experience" as part of the Trust's recovery strategy.

Isobel (PM11) was more assertive and advocated that it was the manager's role to supervise and support the individual staff member to determine how to get the best outcome for both them and the service user that they were caring for, for as Fraser agreed:

> Lived experience can be hugely powerful but has the potential to be dangerous (Fraser, PM15).

However, Sue (PM21), while supportive of staff disclosure to patients in specific circumstances, expressed concern as to how managers would be able to "police" this, to ensure that it was used safely and effectively. By allowing it she suggested "we are opening up a can of worms."

Conversely Christine (PM23), an advocate of staff being empowered and supported to share their lived experience with patients, providing the situation is appropriate, and that they were well enough to do so, asserted that all colleagues had a shared responsibility to support the staff member with lived experience, including recognising and reporting if they are unwell. Louise corroborated this stating that although the onus is on the individual

with lived experience to look after their own health and wellbeing, and how they:

> need to feel comfortable enough to say to HR or their manager that they're not coping, [it is essential that we] if we're worried about them say we're worried they are not coping 'at the minute' (Louise, PM18).

Carol (PM16) and Esther (PM19) both believed that it was inappropriate for staff with lived experience to share their lived experience with patients under any circumstances. As a clinical therapist Carol explained that she was against it as it:

> …relates to transference and attachment and boundaries and difficulties around clients being and feeling safe (Carol, PM16).

Esther shared this perspective but strengthened her resolve through the recounting of an example where staff disclosure to a patient resulted in boundaries being crossed as the staff member used the relationship for personal therapy. She described how the patient's mental health deteriorated and then finally spiralled, whereas the staff member simply moved onto the next patient, oblivious to the fact that they had been the cause of their patient's decline. When asked how she would respond if a staff member approached her for advice on whether they should disclose to a patient she said emphatically:

> [I would say] no! That's not what we're there for. Peer support workers- they've got the remit to be in that area, "yes I'm a staff member with lived experience and I felt like that"- but there's got to be a very clear boundary about it.

> But if you're not a Peer Support Worker, if you're a CPN, if you're a Healthcare Support Worker, if you're a Psychologist, if you're an OT… that's what you're there for (Esther, PM19).

4.3.2 Leadership, Vision and Values

The second area where policy makers suspected the organisation was falling short in meeting the needs of staff with lived experience related to leadership, values and vision. One-third of interviewees questioned whether the Trust had a clear strategy and whether its vision was sustainable in light of leadership changes. An uncertainty as to who was accountable for monitoring and performance management of it was also evident.

4.3.2.1 Clear Strategy and Plans

Jack stated that he believed that the Trust had a vision as to how it wanted to support staff with lived experience of mental health problems, however he felt that it was "more ideological than strategic." Furthermore, he felt that it lacked ambition and could be strengthened. For him the organisation's vision did not translate into actuality across the organisation, as the attitude of colleagues to staff with lived experience varied considerably:

> [There are] some people that think it's really, really good and some people that are cautious and some people that just don't get it (Jack, PM22).

In spite of this Jack stated that if he had a family member with lived experience who wanted to work for the organisation, he would encourage them to do so, as despite the mixed experience of staff. The Trust, he believed, was an exemplar and is much further ahead than others, but there is more work to do.

Grace's critique (PM12) was similar believing there was no pattern to promoting a positive approach to mental health problems in the Trust or encouraging staff with lived experience to join the organisation. She asserted that as a mental health trust all staff should be promoting this, not just the Chief Executive at Trust Induction.

Billy (PM17) interpreted the Trust's vision as being a great place to work for all staff, including those with lived experience. This he did not believe was the experience of many staff and qualified this by asserting that the senior leaders do not seek out staff with lived experience that have ambition, talent and skills, who could help the Trust on its journey.

This was supported by Sue who asserted that an organisation-wide approach was needed; as to date the source had been from one direction, namely the Peer Support Workers. She explained:

> It's been poor old peer support workers who have been carrying the can for us all. And by having the guts to say I have got mental health problems; they then get all of the discrimination. Meanwhile the staff are probably saying it to themselves, nipping off to their outpatient's appointment the next day (Sue, PM21).

Molly advocated that the Trust's approach needed to be part of everything it does, which is not how it is at this point in time. She suggested that meaningful action is needed beyond a public declaration of Board support. In spite of lots of good work taking place within clinical teams regarding developing recovery champions, she was convinced that HR needed to do a lot more:

> HR should be encouraging teams to recruit staff who have the right values, not just the right skills- people who bring more to work than the skills they have, encouraging people with a variety of lived experience to take up a variety of roles in the organisation (Molly, PM24).

While Esther (PM19) did not think it necessary for staff with lived experience to "shout it from the rooftops", she was saddened that some staff do not feel able to have an open, honest conversation with their manager about their experiences and how supported they feel in the workplace; something she believed indicated that the organisation's vision was far from a reality at this time.

4.3.2.2 Accountability and Sustainability

Jayne, an Executive Board member, emphasised that despite the departure of the previous Chief Executive, who had played a pivotal role in this area, discussions concerning the organisation's vision and values still took place at the Trust Board level. However, she noted that there was now less emphasis on addressing mental health problems during these high-level discussions. Suggesting caution, she stated:

> I think the values and vision and everything else is set up in a way to try to push it- but I think we need to not fool ourselves into thinking that because we say at the top this is how it should be, that turns into people's experience actually on the ground working for us (Jayne, PM6).

Effective performance management was essential for Isobel (PM11). A personal advocate of reflective practice, she concluded that no data were kept on how effective managers were at supporting staff with lived experience. Furthermore, she

questioned what that data would reveal were they available and postulated that it would be very difficult to be a mental health employer whose staff say that it stigmatises them due to their lived experience of mental health problems. Isobel proposed that the organisation needed a clear strategy, which encompassed employment, wellbeing and retention, with a particular focus on the retention of staff with lived experience. This, she stated, should have Trust Board sponsorship from beginning to end and be backed up by performance data which showed the workforce demographics of staff with lived experience; how many staff the Trust has employed, how many have stayed "and more importantly that they have progressed in the way that they'd want to progress".

> Because wouldn't it be great if [X] Trust was seen as the most outstanding provider of services for people with mental health problems, that was equally recognised for being an employer of choice for people [with] mental health problems (Isobel, PM11).

The need for a strategy with clear accountability was a view shared by Donald, a Non-Executive Director. He personally commended the positive action statement placed on job advertisements that encouraged people with mental health problems to come and work for Trust, but queried whether or not the organisation could measure how effective that, or its wider strategy had been. He explained:

> If you were to ask me whether I could actually quantify and say how well we were doing on that, the answer honestly is I wouldn't have a clue. I think you know, the HR department are… doing good things, but I think that we've talked as a Board on at least three different occasions about how we

> actually make sure that we have values-based recruitment and whether we're actually recruiting people for non-technical things as well as for technical things. And I'm still looking and waiting as a Board member for the evidence that we've had a change in that particular regard. So, I don't know (Donald, PM20).

The lack of follow-through on the Values Based Recruitment Strategy was also highlighted by Molly (PM24) who described it as "a little bit hit and miss".

Donald added his belief that the Trust needed to do a lot more research around what good really looks like for staff with lived experience and, where it exists, transfer it back into the organisation. He suggested that the organisation still has a lot to learn and although it felt right, the Trust needed "some validation and corroboration from experience elsewhere".

4.3.3 'Wicked' Management Challenges

Two key management challenges were identified by the interviewees, which they acknowledged, but felt that they had little or no control over due to external factors. These have been classed as "wicked" challenges, to denote the existence of complex interdependencies that make these management challenges impossible to resolve.

4.3.3.1 Professional Training and Personal Fears

Jayne (PM6) identified that one of the key issues for her related to the expectation by junior doctors (psychiatrists) that they should be able to do everything and be competent at everything within their job role from the outset. She blamed the system for not tackling this in medical training, which resulted in doctors having

"superhuman expectations" of themselves, never admitting doubt or indecision and not seeking the support of others when needed, including when they were unsure or concerned. This, she highlighted, resulted in high levels of anxiety and other mental health problems, something she admitted the organisation needed to get better at managing. Noteworthy, is that over half of respondents highlighted that the general public had high expectations of mental health clinicians too:

> They think 'oh if I go into an NHS hospital then I'll be looked after by somebody who knows better than I do about where I'm at either physically or mentally and these are very competent, trained, able, together, [laughs] professionals' (Jayne, PM6).

The identification of gaps in professional training was supported by Grace, but from the perspective of understanding the needs of others. Grace felt that professional training for physical healthcare nurses was not on par with that of psychiatric nurses from a holistic care perspective:

> If you're a CPN or whatever role you're, you're doing erm… within our trust […] you're not only looking at their mental health aspects, you're looking at their physical health and you are dealing with it as a whole, whereas when you're physically, a physical nurse, or physically er looking at patient, you're looking at those… I don't know pressure sores or badly broken legs or whatever and you're homing in on that because you're not looking at the person as a erm a whole, er identity. You're just focusing on what you're going to deliver to that erm client (Grace, PM12).

Consequently, Grace believed that even though the gap was reducing, mental health nurses would still, in general, be the more supportive of the two groups of professionals to colleagues with mental health problems.

Carol (PM16) and Louise (PM18) disagreed that mental health clinicians were more supportive than other disciplines, both to self and others. Louise explained:

> Although we are a mental health trust, full of mental health professionals, I sometimes worry about the ability of some of our mental healthcare professionals to have conversations with colleagues about their mental health and wellbeing, when they can have the conversation perfectly well with clients or service users who they may work with (Louise, PM18).

When asked why she thought this was the case, Louise responded that when she had asked staff why, they struggled to explain it, so she did not think she had had a decent explanation yet. The best explanation she had to date was from a mental health professional who said that it related to boundaries; that there was a subtle role difference when you are with a patient on a ward compared to managing staff. While acknowledging the subtle difference, Louise believed that there should be transferable skills between the two, so she admitted "it always has been a fantastic mystery to me".

Furthermore, Carol said she thought it ironic that mental health clinicians found it more difficult than others to be open about their own mental health problems, something she believed would have been easier for them, working in an area where she assumed there would be less judgment:

> It's almost difficult for people to say they suffer from the ill that their patients does… and I think it's a scary prospect for them because they, they see where it could potentially go. They may be at level one and their patient may be at level seven- but when they are feeling vulnerable or ill and they're maybe looking at a patient at level seven thinking that could be me… and they may go into denial, to deal with it; it may be a lot of fear based I think (Carol, PM16).

As managers, Isla (PM8) and Lyn (PM10) both recounted examples of staff in their respective teams who refused workplace support from them. One of Isla's reports, who is a team manager, refused to have a wellbeing plan as she did not want her mental health support needs to be highlighted. Similarly, Lyn's staff member declined disability leave as she "didn't want to use the mental health card", effectively saying that she did not want colleagues to think that she was using her mental health problems to gain an advantage.

For Molly, however, the reasons were evident: self-stigma. Believing 'ashamed' to be too strong a word, Molly settled on the word 'embarrassed' to describe how some staff with lived experience self-stigmatise. She explained that many believed that they should be immune to mental health problems since they work in mental health. Furthermore, as regards colleagues' lack of support for each other, she asserted that this was due to working in a highly pressured, ever-demanding environment:

> What I see is teams that have, are so pressured and so under the cosh a lot of the time that it's just one more thing to think about and they just don't have the head space- they're there to provide a service to the people who need it:

> their patients, their clients, their service users… and don't always attend to each other very well (Molly, PM24).

Regardless of all the caveats and explanations she has heard in the past, including those made by her, Carol concluded:

> I suppose it ought to be kind of gold standard in that, you know, that's our area of expertise so surely if, if we can do it for patients surely we can do it for the people we employ (Carol, PM16).

However, Carol later added her belief that a gold standard is not achievable due to the organisation's policy structures and the inherent complexities managers face in running services under challenging circumstances, for example meeting targets. Carol believed the difficulties were caused by "conflict between… providing a caring, empathic, compassionate environment in which to work and ensuring the work gets done and the business is run efficiently".

4.3.3.2 Negotiating a Balance

Over half of the policy makers described external challenges, areas that were outside of their control, as being a key concern for managers. Fraser (PM15) described the dilemma that managers sometimes encounter when supporting staff with lived experience in terms of trying to do the right thing for the staff member, while simultaneously protecting the organisation and its patients. He provided an example of a staff member who was reintroduced to work after a very long period off with mental health problems, during which she was sectioned. The challenge for management was helping her to return to work in a job she wanted to do, in the knowledge that when unwell she posed a significant security risk

within the prison environment. Due to management awareness of her past struggles with poor concentration and "tremendous lack of insight", she was assigned a high-risk score. This is because even a momentary lapse in concentration could result in a significant security breach. This could put herself, her patients and her colleagues at risk, for example by leaving gates unlocked. He defined it as a "delicate balance" and went on to elaborate that at such times "it really is like walking on really, really thin ice".

Six of the interviewees described the impact of a staff member with known mental health problems on the team being absent due to poor mental health. This was described as putting added pressure on their colleagues, which contributed to peer stress, leading to their absence, resulting in "a vicious circle" (Donald, PM20). This was particularly difficult, Esther (PM19) said, in small teams as having two members of staff off on long-term sick or unable to take on complex cases had a huge impact on the rest of the team. However, Esther was quick to point out that this impact would be regardless of whether team members had physical or mental health problems.

Carol concluded that being a clinical manager within a mental health trust was a very difficult job:

> If they've got a staff who have a secondary mental health issue, they have to be able to look after that person, they also have to be able to look after the, for want of another term business of the day… so I think it's very, very challenging for both the member of staff and the person managing the situation (Carol, PM16).

Louise (PM18) agreed and suggested that the biggest challenge was how to effectively manage the team when the staff member was at work. She provided an example of a colleague with bipolar affective disorder, who had considerable support needs. The staff member decided that they did not want the rest of the team to know about their mental health problems, which created tensions and made managing the team dynamics very difficult. While Louise accepted that it was the individual's right to decide whether or not to disclose it, she said that others felt that she was accepting behaviour from this colleague that she would not accept from them, which created resentment.

4.4 Failings

In addition to identifying areas where they deemed the organisation to be falling short of meeting the needs of staff with lived experience, over three-quarters of the respondents expressed strong criticism towards the Trust, with some suggesting that staff with lived experience were being failed. Analysis of the interview data suggested three key sub-themes: tokenism, no time to care, and systemic failure.

4.4.1 Tokenism

Five of the policy makers were critical of the Trust's approach to supporting staff with lived experience, one of whom described it as "tokenistic" (Jack, PM22). This included Sue (PM21), who asserted that the strong, positive reputation the Trust enjoyed in the outside world, as an exemplar in involvement and recovery, did not reflect the experiences of staff within. She highlighted that staff in the lower bands were scared to disclose their lived experience for fear of losing their jobs, something evidenced in the organisational results from a recent NHS Staff Survey. Furthermore, Sue admitted

that she would not have the confidence to suggest to them that they were wrong. She added that the results of the staff survey were sent to the Trust Chair, with the aim of seeking support to drive the necessary change, however she affirmed that nothing happened.

Jack verified his rationale for highlighting such organisational "tokenism" by describing a very senior manager's behaviour during a staff engagement session, one that he stated was solely arranged so that the Trust Board "could tick their engagement box". He said:

> […] it was shocking, [he] was arrogant. People were talking about their lived experience as somebody that works [for the Trust]- and […] it was literally "oh I've had enough of your story now." I was appalled, it was disgusting […]. It made the whole team feel absolutely shit to be brutally frank. […] I was nervous the whole way through, it was like we were justifying our existence to who? Now that's where this model is completely flawed. He made us feel so… […] (Jack, PM22).

For Billy (PM17), the Trust's approach to staff with mental health problems is no more than percentages, figures and sickness targets. He asserted that senior leaders convey the story in a way that makes things sound much better than they are. He described the language he has heard as "oh we're positive about this, we're positive about that", but concluded "actually I think some of them are just blowing wind".

The organisation's approach to achieving its ambition of employing more staff with lived experience has a key flaw, according to Isobel. She highlighted her worry that there are a number of very talented staff employed by the Trust, but who have been defined

by their mental health. Consequently, they have almost been herded into a career in mental health, despite there being so many career opportunities open to them:

> You can't assume that because somebody's had a lived experience that they will necessarily… […] that your best employment is in the mental health service. It might be in a bank it might be erm running ICI, I don't know […] (Isobel, PM11).

Jack was critical of how some staff with lived experience were portrayed in organisational communications and at events, and did not think that the approach fitted with that of a recovery focused organisation:

> [X] was put on the pedestal here there and everywhere. She was wheeled out, [...] it's not right… it's almost like freak show mentality… "ooh here we go let's show, let's show these people" (Jack, PM22).

4.4.2 Less Time to Care

Over half of the respondents identified that budget cuts, cost improvements and increased bureaucracy negatively impacted many staff employed by the Trust. While it was acknowledged that the majority of these criticisms were out of the organisation's control due to commissioning and funding arrangements, policy makers maintained that this was important to highlight as it contributed to the organisation failing its patients and staff with lived experience.

4.4.2.1 Finance, Budgets, Commissioning

The negative impact of budget cuts and alternating funding streams on staff mental health and wellbeing was not only evidenced in the words policy makers uttered, but in how these words were said. Over half of the policy makers identified concern for the stability of their own jobs when invited to introduce themselves at the beginning of the interview, however Isla's matter-of-fact response (PM8) provided a particularly poignant example. She explained how she had been appointed to her current role as a senior manager in 2015, for which she felt "very blessed in a way", before adding with a nervous laugh "so just now waiting for another reorganisation to get bumped back".

The majority of interviewees referenced the challenges imposed on mental health services, in line with what Isobel (PM11) described as "the changing face of the NHS". Appreciating that change was often necessary, particularly to enable growth, policy makers shared little positivity for the new regime. Jayne (PM6), Lyn (PM10), Isobel (PM11), Kate (PM13) and John (PM1) depicted the NHS as being fragmented due to political variation and budget cuts, resulting in staff having to be more task focused than person centred because of imposed time restrictions. These constraints extended to management who were able to spend less time supporting staff owing to added bureaucracy.

Isobel described this in terms of being more interested in the problem than the person. She added that this brought about changes in the NHS, resulting in the loss of things that made it unique. She reflected back to when she started her career and worked as part of a multi-disciplinary team, describing how the team bonded, shared things, challenged each other, contributed to

a common goal, laughed and cried together. Now, she admitted, there was no time for that. She said:

> I'm now doing reviews on people, serious case reviews, or homicide reviews where people [staff] have got in excess of thirty or forty people in their lives at any one time. I, I would struggle with that so… I think I have got a strong ability for change because I think change is how you grow…but I'm not sure I like the way that services are changing (Isobel, PM11).

Isobel was troubled that there was now "less time to care", a view shared wholeheartedly with Billy who emphasised:

> I think there's just not enough consideration sometimes put into the fact that actually you need to be letting me have time with my staff. You need to be letting me invest in my staff in different ways (Billy, PM17).

The changing business and political environment, according to Lyn, has meant a greater focus on individual activity and performance, which she suggested can in itself create an environment of self-criticism, which negatively impacts on staff wellbeing, particularly for those staff with lived experience:

> I think people can internalise it as "I'm not doing enough", "it's not good enough", "I've got to, I've got to keep up with this" whereas… what kept people well and I don't just mean people with mental health problems I mean staff, what staff's wellbeing is around, is being more […] more than just core business [...]. That means we don't do any of the things that we don't get paid for any longer. It's the work bit about what

> makes your role, because most of us have come into mental health […] for a whole, different reason (Lyn, PM10).

Lyn added that that it is her belief that the NHS has now become more of a business, which has meant that she and others who entered the mental health profession, due to a genuine interest in helping people, are no longer having their personal ambitions met:

> We are now having to break the role down into a number of contacts but not do the bits that enhanced the role [...] (Lyn, PM10).

Furthermore, from a management perspective, when supporting staff with lived experience that are off sick, Lyn admitted that at times it has been reduced to:

> Can we afford for that member of staff to continue working? Can we afford as an organisation to continue to support somebody? Whereas if I was working with a patient that wouldn't come into it (Lyn, PM10).

Conversely, Donald (PM20), a Non-Executive Director, argued to the contrary and said that the NHS was over-resourced, not under-resourced. Money, he suggested, was often ill or inappropriately used, as it was not apportioned properly. He demonstrated this in terms of cost improvements, which he submitted should not be applied equally as some services were deemed high value and worthy of full investment, while others "shouldn't even be here full stop because the service has got no evidence base behind it".

4.4.3 Systemic Failings

The final area that interpretation of the data highlighted as having garnered considerable criticism from policy makers can be précised under the heading of systemic failings. These ranged from attaching blame to the organisation for not providing adequate support for staff with lived experience, to assertions of incompetency and/or breach of trust.

4.4.3.1 Inadequate Support for Staff with Lived Experience

During the interview James (PM3), a union leader, did not share any positive examples of the Trust's approach to supporting staff with lived experience, in fact he was quite critical throughout. One of the issues he said that he was particularly enraged by related to the treatment of a nurse, whom he believed had quite a severe mental health problem. He recounted how the staff member had been exhibiting secretive behaviours and paranoia at work, and despite requesting that the Trust afforded her a psychiatric evaluation, he was unable to convince (HR and management) them that it was essential, so he lost the case, and she was sacked. Not long after she was sectioned under the Mental Health Act following an attempt to kill her husband. James expressed that he still felt guilty, as he was not able to convince the Trust that her need was great. He stated:

> I believe the organisation has let her down and that the organisation has failed her. We are one of the biggest providers of mental health services in the country and yet when we have staff who become ill [sighs]… (James, PM3).

Lyn (PM10) expressed her frustration as to the Trust's response when she tried to secure access to secondary mental health services for one of her team who was in crisis. Lyn reported that

the approach of the "decision makers" was paternalistic until she challenged them. Rather than asking the individual where she wished to be treated, they spent a huge amount of time debating whether or not she should be granted access to Trust services. It is worth mentioning that the staff member ultimately decided that they would prefer to access Trust services rather than seek support in a neighbouring trust.

For Grace (PM12), her critique was not around which service to access, but the time taken to access psychological support. Grace advocated that the Trust needed to get staff with mental health problems treated sooner, which she demonstrated through her own personal experience of having to wait three months for an appointment. She said:

> I think that it's unacceptable. And if it wasn't for me speaking to my staff side colleagues and my family, […] and I didn't… I haven't been off sick, but I think that, that, that would have been inevitable. I felt so low and so poorly. Erm… and I, and I was asking for help, and I didn't get it and I think we need to be… on the ball more…of accessing the services that we provide for service users. I think we need to access services for our staff (Grace, PM12).

Grace also felt that only certain areas of the Trust could access particular services, which she deemed to be inequality of provision across the organisation. She therefore questioned why some staff were treated more favourably than others, something that she said goes back to her values, one of which is fairness. Grace said it hurt her when people were not treated fairly and with reference to the inequality of staff access to services, she stated: "to me that's not fair".

Fraser's critique related to an aspect of the organisation's sickness absence policy, namely phased return, which is a gradual return to full duties after a period of absence. Fraser said that he has never in his long career with the NHS seen a phased return to work. He said:

> I think generally people make all the right noises and erm and […] they're sympathetic, empathetic for the first twenty minutes and then you're at your desk, you're answering your phone, you're answering your e-mails so you know, you're being paid you must be alright erm. My first two weeks back to work really, really took their toll […] and it was only sort of two weeks in when I'd stepped away from it and really reflected quietly at home… I thought you know, "what the hell have I gone back to?" (Fraser, PM15).

Furthermore, throughout her career with the Trust, Isla has observed a number of managers who have lacked compassion, who did not care about their staff's personal lives, including their lived experience. She stated that she had heard manager's say things such as:

> Do you know what this is? A job, we've got to get this job done, I don't care what's happening in your life at home, this is what you're paid to do (Isla, PM8).

This, she affirmed, often impacted on the staff member's performance at work. She provided an example of a case she had been tasked to investigate outside her division, where the manager in question had not treated their staff member with compassion. The impact of such poor treatment was that the staff member remained off sick, their mental health deteriorated, and they had to

be referred to a psychiatrist, which resulted in her becoming "part of the system".

Earlier in this chapter, good management support was identified as being needed to better support staff with lived experience, however Jack was even more critical. He described good management support within the Trust as "a bit like a postcode lottery".

4.4.3.2 Incompetency and/or Breach of Trust

Jack recounted an example of when he witnessed a colleague being told off by their manager for allegedly not doing a job properly. The staff member, he stated, was described by their manager as "pathetic" in front of others and made to feel uncomfortable. Jack continued that the staff member was very upset and took time off, but never returned to work. Jack said:

> It shocks me that [senior managers] can describe people as pathetic, can breach confidentiality… because someone doesn't meet expectations quickly enough […]. It's truly, truly worrying […] Bad management can be destructive, it can be damaging, and it's ironic… when that comes out of the mouths of the very people… when it's rhetoric, when it makes me think it's just rhetoric […] It's a failing and then it's cruel (Jack, PM22).

Sue supported this perspective and was forthright in her claim that the organisation often enabled discrimination to propagate without challenging it, thereby failing its staff. She highlighted that many of the things she has overheard about staff with lived experience go beyond stigma and manifest themselves as discrimination. She explained:

> [There is] a sense that erm… people who have mental health problems will inevitably have more time off sick, be more of a burden to employ erm… you know, there, there're even people go so far as to say "oh my god you know, we've got enough patients on the wards without needing them on the staff as well" and that's the kind of thing that is quite discriminating (Sue, PM21).

Sue shared further discriminatory views she had heard with specific reference to Peer Support Workers, who she stated have a very strong sense at times that they are not trusted or accepted as equal and valued members of the team. She described examples where Peer Support Workers have been told that they should not have access to patient notes, that they could not work on the team because of their lived experience. She alleged that one of the Peer Support Workers was told by their manager, "I'm going out on a visit to somebody who is very distressed, so I'd rather you didn't come with me with your history".

Tina (PM5) was also able to provide an example of a staff member whom she believed had been discriminated against and ultimately failed by the organisation. While investigating an employee relations case, she recounted how she interviewed the member of staff who was under investigation, and learned that despite his experience of anxiety, depression and other aspects of poor mental ill health over a period of 18 months, which he had disclosed to his manager, he had never been referred to Occupational Health. Tina asserted that this disclosure put her, as the investigating officer, in a difficult position as she did not want to break his confidentiality, but she believed that she needed to know that he was well enough to cope with the investigation. Tina's view was that no one seemed to care about his mental health but her. She was so concerned that

she sought advice from HR in terms of a referral to Occupational Health. She added that this experience left her with questions as to how the mental health arm of the Trust looked after staff who were mentally ill. She concluded that she did not believe that the Trust's mental health services were any better than its physical health arm in supporting staff with lived experience. In fact, based on her recent experience she suggested they were "a lot worse".

Marie (PM14), an HR Leader, confirmed that she too had encountered examples of teams within the Trust where the mental health and wellbeing of team members had not been well managed, and which amounted to discriminatory behaviours. Recalling one particular example, she advised that the team, led by the manager, was proven to have been complicit in isolating the individual, blocking their return to work, trying to manage them out by deleting their job role from the establishment, and depicting the person as difficult and unable to contribute.

4.5 Conclusion

As outlined in this chapter, all of the policy makers subscribed to the belief that Trust was a supportive place for staff with lived experience to work. However, as drawn attention to earlier, with further scrutiny, contradictions in what the majority had stated became evident. For only one of the interviewees did the organisation's narrative match the experiences of its staff in the main. The others refuted their initial assertions and acknowledged areas where the organisation had fallen short, highlighting gaps and suggesting things the organisation could and should have done. As stated, some of the policy makers' opinions were highly critical of the organisation; in spite of the acknowledgment that at

times its hands were tied as a result of national policy and subsequent commissioning decisions.

The next two chapters set out the findings of the interviews with staff with lived experience of severe and enduring mental health problems (lived experience), who undertake diverse roles within the case study organisation. To achieve this, twelve semi-structured interviews and a Peer Support Worker (PSW) focus group were carried out to identify how staff experience work, in light of their mental health problems. Involving two distinct groups of staff, namely PSWs who are formally acknowledged as having lived experience, and others from a variety of clinical roles, whose lived experience was not formally known, will enable the elucidation of a broad spectrum of staff perspectives and commonalities. These, it is asserted, will help determine if Glen Forest's ideology and rhetoric, considered in the previous chapter, matches the reality of their experiences.

Analysis of the interview data revealed two overarching themes in relation to the experiences of staff with lived experience of mental health problems within the workplace, namely identity and power. Within both of these themes lie a number of sub-themes, which are summarised in Table 8 and will be addressed as subsections under the main thematic headings. It is important to acknowledge that due to the strong inter-relationship between elements of this study, identified sub-themes such as disclosure and boundaries could be appropriately cited in either of the following two chapters. The researcher has therefore chosen the chapter that serves best to reinforce the key messages within the findings.

Chapter 5: Findings: Exploring the Identity of Staff with Lived Experience

5.0 Introduction

This second data chapter begins the exploration and analysis of the findings of how staff with lived experience respond to the work environment. Addressing the concept of identity, it will begin by demonstrating how the identity of staff with lived experience is heavily influenced by society, and the stigma of mental health problems perpetuated within. It will then explore how these staff, who are a product of their society, negotiate their personal identities, while highlighting some of the challenges they face, particularly around dual identity, and the personal quest for a resultant identity in which they can use their lived experience to help others. Their autonomy, or lack thereof, to use such lived experience for the benefits of others will form the third findings chapter, Chapter 6, through a study of the theme of Power and its antithesis Powerlessness. This in turn will provide a framework to determine the extent to which the case study organisation supports staff with lived experience.

5.1 Crafting Identity

As highlighted, one of the strongest themes to emerge from the data that influenced the participants' experience of the workplace was that of identity. Using the social science construct advocated by Burke (2020, p.63), identity or identities can be described as

> sets of meanings that define who we are in terms of the roles we have, the groups or social categories to which we belong, or the unique characteristics that make us different from others.

Identities, Burke endorses, guide us as to how we should behave and act both personally and professionally, as friends, as patients, and as nurses.

Whilst some staff were clear that their professional identity, as a nurse, doctor, therapist, PSW, and so forth was at the forefront of their workplace persona, the majority spoke of a duality whereby they self-identified as both a professional and a patient, on occasion alternating between the two, sometimes in harmony, at other times with conflict, yet always intertwined. What was evident was that the adopting of these often-contradictory roles was heavily influenced by societal views of people with mental health problems and sometimes depended on the audience. It was immediately apparent that the clinical workplace was not impervious to society's opinions, and neither was its workforce.

Consequently, before exploring the interplay of identities discussed by participants and the major determinants expressed, it is important to briefly explore the participants' interpretations of how society views people with mental health problems; for not only is the workplace a microcosm of the wider society, but society is known to shape how we see ourselves, and thereby influences how we self-identify (Tajfel and Turner, 1986).

5.1.1 The Workplace as a Microcosm of Society: Stigma and Oppression

Societal disapproval of people with mental health problems [stigma] is well researched in academic treatises, as is the corresponding misunderstanding and mistreatment [oppression] as evidenced in popular media (Read and Baker 1996; Byrne, 2000; Corrigan, 2000; Sharac et al., 2010; Stuetzle et al., 2023). It is perhaps unsurprising that all of the interviewees highlighted

examples of stigma and oppression that they had experienced in their everyday life, where the perpetrators, like them, are products of a society where such views and actions are often endorsed.

Alex used his own experience to highlight societal attitudes towards people with mental health problems:

> Over the years you are brought up to believe, not only through your own family, [but] I think through the media, through the TV everything is geared towards when you are suffering from a mental health problem that you are well… crazy [...] (Alex, LE4).

This was a view shared by Victor who expanded on it:

> As soon as you tell somebody you've got a mental health illness there is, not with everybody, a reaction: 'oh he's an axe murderer', 'he's this', 'he's that and that' (Victor, LE1).

Danny explained this in terms of ignorance and fear:

> People that don't have mental health problems, a lot of the ignorance I think is down to fear… because of a lack of understanding, a lack of education […] people's fear of people who have mental health problems is they're violent, when actually what we really know through the statistics is that people with mental health problems are more likely to be the victim of assault than perpetrator of assault […] (Danny, LE8).

Consequently, Ted (LE3) and Jake (LE6), on considering the public's potential reaction to the idea of staff with mental health

problems working in mental health services, responded using the word 'lunatic'; Ted voiced the newspaper headline "rampage by a lunatic" and Jake referenced the 1980's UK Top 20 pop hit "The Lunatics (Have Taken Over the Asylum)".

As the workplace is a microcosm of society, and its staff are products of the society in which they live, one would expect their experiences to be the same as in the community. However, one could posit that individuals who work in mental health services, by the very nature of their profession and consequent training to be caring, compassionate and understanding, would be more progressive in their perception and acceptance of colleagues with mental health problems; and that the resulting workplace culture would be more welcoming and supportive than in wider society (Warelow and Edward, 2007; Wiklund-Gustin and Wagner, 2013). Equally, that those clinicians with lived experience would be relatively protected from workplace stigma around mental health problems, particularly in an organisation where its core values include 'care' and 'compassion', its job adverts encourage staff with lived experience to apply, and the organisational rhetoric urges staff to bring their whole self to work.

This study found that stigma pervades the mental health workplace and that staff with lived experience are not immune to it, experiencing it at work as well as in wider society. All participants were able to recount experiences of how societal stigma transgressed into the workplace and how oppressed it made them feel. Three pertinent examples will be shared here to highlight how societal stigma filters into the workplace; however, others will be used later to elucidate how such stigma and the aligned act of oppression impact on professional and personal identities.

Danny reported feeling "robbed" and personally devalued when a colleague deliberately "outed" him to a family by sharing his "discreet mental health problems", resulting in overt stigmatisation from the family who insisted that he no longer work with their young person:

> I had a lot to contribute which could have […] contributed to my recovery, but as I say the organisation, people within the organisation… robbed me of that and actually robbed the patients of that opportunity to have improved practice and learning from that (Danny, LE8).

Later he added:

> I don't think I realised how deep seated sometimes the prejudices, values and attitudes [were] around mental health that existed within the staff group… which was ironic because they were working in mental health services (Danny, LE8).

Aisha identified the impact of societal views on her, both personally and professionally:

> I recall being not alright, being a bit upset one day and I remember some patients had commented 'how could she be the psychiatrist, she's upset? She can't make decisions about our care' (Aisha, LE11).

Ava described her managers' views of staff with lived experience of mental health problems as positive on the whole, with one notable exception, which had a profoundly negative impact on her:

> I was working with a patient and I ended up having to pull it [personal alarm] and I was very upset and my manager took one look at me upset, one look at the patient who had a PD [personality disorder] and was very in control, very calm and shouted it was a false alarm, in front of the patient. […] I've never pulled my alarm before; I don't make a fuss about things. I felt it was very much related to my diagnosis and her reading my language, my presentation as pathological… I don't think that would have happened to another member of staff… I think she'd be different if I had anxiety or depression, I think she'd be different but because it's secondary… (Ava, LE5).

This section has identified the societal stigma towards people with mental health problems and how it can impact on the workplace experience. It demonstrated how study participants experienced such stigma and suggests some initial impacts, both personally and professionally. It also highlighted that despite working in a mental health environment, which one may assume would be more progressive and supportive of people with lived experience, this is not the case as all of the participants experienced workplace stigma. The next section will take this a step further by exploring how societal stigma impacts on the formulation of identity of the participants through the dual lens of professional and patient, influencing and challenging the configuration of personal and professional identities via the distinguishing concept of 'us and them'.

5.1.2 Perpetuation of Societal Stigma in the Workplace: Distinguishing 'Us' and 'Them'

The concept of 'Us' and 'Them', whereby staff with mental health problems are seen as different and lesser to others, largely based on the prevalence of societal stigma, was highlighted by all of the interviewees. Each recounted their experiences and the resulting impact on how they perceive themselves and their role in the workplace, particularly as a consequence of having this dual identity.

Victor described the reception he often receives from colleagues daily:

> When you actually say 'oh I'm a service user' it's really hard to describe, they're not all like it, but there are ones that just take a step back… it might be the way that they talk to you… like you're a child… or their language changes from the professional approach, […] and they seem to talk to you, sorry, they talk at you not with you […] (Victor, LE1).

Even more discernible is the example Alex recounted of an experience on the acute ward where he worked:

> I heard a cast-off comment, which I wasn't meant to hear, about 'oh he should be in there with them, he's not one of us' (Alex, LE4).

Similarly, Betty detailed her experience working in a large multidisciplinary team of twenty to thirty staff where, with the exception of two individuals, "the rest of the team… really were the definition of 'us and them'… they would not cross that line". When asked why she thought that was the case, she replied:

> [I] think because… they perceived the people on the other side of that line as… flawed or weak or… something that they don't want to be and don't want to be associated with […] they would see… people that have experienced mental distress as in terms of medical diagnosis like personality disorder or schizophrenia or bipolar and… they don't want to have those labels because they are highly stigmatised… terms. And so, to have their identity encompass those is just… too much (Betty, LE7).

Betty recounted how this impacted on her both personally and professionally:

> It was lose-lose for me. I either could stay quiet and feel like… I'd let that person [patient] they were discussing down by not offering an alternative, or I could speak up and come away with the feeling of… being different and… somehow lesser and… so I guess I weighed up the options of what would feel least bad in that situation and I chose not to say anything (Betty, LE7).

Consequently, she suppressed her feelings, highlighting that she felt it "difficult' being in that team and that she and her colleague "felt quite gagged".

Jake shared this view:

> I suspect that's something about people thinking 'oh can we trust them?' are they going to let us down?', I mean it's because it's seen as a weakness. I think that there's this fear that 'are people going to… I don't know… are they all going to stick together? Is there that solidarity?' (Jake, LE6).

Jake explained this phenomenon by introducing the concept of 'othering', which he summarised as:

> …when people treat people separately basically 'the them or us' (Jake, LE6).

He continued:

> 'Othering' is almost like a psychological defence mechanism because if we [mental health professionals] see ourselves as so traumatised or distressed or it becomes difficult… it's a lot to bear. It's one thing if we… care for people like that but if we see ourselves through those lenses, I think it really challenges our self-concept, our self-worth, of where we are in the world… I understand why it happens, but a result of it is that it then leads to stigma [and] discrimination because we're separating ourselves (Jake, LE6).

He concluded:

> It's a natural process and that almost explains why sometimes you've you got mental health practitioners who are nurses in my experience who are really caring but still see themselves as different from the people they are providing… care and treatment for (Jake, LE6).

Similarly, Ted spoke of his frustrations with those staff that wittingly or unwittingly place colleagues with experience of mental health problems in the patient role.

> In here [X Secure Hospital] they [staff] compare a member of staff with a mental health condition to a patient with a mental health condition. By definition our patients here have

> already gone through a long process and are usually quite disturbed or have been quite disturbed. You're not comparing like with like […] I think the problem here is… they make that leap all the time that somebody with a mental health condition equates to a patient (Ted, LE3).

Undoubtedly, however, the most common experiences of stigma and oppression shared by interviewees resulted from negative attitudes of colleagues with whom they worked:

> If I make a mistake certain people will put that down to my mental health condition (Ted, LE3).

> If anybody discloses that they've got particular mental health distress then people start questioning your competencies, and abilities, and professionalism... and they think that you're too fragile, and… they're concerned that… we might… do some damage to the service users… because of… our own issues (Sarah, LE12/PSW2).

> They're looking as though you're going to fall at some point… waiting, or if you have a day off, like "told you so" […], you know waiting for that to happen, cos I… was in a room with some staff members one day and saw them being careful with Peer Support Workers over this because "you know they might become unwell at any point". But I did say any one of you in this room can become unwell at any point and left it there… (Myra, PSW4).

Danny explained his colleagues' attitude towards staff with mental health problems as a "fear of the unknown". However, he asserted that some of his colleagues justified their behaviours by saying that

they were not afraid of him personally, the rationale being that they knew him. A colleague once explained this to him:

> We couldn't just have any random stranger who has had mental health problems running an inpatient psychiatric unit, but you'd be all right at it 'cause I know you (Danny, LE8).

However, when Danny was hospitalised due to having a mental health crisis, he reported colleagues openly mocking him:

> How the bl**dy mighty have fallen; now you're one of them (Danny, LE8).

Similarly, Jake recounted an example of when he witnessed poor treatment of a fellow staff member in his early career at X Hospital, which had a profound impact on him:

> This has stayed in my mind throughout my whole career actually… I used to go into the staff club on occasion and there was this guy who used to sit in the corner all the time… a pretty lonely looking guy and we would talk occasionally and [he] always seemed really sad and every night he was in there and then he wasn't in there for a period of four or five days and they found him hanging, in accommodation. And everyone then started saying 'oh we always knew he was funny' or 'we always knew he was different', 'we always knew this was going to happen'… and I asked a question which everyone looked at me in a stunned silence and they couldn't answer was 'did anyone ever talk to him about it?'. And it just struck me that it was such a captive place, we've got a mini world full of mental health professionals and yet nobody could talk to each other about that […] (Jake, LE6).

Ava acknowledged that there are some understanding and supportive colleagues, but highlighted that there are still others who identify anyone with experience of mental health problems in the subjugated role of patient:

> We've got some cracking staff… who I'd have looking after me… but there are some staff where it's a bit more negative […] it's a freak show and an unknown, and dangerous and 'oh my God' and 'she's one of them'. There's very much a divide between how staff see themselves and how staff see patients, never the twain shall meet (Ava, LE5).

In fact, Danny claimed that a senior manager blocked his application to go on a non-medical prescribing course that his line-manager had already approved. He alleged the senior manager stated:

> 'I'm not signing that because we're not having some mental health nutter signing prescriptions' (Danny, LE8).

Sometimes, however, the views of staff with lived experience themselves unintentionally strengthened the idea of 'us and them':

> I think that's nowadays certainly more so with people who end up having a label of schizophrenia or having a label of personality disorder…If I had one of those labels, I think I'd be more worried in disclosing it- very, very much so (Duncan, LE10).

Likewise, Jake, recounting his experience of working at a particular hospital, reinforced it by suggesting having a mental health

problem is a weakness, despite highlighting earlier how damaging doing so can be:

> When I think back now there was no encouragement to show any sign of weakness or to really talk about it (Jake, LE6).

However, according to Sarah, sharing lived experience is the solution to breaking down the barriers between 'Us' and 'Them'.

> I would like to see… more people in the Trust feel empowered or able to share their lived experiences, because…. I think it's so powerful, because it makes you more human; it breaks down the barrier of […] the 'us and them' situation (Sarah, LE12/PSW2).

Before moving the discussion on to look at how self-stigma, perpetuated through the distinction of 'Us' and 'Them', is manifested through the lens of shame, it is important to consider the fact that PSW colleagues as a whole were keen to distinguish themselves from other clinical roles, reinforcing their contentment with the notion of 'Us' and 'Them'. It is noteworthy that they included clinicians with lived experience in the 'Them' category.

5.1.2.1 Occupational Identity

It was interesting to the researcher that the PSWs talked very little about themselves as individuals in the focus group setting and responded much of the time from what one could describe as a collective standpoint. One possible explanation for this is that they were in a group setting and whether through choice or led by other group members, identified as a collective rather than individuals. Alternatively, it could be said that this was a group who had shared much of their professional and indeed personal lives with each

other; through training, establishing the peer role for the first time in Glen Forest's services, supporting each other through disclosure, and identifying how much to say to others i.e., colleagues, patients and carers, team working, and personal support, therefore everything personal about themselves had been said. In fact, at times, they even finished each other's sentences. Any, or a combination of these explanations, may have been possible, however due to the language used there was a militant element to their responses which emerged as a collective identity; a shared voice which asserted that the organisation had let them down in some areas, particularly in relation to the absence of a career pathway for PSWs:

> I think… yes, it's a 5-year long-standing… (Alice, PSW5)

> battle and it shouldn't be and they're still saying they're trying to implement and get Peer Support in all different areas. They're still trying now, why are they still trying after 5 years, why? (Myra, PSW4)

> Exactly! (Sarah, LE12/PSW2).

It was clear from listening to the PSWs that they felt that their job role was unique and one that they had to fight to protect from being subsumed within an operational clinical role.

> I applied for a Peer Support Worker. I know what my role is. I didn't apply for an HCA role- not taking away anything what anybody else does- but that's not the role I applied for […] I did actually have someone come to me on the ward and… I'm talking to somebody that was very poorly, [and] was listening to this person… and I was asked to go and make beds while I

> was talking to this person and I said that "I'm talking to someone"- "yes but you're not doing anything"- believe it or not [laughs] (Myra, PSW4).

Consequently, a discussion on whether the PSW role was equal and on par with others emerged, with the resounding agreement that PSWs had a unique role and did not want to be equal to others:

> We all work in different services so our experiences are all very, very, different, but in my experience it's one of those areas where it's like, you fight so much for equality and to be equal to everyone else, it's part of who you work with and in the team, that in becoming equal you lose the individuality of what you do, and that's already happening on the wards with HCA Peer roles and the lines are being blurred […] so it's like to me, personally like- is it important to be an equal part of the team? No, it isn't… why would I want to be? […] I am not equal to them, and I don't want to ever to be equal to them, because we, we offer something totally different to what they offer (Elise, PSW3).

This section explored how societal stigma contributes to the concept of 'Us' and 'Them' within the case study workplace. It showed how the staff with lived experience, as products of the society from which they come, sometimes reinforce that stigma by separating themselves from the patient role, whilst others actively embrace it at times. It is worthy of note that PSW colleagues as a whole were keen to distinguish themselves from other clinical roles where the focus on 'peer' or 'self as ex-patient' was not an integral part. The next section takes this one step further by looking at how study participants explore stigma and self-stigma, including

through the notion of shame, and how that contributes to individuals' identity.

5.1.3 Self-stigma

Self-stigma, "a form of mental self-harm" (Iain, LE9), was identified by a quarter of the interviewees as something that impacted on the personal identity of staff with experience of mental health problems. In addition to the actual phrase 'self-stigma' being used, words such as guilt, coping and worry were used to describe its impact on individuals and their sense of self. Although these words have different meanings, the outcome was clear, whereby staff with mental health problems often judged themselves, sometimes harsher than others would. According to the interviewees, this resulted in feelings of weakness, failure, inadequacy, and self-isolation; a perception based on the concept that clinicians as an entity have to be strong all of the time. This, they expressed in terms of the inner conflict this created which impacted on them both personally and professionally.

However, Danny believed that his mental health problems not only affected how he saw himself professionally, but as a husband and a father, significantly affecting his wellbeing:

> Part of my illness was that everything became a double-edged sword to me, my family were a double-edge sword- I love my family with all my heart, I love my kids with all my heart- but when I was ill well what a shit Dad I am, what a shit husband I am… I can't stay well, and I can't stay at work- well what a shit nurse I am- you know that self-stigmatisation, and it just knocked on from one to the next, to the next and you know before I'd know it I'd be very unwell again very quickly (Danny, LE8).

For Duncan, self-stigmatisation reveals itself as a weakness, which makes him shy away from sharing that part of his identity, but also leads to him questioning his professional abilities and internalising the pressures.

> There is a fear of wanting, not wanting to be publicly known and publicly acknowledged if you like, your own mental health issues… I think for me it's perhaps less about the shame aspect, which I think is still there. I think, "oh people will think I'm not very good or weak or, or that kind of thing" which I think is still there". […] I worry a- about whether I'm cut out for this, I think that's, that's an ongoing, that's a constant dilemma- obviously the work I do is really often around risk and decisions and that's not an easy area for me personally (Duncan, LE10).

This weakness or self-stigma is compounded by the fact that he takes medication, something initially difficult for him, as a psychologist, to accept:

> It took a long time to get my head around the fact that I couldn't use solely psychological methods to deal with what I was going through… It really shook and challenged all the models and… knowledge that I had as a psychologist […] seeing people and almost offering them thoughts on what might improve things when I know at times that hasn't worked for me… (Duncan, LE10).

It could be implied that despite the strengths he suggests his lived experience affords, he also sees it as his "Achilles' heel".

It is noteworthy that when recruiting staff with lived experience of mental health problems to interview, it was initially difficult to secure interviews with senior clinicians i.e., psychiatrists. When the opportunity to interview a psychiatrist arose, it was explored why this may have been. When questioned, Aisha responded:

> I get the impression that the more senior you are as a psychiatrist the more infallible you can't be, you can't show any weaknesses, people can't cope with you if you have weaknesses […]. Talking about it might be having to acknowledge that it's actually there (Aisha, LE11).

Being strong enough to support others was reported to be important to Jake and intricately linked to how he sees himself:

> […] I've got this sense I'm supposed to be strong enough to support, to help people. [Consequently] it took me a long while to accept that I needed help or had any issues. I mean I actually had a total breakdown before… […]. I do think there's an expectation that we professionally you've got to be strong to support people (Jake, LE6).

The language Jake used, namely "I'm supposed to be" and "I do think there's an expectation", suggest that his views are conditioned by the expectations of those around him. This was further exemplified in his reference to a colleague that had mental health problems:

> Everyone used to talk about him… he was seen as weak, he was seen as less, he was seen as a burden… he was just tolerated… (Jake, LE6).

Ted described how his feelings of inadequacy, simply due to having a mental health condition, impacted on him personally and how that manifested itself in the workplace; his manager helped him to see that he was unnecessarily overcompensating and taking more responsibility than he should have, which he advised would lead swiftly to burnout.

> [My manager] said to me very clearly one day […] "the problem is when you're here you try to work 110% all the time" [….] "and then you burn out" […] "You don't pace yourself because you're trying to prove when you're here that you're superhuman, so when you're not here people will forgive it". […] It wasn't about not doing the job, it's about taking that responsibility for the job and what I've found is I was overly focused on responsibility, my responsibility on getting the job done. If something went wrong I was feeling guilt even though I wasn't in the building. You know it was like well I, I'd failed. I was taking it for the whole team (Ted, LE3).

Ava's personal experience, however, is rather different from the anecdotal evidence she has heard from colleagues, whereby their self-stigma has resulted in them becoming isolated. The aforementioned self-assurance that she has developed over time appears to negate any possible feelings of weakness or inadequacy that lead to self-stigma. When discussing why her managers asked her not to share her story as an educational anti-stigma piece with a local newspaper she stated:

> They [managers] were worried that somebody'd say something unpleasant to me and I would be upset by it, which I wouldn't. I mean that's a reflection of where that

> person's at mentally, self-stigmatising themselves. If they were going to call me for being a service user that's actually telling me that they're not very happy that they are, do you know what I mean? But, but they're underestimating me you see because 'I'm mad', so I can't cope with it, I can't tolerate it [...] (Ava, LE5).

Betty recounted how she was unable to see her own mental health problems, however, rather than internalise it, thereby challenging her own personal abilities and self-stigmatising, she instead questioned the teaching on her psychology course. One might suggest that this was a form of self-preservation aimed at raising self-esteem:

> I think probably in the last year or the last two years of my psychology degree I was becoming a bit of a text book case myself and I didn't notice it and I think that's the one thing that… shocked me about my psychology degree is that my diagnosis were being projected onto the lectures and I couldn't see it and that's what makes me think there's something really wrong with how things are being taught here if I can't look at that and see that I need help or identify with any of those things (Betty, LE7).

This section looked at how stigma and self-stigma contributes to the individual's identity and how it impacts on how they see themselves in the world. Before concluding the section on stigma and self-stigma it is important to explore this phenomenon through the concept of shame, as this was a key notion highlighted by participants.

5.1.4 Shame

From the data, shame (or lack of), was an important issue that contributed to each interviewee's identity, as a person with severe and enduring mental health problems.

Ava conveyed being happy with her identity as someone who has mental health problems and had a sense of pride in her assertion that ninety per cent of her friends have mental health problems, feeling no shame whatsoever. The significance of this absence of shame was compounded by her assertion that her mother influenced her identity at an early age:

> My mum pathologised me as a child; my mum would tell me I was not normal. […] I'd been conditioned as a child; my identity was already that I wasn't right (Ava, LE5).

Unlike some of the interviewees, she has no issues being on medication, in fact quite the opposite:

> I love my meds, like I wouldn't be where I am now without my meds' (Ava, LE5).

She stated:

> I've got bipolar because genetically I was pre-disposed to develop it and my environment switched on my genes to create it… hopefully they're not switching on my son's genes. But if they do… I will hopefully instil in him the same absence of shame, because that's what screws people up and that's why I think I've been ok (Ava, LE5).

She continued:

> I don't help other people have no shame if I'm shameful. And I'm not shameful so I need to capitalise on that lack of shame and do what someone else might work to do in five years' time (Ava, LE5).

Similarly, Danny articulated:

> I do passionately and morally believe that I have nothing to be ashamed of having had an illness and hopefully by role modelling I can demonstrate to people that actually you can rebuild your life and your career after such a debilitating illness and things can be positive about it as well (Danny, LE8).

Naomi went one step further, suggesting that she is so self-assured that she has nothing to be shameful about that she will happily use Glen Forest's services when needed:

> I don't have any problem with being treated by people that I come across professionally, because I don't feel I have got anything to hide or be ashamed of (Naomi, LE2).

Likewise, Iain is not ashamed of having mental health problems, as evidenced in a story he shared of a conversation that took place while working in his second job as a swimming teacher. Talking to two parents after the class, the topic of mental health problems came up. Iain comfortably mentioned that he had lived experience, the result of which was that one of the individuals concerned no longer speaks to him beyond a curt hello. When asked how it impacted on him, he said:

> The old me would have got annoyed and would have been "go on let's have a push and see if I can work out why they're being so off with it" but […] I kind of leave it "well it's your opinion, it's not going to impact on me, it's not changing my kind of view and where I am really so it's up to you, really" (Iain, LE9).

However, it is notable that Iain identified hiding his self-harm from others at work and at home due to the shame he feels and the fear that such a revelation would make life more difficult for him. In workplace terms he strongly believed that a few of his colleagues would bully him into leaving:

> I think they would tell me that I need to leave and that I wouldn't be capable of doing my job (Iain, LE9).

Jake's sense of shame, however, was palpable when he described why he avoided accessing mental health services, despite being particularly unwell at the time:

> I was ashamed… I just saw myself as a failure and all the things you associate, a lot of negative thinking and to think that you've got to face people you might have either known or might see in the line of your job was pretty tough and I imagine lots of people go through that but I did definitely (Jake, LE6).

Although the words 'shame' or 'ashamed' were not always used, the data suggest that some of the interviewees were particularly ashamed of their lived experience in their personal lives, so hid their true identity from friends and family.

While Ted's partner was aware of his mental health problems, he said that he would never tell his children or his wider family. While he suspected that his in-laws are aware, it is not something he would raise, so he masks that part of his identity when in their presence; something that is not easy to sustain from a wellbeing perspective:

> If I'm going through a very bad patch at home, especially now I've got children I have to act differently- I can't let them see me go through it- so I have to go away and sneak away and breakdown for a little bit and then go back again. It's the same with her [partner's] family, they would actually probably be very, very supportive, they'd probably be fantastic it's just never ever been raised (Ted, LE3).

For Duncan, his wife and immediate family are aware of his experiences, with the exception of his children, but he is concerned how he will approach this in the future.

> My kids don't know, and they don't know about my mental health issues which is an interesting one and I, I, I don't know what, what I will do about that in the future. They've never asked me what are the tablets, and you know that kind of thing but they're getting a bit older now and I guess it's not something that we've ever shared with them (Duncan, LE10).

It is interesting to note that he recounted that when his wife had cancer several years ago, they collectively agreed to share it with their children, yet not his mental health problems. He is less concerned about his close friends knowing, as many of them are psychologists who deal with similar issues on a daily basis;

consequently, he believes that they will be less likely to judge, even though he judges himself:

> God if you've got a psychologist that thinks if you've had experience of distress means you can't help people with distress; you're in a real bad situation then (Duncan, LE10).

This section explored stigma and self-stigma, including through the notion of shame, and its impact on each participants' identity. It reinforced the idea of competing and conflicting identities, namely patient versus professional, and at times the acknowledged default of hiding one's personal identity as someone with lived experience of mental health problems. The next section will move the argument forward by exploring the workplace as an integral part of identity, a place that offers purpose, value and belonging. Through this discussion it will suggest a third identity; one which is a hybrid identity where all staff, regardless of how they identify, have a common goal to use their lived experience in the specific pursuit of helping others.

5.2 Work as an Integral Part of Identity

Research suggests that many staff in the caring professions assert that working in healthcare is an integral part of their identity. Consequently, language such as "vocation" or "calling" rather than "job" or "role" is used to describe and distinguish their beliefs that it is something that they cannot separate themselves from when they leave the workplace at the end of their shift, whether they choose to or not (Heyes, 2005; Parkes et al., 2010; Puchalski and Guenther, 2012; Arevshatian and William, 2015; Colomer-Pérez et al., 2020).

Puchalski and Guenther (2012 p. 255) state:

> The choice to be a clinician is a calling to care for others, a desire to serve and a commitment to make a difference in the wellbeing of our patients. […] Medicine and health professions are vocations, not jobs. In this vocation, we are deeply dedicated to serve the needs of those who are ill or suffering. This dedication goes beyond a job and is rooted in altruism. Our personal identity is rooted in our profession. Thus, we are doctors or nurses all the time, not people who work as doctors or nurses for 40–50 h per week.

For many of the interviewees in this study it was clear that this was the case. They suggested that their work role was part of their very being, at their very core, and a major factor in why they entered healthcare in the first place. This was something they appeared to be extremely proud of.

Working with people and championing their cause was always part of Ava's ambition; quite simply, it fulfilled a key purpose in her life:

> I feel valued, I feel like I've got my self-respect, I feel like I've got freedom… The creativity and the flexibility I've got I wouldn't swap for anything and the actual content of my job and the people I work with and the teaching I really enjoy… (Ava, LE5).

Likewise, Aisha talked about her career choice as somewhat predestined:

> When I was at medical school we had to do clinical attachments and I did a clinical attachment erm well… a

> psychiatry attachment erm and I found that I, the minute I started on it I wanted, I knew that was what I wanted to do. I'd already decided at medical school that I wanted to be a psychiatrist. […] I found it interesting work. Erm, I wanted to help people- I suppose that always comes out and the NHS I never, I've never really thought about not working for the N[HS]… (Aisha, LE11).

Naomi shared a similar ambition based on her experience as a teenager:

> When I was 17/18 I wanted to work as a Samaritan, so… it's something that I've been interested in for a long time erm… and that interest came about because I was diagnosed with depression when I was 14 erm… saw a psychiatrist for a good few years when I was 14… erm…. I thought the treatment was crap; it was awful [scoffs]. Erm… I didn't really get any help so even when I was 17/18 I was thinking I want to be able to help people to actually be listened to and to actually get the help that I hadn't had at that time (Naomi, LE2).

However, Betty recounted her experience as more of a sudden realisation than a considered career choice:

> I was using mental health services at the time and really not getting very much from them at all and I s- saw this job advert come up […] and it was like a bolt of lightning had hit the office, it was like that, that is exactly what mental health services need, that is what my experience in mental health services has been lacking and that is the thing that I need […] it was just perfect timing for me and then perfect sort of job that really spoke to me as well (Betty, LE7).

This was also the case for Alice (PSW5), a PSW colleague, who stated:

> When the adverts came out I looked at the job description and read what the Peer Support role entailed in the Trust and… there was an immediate resonance that I could identify with and… that gave me added value to my experiences.

Duncan was particularly clear that his identity as a clinician was part of who he was. He stated:

> You can't not be a psychologist when you go home (Duncan, LE10).

It is therefore evident that many of the participants saw their professional role as more than a job, in fact an integral part of their identity, or as described by Puchalski and Guenther (ibid) as a 'vocation'. Moreover, the data suggested that work offers even more benefits for those interviewed, such as purpose, feeling valued, giving a sense of belonging, and supporting self-recovery, in spite of any challenges they may face around workplace stigma.

When Aisha was particularly unwell, she identified that being at work was important to her as it gave her a purpose:

> I got better through work, through actually having a purpose in my life rather than just sitting at home feeling like a failure… (Aisha, LE11).

Duncan's experience was similar. He recounted how at one time when he was particularly ill, he reflected that he was so afraid that if he stopped working he would collapse and have nothing left, that

if he went off sick he would never feel able to return; something he feared admitting to his manager, family and friends:

> I felt work was helping me kind of keep going…which is selfish and not the right way to think about it in some ways… I thought if I stop work now I'm going to be spending hours on my own, with my own thoughts and then it becomes the public acknowledgement that you're not coping and that you're not well… (Duncan, LE10).

However, Iain's reasons are more philanthropic; his career as a psychiatric nurse enables him to help people and give something back:

> I always say to people we nurses are a strange breed we don't do it for the money we do it 'cause we want to help people... It's nice to be able to give something back and do those kinds of things (Iain, LE9).

Betty's stance was more altruistic, as she highlighted how supporting others has assisted her own recovery, in a work environment where her mental health experiences are seen as an asset:

> There's not many jobs that you can work in where your lived experience is so open and such a strength in your work role, and it's completely transformed my recovery being able to be so open in who I am as a person and what I need (Betty, LE7).

Victor's experience was a hybrid, one of altruism and philanthropy:

> I think I've got the best job in the world… Working for this Trust helps me in my own recovery because I've still got mental health illness… I still have that purpose and drive to get up in a morning so coming to work, helping other people with similar problems helps me (Victor, LE1).

Regardless of the job staff with lived experience assumed, whether it be as a PSWs or other clinical role, there was a consensus that unless you had lived experience of mental health problems then you could not truly understand the experiences of your patients; something that the majority of interviewees deemed crucial for effective care and an important element of their self-identity.

As Rowan (PSW1) stated:

> [Lived experience gives you] empathy, compassion, understanding, acceptance… non-judgment, seeing things from a completely different point of view… just having someone there that knows… sort of what it's like to go through what you're going through and therefore believes what you say instead of just dismissing it, or patronising you. Young people have said things like "I like talking to you because you've been there, you know what it's like, you're an ex-patient so you know what it's like on that unit", "I like talking to you as you are a survivor, you've got your battle wounds on show" (Rowan, PSW1).

Iain echoed this:

> You can't understand what it's like to have it unless you've been there, and you know what it feels like to have a lived experience (Iain, LE9).

Interestingly though, all of the PSWs in the focus group referred to the value of lived experience as a strength and something of value, unlike all of the participants in the individual interviews. There was no mention that PSWs personally saw lived experience as a weakness.

This section explored the workplace as an integral part of identity, a place that offers purpose, value and belonging for all of the participants. The next section will explore these identities further and look at what one might describe as the resultant identity, specifically the identity that emerges as a consequence of the surrounding internal and external influences.

5.3 Resultant Identities

Differentiating between personal identity and professional identity is somewhat difficult to do as they are often inextricably linked (Bruss and Kopala, 1993; Öhlén and Segesten, 1998; Gazzola et al., 2011; Richards et al., 2016). This is particularly challenging since staff are invariably a product of the society from which they come and so bring their personal experiences into the workplace. Balancing these identities is likely to be arduous due to the pervading existence of societal stigma and how it manifests itself in the workplace. This is not only evident in the way the interviewees expressed how they were treated by others, but through the self-stigma experienced by a number of these staff with lived experience. Having the dual identity of service user and professional is something that, for many, requires constant negotiation and renegotiation, depending on the circumstances, including how safe they feel sharing their lived experience with others. For some staff this experience was positive, resulting in

harmonious identities, whereas for others there was a conflict of identity.

5.3.1 Harmonious Identities

Half of the interviewees intimated that they were comfortable with the identity of both professional and service user. It is, however, interesting to note that those staff who are comfortable with having a dual identity mentioned that they work in an environment where they are supported and/or valued by managers and/or colleagues and had appropriate support systems in place.

When discussing a Trust support group called 'Living in Both Worlds', aimed at staff who use mental health services and also provide them, Iain alluded to the image of two hats on the front of the Group's marketing brochure:

> 'Cause that's where the two hats on the front of that book comes from 'cause that's me- two hats: nursing and [service] user […] (Iain, LE9).

For Naomi, colleagues and managers supported her to be fully open about her mental health problems, suggesting that to do anything different would be contrary to the very nature of the services they provided:

> People have thanked me for being so open about it… so I've had conversations with people where they've said that they really value the fact that I am so open about it because why shouldn't we be?… I've had other members of staff come to talk to me who haven't been able to be so open about their illnesses… and ask me for advice about how to go about getting support… I think [with] all of the… supervisors that

> I've had I have been very matter of fact about it: you know it's nothing out of the ordinary, this is our bread and butter, so [laughs] why wouldn't I be one of the people that had some mental illness? (Naomi, LE2).

Despite not being able to share her lived experience with patients, Ava felt professionally and personally valued in the workplace, as both clinician and service user.

> I will stay with the Trust and that's because I feel valued, I've, I feel like I've got my self-respect, I feel like I've got freedom, I feel like I've got support from my managers to work creatively (Ava, LE5).

For Victor, the order of his identities depends on his audience; something which he seemed very content with:

> [If] it's a meeting with patients I'll introduce myself as a service user and the Manager of [X]. If it's a staff meeting I will normally introduce myself as the Manager of [X] and a service user (Victor, LE1).

When questioned why he alternates his status, he responded that he was comfortable with his dual identity and therefore did it for practical reasons:

> I think if you're going into [X Hospital] I mean the, the patients there get fed up of seeing different people in and out and in and out and who's this lot and n, n, n. And I think if you say it to them first you know, I'm a service user, I know what that's like, you know. Sometimes I'll tell them I've been on a ward or sectioned or whatever. But if you say that first

> there's this wall drops. […] It just opens the doors (Victor, LE1).

And with colleagues, he stated:

> It might be my perception. You go round introduce yourself d, d, d, I'm an [X], I'm also a service user. And you do get the odd look, like... [Looks at me with raised right eyebrow]. And then some people do talk to you differently afterwards and I just find that funny. So, I actually go and talk to 'em even more (Victor, LE1).

As intimated, not all participants experienced congruence between their personal and professional identities. Accordingly, this chapter will now explore examples provided by the participants holding conflicting identities.

5.3.2 Conflicting Identities

For Danny, a conflict emerged for him between his two identities of patient and professional when he became mentally unwell. It was clear from his words that he found it very difficult to reconcile his professional identity with that of service user since he was unable to identify and treat his own illness before he became so unwell. This resulted in him questioning his professional abilities, which then spilled into his personal life, generating self-stigma and negatively impacting his recovery. In doing so, the identity of patient came to the fore, suppressing that of the professional. This is how he described it:

> How can I disclose that I have mental health problems when I'm a bl**dy mental health nurse? You daft b****** you should have spotted the facts of signs of indicators of mental

> illness because you're trained in that, but you couldn't spot it in yoursen' and that process of self-stigmatisation I think was massive and hindered my recovery no end… (Danny, LE8).

Interestingly, this was in direct contradiction of the ethos of the programme that he developed for young people with mental health problems, where the aim was to show participants that having lived experience of mental health problems was only a small part of their identities. When describing the course, he stated:

> I genuinely thought we made a difference you know from kids that would come in on a section frequently lash out, abscond er, etc. through to being able to engage with them, get a working relationship with them, get them to focus on, on the symptoms and improve their outcomes and, and get them back out of hospital and back into society you know and, and, and having a meaningful life and that actually having a mental health problem wasn't the be all and end all of their life- it didn't become their identity.

Similarly, Ava, as mentioned earlier, identifies as both a professional and a patient, however the language she used throughout the interview often contradicted this, more closely aligning with the role of patient. Discussing the establishment of a Recovery College for patients at her place of work, she spoke about the barriers initially encountered:

> I mean this was a battle at first with professionals… because they were frightened of it (Ava, LE5).

Correspondingly, when asked about public attitudes towards people with mental health problems, Ava disassociated from the general public, stating:

> I don't know. I don't mix with the general population- all my friends are service users… (Ava, LE5).

This was an interesting assertion based on the data that one in four people within the general population have lived experience of mental health problems, so Ava was clearly disconnecting herself and her friends from the general population and identifying as a separate entity. It would also suggest that she is secure in her identity as a service user, however this was, again, contradicted when she proudly declared:

> I feel proud to work for the Trust. You know I tell people… I say I work for X Trust. And sometimes I go into [X Town] with my name badge on, it's so sad, isn't it? [Laughs] (Ava, LE5).

Furthermore, she later took on a professional stance where she described her approach to work, asserting:

> Everything's co-produced; we don't offer anything that we particularly want to. We go to the patients (Ava, LE5).

For Duncan, however, the data suggest that the professional and senior nature of his role in the organisation makes open disclosure inappropriate and "too exposing", thereby creating an obvious conflict between his dual identity; one in which he systematically defaults to that of the professional. His rationale was explained when he shared that, although he is aware of other psychologists

in the UK whom he respects, such as Rufus May, someone who openly shares their lived experiences of mental health problems, he does not want to be in that position himself, which he described as a "celebrity psychologist/service user". He was clear that he would rather people see him first and foremostly as a psychologist:

> Respect me, come to me, value my opinion as a psychologist... (Duncan, LE10).

Wallace (2012, p. 7) solidifies this belief by asserting that the transition from the healer role to that of a patient can "seriously challenge and undermine the personal and professional identity" of clinicians.

The data therefore suggest that for some of the participants their dual identity of staff member and service user is harmonious as they believe it works for them, whereas for others there is evident conflict, whether apparent to the participants or not. The next section seeks to further examine the resultant identities that participants alluded to in the interviews and consider the notion of 'an ideal' hybrid identity where staff, regardless of their diagnosis, professional role, levels of disclosure and so forth, share the common denominator identity of a professional who simply utilises their lived experience to help in the recovery of others whenever and in whatever way they can.

5.3.3 Negotiating a Single Inclusive Identity

Of interest to the researcher was that none of the participants alluded to an unambiguous middle ground. Instead, they exist in what Ybema et al., (2011, pp. 21-22) describe as a place of 'perpetual in-betweenness', where they are constantly switching between identities and 'balancing on the notional boundaries in-

between two or more social categories'. They have no liminal space to occupy, no single identity to describe them; they identified either as the professional or the patient, and almost always solely the former when at work. This exacerbates what Kipping and Armbrüster (2002, p, 203) define as the "burden of otherness"; a concept introduced earlier in this chapter.

Consequently, despite obvious attempts by individuals to try and bring together their personal and professional identities there was no evidence of them being able to successfully create what one could define as a hybrid functional identity; one whereby both identities, though somewhat incongruous in the minds of the participants, could survive and be pseudo-rationalised to enable the participant to function as a whole. In fact, the title of the staff group alluded to earlier, 'Living in Both Worlds', reinforces the concept of two completely different human entities that have no shared central space.

Jake, who has throughout his life deliberately avoided accessing mental health support despite his self-confessed needs, described this through his battle to retain this often-fragile professional persona:

> I've experienced anxiety a lot; […] even now they still don't get to see that because of the job I do and the way I do it […] but you have to work harder to do it […] (Jake, LE6).

This was supported by Betty, who recounted the frustrations that she often experiences when unable to advocate for patients in multi-disciplinary team meetings, simply because of her own lived experience. She believed that if she were to challenge the

psychiatrist's underestimation of the courage people with mental health problems demonstrate every day:

> The psychiatrist would maybe write me up for a prescription too… he would see that in the context of my lived experience, maybe think I don't really understand what I'm talking about or that it's a slight delusion (Betty, LE7).

Whilst it may have been helpful to them to have a single label that described who they were, thereby engendering a sense of belonging and acceptance, this was not something any of the participants suggested was available to them. Consequently, the data suggest that none of the participants were able to truly bring their whole selves to work, therefore reinforcing the suggestion that a gap exists; a chasm that separates their two worlds, with participants precariously balancing with one foot on either side.

It could be argued that if the working environment was truly conducive to the notion of peers sharing their lived experience and regulation identity appropriately adjusted, more staff with lived experience of mental health problems would feel confident and supported to use their lived experience to help their patients; something currently frowned upon in spite of the organisational rhetoric that suggests otherwise, with a focus on the principles of recovery and the resultant appointment of PSWs in many of the mental health teams. If the gap was removed, the two worlds could better align, and a hybrid identity be achieved; one in which perpetual in-betweenness / liminality was eradicated (Figure 4).

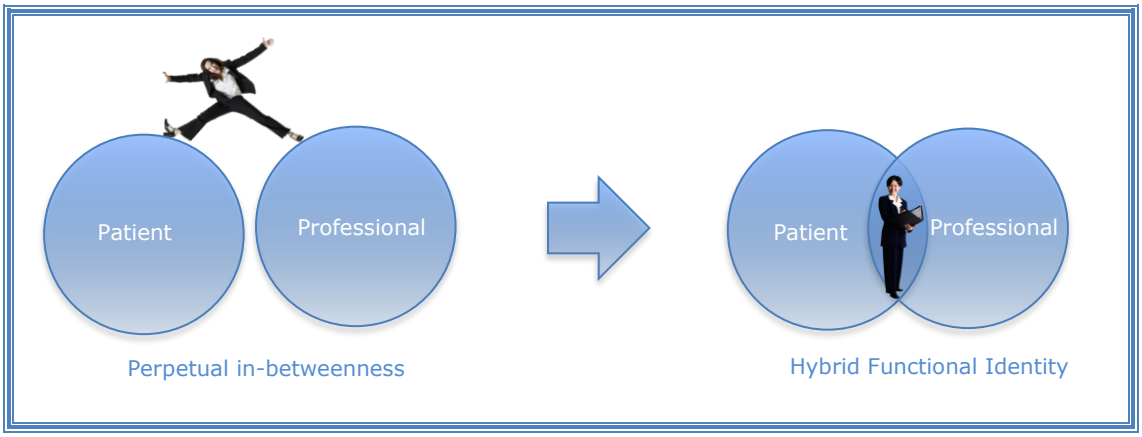


Figure 4: Illustration of Movement from a State of Perpetual In-Betweenness to a Hybrid Functional Identity

Despite this, one might suggest that the majority of staff with lived experience do use their experience to benefit their patients; they simply do not do so openly, or even knowingly. This was indicated by Naomi who described her lived experience as an additional competency; an extra skill that she can use to help others with mental health problems:

> When people come feeling suicidal, having been there myself it helps me to […] empathise on a different level, because […] unless you've experienced something like that depth of mental illness, I really don't think you can understand… how that affects you as a person (Naomi, LE2).

Similarly, Iain believed that as a result of his own lived experience he has a better understanding of his clients' experiences and is more receptive to what they may be experiencing:

> When I go through the different kind of psychosocial interventions that I use I think having an awareness myself of how they impact on you and what it feels like for somebody to sit there and get you to try and talk about stuff that you don't want to talk about and is really scary, I think

> that changes how you will give the question or how much time you would then allow for them to feedback […] (Iain, LE9).

And Danny, rather than completely accept the pervading culture of identity regulation within the organisation, made the conscious decision to use his experience to navigate the system by making small changes from within. Providing an example based on the search process during his first personal psychiatric hospital admission, he explained how he was able to improve the process for his patients:

> The staff had done nothing wrong… it was done respectfully, it was done with dignity […] I've been on acute wards for years, but I'd never seen it from that side. So, I changed the practice on the units that I worked on… about the admission process. I still did the searches, but I did them more sensitively, even more sensitively… […] to reassure, it's a frightening thing, it's an undignified process but it's a process nonetheless… (Danny, LE8).

The data therefore suggest that a gap exists. Due to the heavily regulated environment in which they work, it is extremely difficult for staff with lived experience to bring their whole self to work. As a consequence of this, there is no hybrid-functionality where they can comfortably exist in the space of both staff member and service user, regardless of the organisational rhetoric espoused. Subsequently the workplace environment for staff with lived experience lacks some of the support mechanisms needed to truly thrive and achieve their full potential.

5.4 Conclusion

This chapter set out the data from the semi-structured interviews and the PSW focus group and provided an overview and discussion on the interpretations made during data analysis in relation to identity. In order to do so, it provided an analysis of participants' experience of stigma within the workplace and beyond, based on that perpetuated by society. It then explored key determinants of identity regulation through an examination of individuals' experiences. Next it offered an explanation of resultant identity, before drawing to the conclusion that clinicians with lived experience of mental health problems, regardless of how they personally identify, feel bound by a system which does not fully value lived experience as a professional credential. It concluded with the suggestion that within an environment where staff identity is so heavily regulated, there is little ability for staff to formally use their lived experience to help others, which is in contradiction to the organisation's 'recovery' ethos described in Chapter 4. Subsequently staff, whether consciously or subconsciously, are often resigned to use their lived experience informally in the healing of others, in what Conchar and Repper (2014) described as a key element within the identity of the Wounded Healer.

Consequently, the third data chapter: Chapter 6: Power and Powerless will take this discussion forward by exploring the second theme that emerged from the data collected from the semi-structured interviews with staff with lived experience of mental health problems and the PSW focus group.

Chapter 6: Findings: The Power of the Powerless

6.0 Introduction

This third findings chapter carries on from the previous chapter on 'Identity', beginning with an exploration and analysis of how staff with lived experience of severe and enduring mental health problems, as interpreted from the interviews and PSW focus group, make sense of the dialectically opposite feelings of power and powerlessness that they have experienced while at work; and how these interdependent concepts have impacted on them as individuals, both personally and professionally. It will then conclude with how the interviewees view the organisational rhetoric, through the application of its formal and informal policies and practices, with particular reference to the convention of boundaries and disclosure and how these serve to empower and/or disempower its staff.

6.1 Decoding Organisational Power Dynamics

All of the interviewees were cognisant that their lived experience had the capacity to benefit both themselves and the Trust, based on the enhanced insight they have, which cannot be learned from a textbook; and many alluded to this as giving them power. Conversely, due to the medicalised model utilised within psychiatric services, this same power worked against individuals, isolating and weakening them, and at times rendering them in what they described as somewhat powerless. By exploring each of these concepts independently, this will help provide an understanding of the extent to which the case study organisation supports staff with lived experience.

6.1.1 Power

All of the interviewees highlighted that lived experience of mental health problems gave staff (with lived experience) an added authority. Some described it in terms of enhanced skills or competencies, whereas others discussed it in terms of credibility, status, but above all, power. Using the Foucauldian perspective of 'Power' offered by Broer et al., (2014 p. 209), this section will explore power as experienced by the interviewees before considering its antithesis 'Powerlessness':

> Power is not a characteristic or a resource of a person but is produced in a relationship to which the material, social and normative elements of the situation contribute. Furthermore, from this point of view, power can be positive and negative; it restrains certain repertoires of behaviour while enabling others.

The sheer power that lived experience gives to individuals who possess it was purported by Naomi:

> I think it's so powerful… it breaks down the barrier of like…. the doctors, or you know the academic and the 'us and them' situation, it's… it… yeah, it's just so powerful (Naomi, LE2).

In fact, Iain (LE9), after the interview had concluded, mentioned that he had forgotten to say that when he was experiencing difficulties with his mental health, he made up stories in his head to get him through the tough times; and that in these stories he was always a superhero, with the power to heal others. This was logged in the descriptive field notes at the time as it was felt to be a helpful metaphor to describe his experiences (Appendix 11.2).

However, Ava described her lived experience in terms of an additional competency, the gift of insight:

> The symptoms that I experience and the ways that I cope with those symptoms give me insight and give me a toolbox that I can share with the people I work with […] and my own recovery journey gives me a very, very strong faith in recovery (Ava, LE5).

This was supported by Betty who expanded on it, saying:

> Lived experience gives people a lot of credibility among their peers and it's… a lot of interpersonal leverage and… that's a very powerful position even though it's not an authoritative, you know in terms of a psychiatrist is a powerful position (Betty, LE7).

However, she later further expanded on the responsibility such power brings. She warned that caution is required, as lived experience can also be used to disempower others:

> Lived experience can be used to invalidate someone else's which is similar I guess, it's like, 'well you say your depressed but look you're wearing makeup and you're out of bed you should count yourself lucky' […]. It's like if I'd clawed myself out of bed and I dragged this makeup onto my face and you don't understand and it's actually really hard, but you know that kind of, it's not helpful, it could, it's a potential tyranny of its own… (Betty, LE7).

Victor was keen to highlight the unique and potentially powerful abilities that staff with lived experience of mental health problems could offer patients:

> It can cut down the revolving door. If you can help somebody just get… snap them out of that revolving door, going round in circles for years and years and years […] If you can change that by using your lived experience […], even if it's one person, it's worth doing (Victor, LE1).

Similarly, Alice claimed that lived experience offered her a unique and powerful connection with patients, one which gave them a voice. She stated:

> That connection with a human being… it's one of the most empowering aspects of recovery… when that person suddenly comes back to life and regains that acceptance of self and who they are and can form relationships back with their family (Alice, PSW5).

This was supported by Rowan who expanded on the "sheer power" of providing a voice for patients:

> … just having someone there that they know is for them makes them feel very empowered because I think, being an in-patient you feel like your rights have been taken away […] having someone who's there fighting your cause, listening to you, and is doing whatever it is that you… need to do… what you want to do, it gives them a little bit of power back, it gives them a voice and that for me is one of the biggest things in recovery… getting your voice heard (Rowan, PSW1).

Later, in response to Rowan's comment, Alice added:

> … the quality and the strength of using and having lived experience to change clinical practice is also so very, very powerful, and critical (Alice, PSW5).

Aisha advocated that her lived experience made the service she provided to patients "more human" but advised that the power this brought could be transient, as no matter how much better it made you as a clinician, colleagues and patients would judge you if they learned that you too had lived experience. This, she believed, could render her and other clinicians with lived experience powerless. Which, in effect, introduced the concept of power as a double-edged sword; one which had the ability to both help and hinder the workplace experiences and ultimately the career of clinicians with lived experience.

> It's about power and if you have that power over someone, people even the patients have this perception that you should never have that mental health problem as well (Aisha, LE11).

6.1.2 Powerlessness

As highlighted earlier, power, as interpreted from the writings of Foucault (ibid, pp. 208-219), is dependent on the material, social and normative elements of the situation, of which within this study, organisational culture is a significant contributor. Furthermore, as explained, the experience of those with power can fluctuate, at times positive, at others negative, sometimes enabling, other times disabling. As described by Aisha (PE11), the double-edged sword of power, when wielded within the organisation, has the ability to make staff with lived experience powerless; a powerlessness that is

perhaps unwittingly propagated by the organisation's culture, rules and regulations, despite its populist rhetoric of being an employer who values and appreciates the lived experience of its workforce. Organisational culture, more commonly described as "the way things are done around here" (Mannion and Davies, 2018, p. 361), was expressed by many of the participants as something that systemically stripped away their power, weakened their resistance and turned the positivity of their lived experience into a negative; one where they were deemed a pariah, where their lived experience was deemed to be shameful and embarrassing, resulting in negative consequences for their experiences at work and ultimately their careers. A rich and diverse body of academic literature exists which highlights the impact an organisation's culture has on its workforce (Stone et al., 2007; Warrick 2017; Mannion and Davies, 2018; Colquitt et al., 2019).

Powerlessness was expressed by a number of the participants in terms of marginalisation and isolation. There was a real fear of being singled out and shunned, having little or no voice and being seen as less than; less of a professional compared to those who embraced and practiced the Medical Model on which psychiatry is built (Huda, 2019; Higgins et al., 2020). Furthermore, the voices of the participants seemed to indicate that, in reality, the organisational culture remained heavily influenced by the traditional Medical Model, in spite of the latter being a professional culture. This is in contrast to the Recovery Model espoused in the organisation's rhetoric, which advocates that some of the daily challenges that people with lived experience go through demonstrates an inner strength that is rarely recognised or appreciated, a view supported in the literature (von Hippel et al., 2022; Watson and Repper, 2022; King et al., 2023).

Ted explained this in terms of the sense of powerlessness that he and his colleagues feel about the prospect of asking their managers for support for their mental health problems; how it subjugates them, making them feel vulnerable and fear being isolated. The consequence of which, is that they do not seek the support they need and often suffer in silence.

> Sometimes the pressures brought to bear are so subtle and people see it being done to their colleagues that… it raises a fear that 'I don't want to make myself so vulnerable because I've seen what happens to people who step out of the group'. Once they're out of that herd they're culled (Ted, LE3).

Ted believed that this disempowers staff, which results in a loss of voice, where standing up for ones-self is futile:

> […] Because… we're not very open about mental illness within our staff… I think that allows these myths and these subtle pressures to be brought to bear and if nobody will stand up and say, 'well actually, yeah I'm like that, what are you doing that for?' Because they don't want to be identified, that it's no good challenging […] (Ted, LE3).

Elise described how powerless, isolated and unsafe she felt when asked to share her lived experience with others as part of a community partnership initiative the Trust had organised:

> People that I didn't even know, who I'd never met contacted me to come and share my experiences, which I thought was quite powerful… until I got there and realized that they didn't actually have any real interest in taking care of how I would deal with it and support me in my role, what my story

> actually was. It was more about the event that was going on rather than trying to make sure that I was safe too, so there wasn't that balance there (Elise, PSW3).

While Betty highlighted the power of lived experience, she also emphasised the contempt she felt for the Medical Model in which psychiatry and the wider mental health field in which she works are imbued:

> My personal feeling is psychiatry is a tyranny [and] there is so much more creative possibility in madness than medicine will give you and it's a travesty that we can't as a culture see that… as an illness it doesn't let you see it as for me what it is…an experience that… is 'crushingly' difficult but also it will give you the strength that you need to survive all the times that are difficult… you are growing those survival muscles to continue with the rest of your life- it's not purely negative, it's negative and positive- it's a strength and a challenge and you can't see it like that if we just see it as an illness (Betty, LE7).

As a consequence, Betty asserted that PSWs in multi-disciplinary teams, who because of the hierarchy and power within healthcare, are often unable to challenge the views of others, in particular psychiatrists. A firm follower of the recovery model, she is particularly frustrated with the medicalisation of mental health problems, which require an "expert", such as a psychiatrist. This, she stressed, is evidenced in multi-disciplinary team meetings where an alternative understanding of patients and their challenges, often presented by PSWs, is disregarded in favour of the medicalised perspective of psychiatrists and other clinicians; something she believed renders them powerless and frustrated. For

her, the fact that people with mental health problems have overcome the daily challenges they face, is a demonstration of strength; something that is built on each and every day and should be recognised as such by all clinicians.

Rather than have a conversation with her about her needs when she became unwell, Sarah described how her managers made her feel powerless by taking responsibilities from her, diminishing her confidence and belief in herself:

> The bit that I could do they were taking off me and so I just felt worthless, useless, unable to… carry out even basic roles […], my confidence dropped big time. (Sarah, LE12/PSW2).

Ted explained why he believed that the organisation and its employees responded in the way that they did, due to an inherent fear of losing power. He described a sense of powerlessness experienced by staff that is exacerbated by the blame caused by the organisation's blame culture. This, he suggested, increased the loss of power and consequent damage to confidence felt by staff, in particular those with lived experience of mental health problems:

> I'm [sighs] a great believer it's all about power, I think… we're not very good in this hospital necessarily about giving up power… because it used to come down to the lowest common denominator in terms of who is responsible when things go wrong? There's still quite a blame culture. I think if you've got mental health issues blame culture is possibly the worst thing, you're already blaming yourself generally for something… so for everybody else to start blaming you it… it just completely up-skittles people and it destroys them in the

> end and you can see, I see staff now who… their confidence is shot because of the blame culture (Ted, LE3).

What was also clear from the interviews was that the interviewees were not only affected by the feelings of disempowerment they personally faced, but those of other staff with lived experience around them. In the words of Ted:

> What tends to happen more now it's more, subtle and covert actions… when I first came it was almost brutal, […] 'I'm not having him on my ward, they're mad'; that's been said before. Whereas now they know they can't say that so what they do is find another reason to not have [staff with lived experience of mental health problems] on the ward and I think they're harder things to challenge (Ted, LE3).

Iain was aware of others whom he believed lost their jobs or were moved elsewhere when it became known that they had experienced mental health problems, while another colleague was put into a role he did not like, forcing him to leave:

> I remember one guy […] and he opened up that he was hearing voices and that kind of stuff, and he was really struggling with it. And although he went off for- I think he went off for about 8 or 9 months- he came back into the job and was clearly finding it a little bit harder but was doing the job and before we realised it he'd been moved onto the wards which was the thing that he never wanted to do, he never wanted to be put in a position like that and he eventually left (Iain, LE9).

Noteworthy is the fact that a few of the interviewees' experiences of powerlessness emanated from before their employment with Glen Forest, when they were unwell and receiving services from the very organisation in which they now worked. This is something that clearly had a significant impact on them both personally and professionally, yet they still chose to work in the very system that took away their power by depriving them of their liberty. As opposed to what one might rationalise as a relatively unpleasant but necessary transfer of power to keep them safe when unwell, the participants used words such as "assaulted", "horrendous", "carted", and "terrifying", when they described their experiences of services.

Ava described her first ever psychiatric hospital admission:

> […] I was assaulted, I was injected with Acuphase three times, which isn't used now because it is so hideous, rapid tranquilisation… I had a horrendous admission […] (Ava, LE5).

Since Danny was a psychiatric nurse, who had most likely cared for a number of patients on Glen Forest's mental health wards, and knew many of the staff, the organisation arranged that he be admitted out of area and consequently was referred to in that hospital as the "political admission". He said:

> I was greeted by four of the biggest bleeding nurses I've ever seen in my life, because all they knew was we've got a bl**dy mental health nurse that's coming in, that doesn't want to come into hospital and that was my welcoming committee (Danny, LE8).

What was evident from these participants was that such encounters often shaped their experiences in the workplace. The negative memories of being deprived of their liberty through incarceration and seclusion at times rendered them powerless in the realisation of their duties, especially when they were required to physically restrain patients who were detained in a way they too had once been. This suggested re-traumatisation; being put in situations in which they were constantly reminded of their own experiences as patients, yet both physically and psychologically devoid of any power to respond in any other way than follow the organisation's procedures.

As stated earlier, Broer et al., (2014) defined power as being something that was highly mutable, which was not embodied in a characteristic or resource of a person, and which can change on a moment-to-moment basis depending on the different relationships. The data from this case study suggest that powerlessness acts in a similar way as power, and it too is dependent on the material, social and normative elements that the situation contributes. Furthermore, it suggests that different aspects of powerlessness exist. What has been alluded to is a powerlessness based on staffs' personal experiences of receiving services, and how historical trauma can re-emerge and impact on them personally, influencing their ability to do their jobs, and a powerlessness imposed on their professional practice based on the organisation's norms; its policies and procedures, its culture and rhetoric, where lived experience, although tolerated and rhetorically valued, is not fully welcomed nor its power understood.

This section explored the opposing themes of power and powerlessness and how the interviewees experienced it in the workplace, both directly and indirectly. Using the analogy of power

and powerlessness as a double-edged sword it introduced the idea of conflicting states between power and powerlessness in the experiences of staff with lived experience and how that same power could often be used to render people powerless. It suggested that any power the individuals had based on their lived experience was regulated by the organisation and therefore dependent on the organisational culture, one which was tolerated and rhetorically valued, but that never fully understood or accepted the power and value of lived experience. Finally, it highlighted that staffs' negative personal experiences of services as patients could exacerbate their sense of powerlessness should they encounter a situation similar to one they had experienced, where despite being in a powerful position as a professional, they had no power to change. This confirms the assertion that power is mutable, at times positive, at others negative, sometimes enabling, others disabling, influenced by material, social and normative factors and dependent on the contexts individuals found themselves in. Using that same analogy, the Foucauldian definition of power was extended to describe powerlessness. The next section will progress the argument by exploring the impact of disclosure and the idea of crossing boundaries, on the powerlessness staff with lived experience feel within the workplace and how much of their experiences they feel able to utilise in their clinical work as bound by the organisational codes culture.

6.2 Disclosure and Boundaries

Disclosure and boundaries were identified as a key theme from the interviews. All of the interviewees referred to these as the values and expectations forced on them by the organisation. This is in line with research that suggests that within organisations professional boundaries are imposed on individuals and that such impositions

can and do lead to tensions (McGarry, 2003). This section explores the participants' experiences of professional boundaries and the impact this has on their practice as staff members with lived experience of mental health problems. In doing so, it seeks to demonstrate how such staff with lived experience determine their own personal and professional boundaries and highlights the tensions they may encounter if deviating from those imposed by the organisation, in particular feeling devalued and ultimately powerless.

6.2.1 Disclosure

Three quarters of the interviewees communicated that they openly share that they have lived experience of mental health problems with colleagues and patients when they deem it beneficial for the individual. Examples of this included demonstrating understanding based on a shared experience or making the point that people with lived experience can and do hold down jobs. The remaining participants practiced selective disclosure, only sharing this information at certain times, and to just a few trusted individuals. For several it has been a positive experience, for others a regretful one.

Alex (LE4), who was generally open about his mental health problems, stated that his decision whether or not to disclose to a colleague was dependent on whom the individual was and what mood he was in at the time. This was surprising, as Alex's previous role was that of a peer support worker, and therefore by nature of his role, identified him as having lived experience of mental health problems, which can be understood to result in individuals openly disclosing this as and when required. Through further questioning of Alex (LE4) and also Betty (LE7), who likewise had worked as a peer support worker, it was determined that peers do not always

share their whole stories with others, whether it be colleagues or patients, and sometimes not at all. As Betty explained:

> At the start I thought oh I'm a peer support worker I have to lay myself bare that's the job and so I would… disclose quite openly… but not because I wanted to but because I thought I had to. Whereas now I would say I am still as open, but only when… I feel it will have some positive effect or it's necessary, or it will help someone to hear it […] I disclose very little but just enough to let somebody know I'm on their level, I hear what they're saying and I feel what they're saying and if they ask more then I'm very open to answer but I would never… reel off any lengthy stories, cause there's not really any need to. […] Less is more quite a lot of the time (Betty, LE7).

The timing of initial disclosures to managers and colleagues varied considerably. Four participants disclosed their lived experience of mental health problems on their job application form; Naomi (LE2) discloses to colleagues, where appropriate, to help further their professional education, while Ava (LE5) waited until she was three months into the role as she was concerned she would not get the job if she had openly stated her diagnosis. She now openly uses her experiences to raise the awareness of and educate other staff regarding mental health problems, enabling them to ask questions that they would not feel able to ask patients.

Ted disclosed to management and colleagues as soon as he received a diagnosis, as he was already in the role. Although now open to colleagues about his experience of mental health problems, he reflected that he regretted disclosing to his manager. The manager was unsupportive and immediately referred him to the

Occupational Health Service to determine his fitness to be with patients. The impact of this on Ted was loss of self-value and self-confidence.

> It does impact on you moving forward well theoretically given the benefit of a couple of years it's taken sixteen years for me sort of with a mental health condition to actually be able to progress [laughs]… (Ted, LE3).

Despite openly sharing his diagnosis, Ted did not share his suicide attempt. He did not state why he never told his manager about this, however Aisha's statement about the organisational response to such matters of self-harm may offer a possible explanation:

> If somebody had had fleeting thoughts of suicide, but they didn't really mean it and they told a colleague what would be the organisation's response…? It would be completely overbearing. It would be 'oh we're not sure you should be coming to work da, da, da'. And then actually that that means you lose support mechanisms because you lose identity when you go down that route […] (Aisha, LE11).

This is similar to Iain, who despite sharing most aspects of his lived experience with his manager and colleagues, stated that he is not yet able to tell them his experience of self-harming, despite his desire to. He stated:

> I wish I could find a way of saying- is that I self-harmed and to some degree I found it quite useful really (Iain, LE9).

This suggests that Iain keeps his self-harming as a secret part of his identity, unable to share it professionally, despite the possible

learning his manager and colleagues could benefit from, including an understanding and appreciation that he found self-harming a helpful coping mechanism, not an incomplete suicide attempt or a cry for help, which he asserted many of his colleagues would assume. Consequently, he worries that he would lose his job if he fully disclosed his experiences of self-harm as he believes that the organisation does not yet understand the therapeutic value that self-harm can have for some. Furthermore, he is not able to bring his 'whole self to work', despite the organisational rhetoric which advocates to the contrary, thereby increasing the pressures on him by having to consciously and deliberately hide part of himself; something which is both disempowering and exhausting. This alludes to a mental health organisation where certain conversations are still forbidden, where many colleagues are not yet ready to explore such issues, thereby reinforcing the stigma associated with such hidden problems as self-harm and rendering the subject taboo.

Despite having worked in the organisation for over 20 years, Jake at the time of the interview had only recently started disclosing his mental health problems to others, and only in certain circumstances. He explained that he finds it easier to disclose to service users within the Recovery College than to his fellow professionals. This may imply a common identity with service users based on shared experience and/or being safe in the knowledge that he is less likely to be judged by them, in comparison to the findings his observation of colleagues towards other staff with mental health problems has shown:

> It's only recently I've been open and disclosed my experiences more willingly with fellow professionals but when I'm working with people in the Recovery College I have been

> quite comfortable with sharing parts of my experiences because I think it's an equaliser […] (Jake, LE6).

Danny, now open about his lived experience with others, did not make the conscious choice to disclose. His manager and a colleague visited him at home when he was off work sick and found him in an unexpected state:

> I was in a mess… and I hadn't attended my personal hygiene for… days, weeks… hadn't eaten, drank, I was in a mess. […] And they came round and just found me in a mess… so I didn't really disclose it, they discovered it (Danny, LE8).

On returning to work, he made the decision to openly share his experiences in a team meeting, something that he later regretted due to the negative reaction he got.

> I just blurted it out and I remember the response [laughs] it was just stunned silence and there was like tumble weed [laughs], coming across the middle of the er team meeting [sniffs] and er nobody said anything and er and then it was er… and then it was like moved on to the next agenda item [laughs], it was like the elephant in the room was not acknowledged and er that actually someone just admitted to having an enduring mental health problems and having been in hospital […] (Danny, LE8).

For Duncan (LE10) and Aisha (LE11), as a psychologist and psychiatrist respectively, disclosure is only on a strictly 'need to know' basis. Duncan's past and current managers are aware, however he highlighted that he had a relationship with them prior to him disclosing. He is unsure whether he would disclose to a new

manager in future. His uncertainty supports a general anxiety around fear of the potential ramifications of disclosure. He stated that he hopes his fellow psychologists, who know about his mental health problems, do not judge him, something that he is not aware has happened to date. In relation to the views of others, he is clear that if he were to publicly acknowledge his mental health problems, he would likely be seen by others as "less" and worries that "it might cloud other people's responses" to him:

> My worry that I would be, it would be seen as… maybe just less expert to them and less knowledge based, more based on just who you are. You think that because of who you are not because of your psychological opinion… not because of your experience as a psychologist or your training and the stuff you've read and all the supervision you've had, your opinion is that because you are a service user... (Duncan, LE10).

Furthermore, Duncan reflected that he would be reticent to share his experience of mental health problems outside the confines of his psychologist peer group for fear of losing part of his professional identity, a group in which he felt safe to disclose:

> I think that comes back to less the sense of they would think 'oh he can't cope' […] I would worry about how they would respond to my opinion… My worry that it would be seen as less… maybe just less expert to them and less knowledge based […] (Duncan, LE10).

Aisha has also disclosed to her current and previous manager, but is very clear based on her experience that she would be highly unlikely to do so in future, saying:

> If I could take it back and not tell them I would. (Aisha, LE11).

She believed that management behaviours, based on her disclosure of lived experience, perpetuated stigma towards her, impacting on her professionally:

> […] I feel like I'm being judged […] it's not even about patient care it's about what I look like as an individual, whether I look stressed or not. So, the patients are all fine […] they have no idea any of this stuff is happening. But yet I'm the one who's had the pink finger pointed at me, by management who want to have chats with me about being stressed, who aren't talking about mental health even though I've told them I've got mental health problems (Aisha, LE11).

She believed that the inability to share such information resulted in her and other colleagues with lived experience being unable to support each other, in line with normal social behaviours:

> There are cultural factors within this institution clearly that don't enable people to be open about their own experiences which means that we can't share our experiences amongst each other, which means we can't support each other... (Aisha, LE11).

Consequently, Aisha believed that Glen Forest would not be able to cope if she, a psychiatrist, openly disclosed her mental health problems to help patients:

> This organisation would firstly view that as un-boundaried, would secondly view that as… probably more about me being inadequate (Aisha, LE11).

A number of staff have confided in Danny saying that they are fearful of disclosing to their managers; they are worried that they will be seen as failing, and to both their managers and team members alike:

> That perception of… being seen as lazy, being seen as not pulling their weight. All of those [sighs] stereotypes and those are a lot of the fears and […] since I started [7 months prior to the interview] […] I've had already probably 6, 8 staff who have disclosed their own mental health problems and they won't talk to their managers, they won't talk to their leadership, they won't talk to their team about it because of that fear (Danny, LE8).

Ava however, clearly asserted how she interpreted her manager's views of her as funny and of no challenge to her strong sense of self:

> It's risk… You know I think she'd be different if I had anxiety or depression, but because it's secondary… because she knows that it's a psychotic illness… I can just see her in her mind thinking, "she's mad and she's got keys and she's got an alarm" and [laughs] it makes me laugh (Ava, LE5).

Despite three quarters of the interviewees highlighting that they have openly shared their lived experience with others, only a few of the participants stated that they were completely open. Issues that were still judged by some to be impossible to share included

practices such as self-harm. Those who were able to be completely open expressed a sense of freedom about being able to be themselves at work, something that strengthened their personal identity and helped others to see that people with mental health problems can work in a mental health trust.

Betty actively encourages disclosure, reflecting on how it benefits her professionally:

> There is so many positives to daily disclosure as a peer support worker because it just means I can bring my whole self to work and it's very freeing to know that… people can see all of me and… I don't have to hide anything and also I can be honest and say, 'well actually I'm having a really difficult week this week' and people get it… in the context of everything that I am… (Betty, LE7).

Naomi shared this sentiment:

> I'm very open about… how I am with my colleagues so… I don't have the pressure of trying to hide being ill or anything 'cause I just don't allow myself that pressure… I'll tell people [laughs]. I think it's important for me and for them to know that this is what it looks like when you're mentally ill and trying to carry on (Naomi, LE2).

Alex took this a step further, highlighting that his role as a Peer Support Worker enables him to use his lived experience of mental health problems to help patients on their journey, to help people better understand themselves and see that recovery is possible. Being a peer is central to his professional identity.

> What a Peer Support Worker is able to do is, through the training they have received, they can use that experience to benefit or support someone in their recovery… we've been someone who has used that service and now we're someone who is working for that service so it shows that the journey of recovery is possible to someone no matter where you're at in your recovery… there's always possibilities to open different doors (Alex, LE4).

Danny, however, was keen to point out that along with the benefits of disclosure there are boundaries to clinicians sharing their lived experience within the therapeutic relationship.

> It's not about fulfilling me own bleeding ego or anything like that it's about helping somebody through that. I see it as it's about role modelling and it's about leading by example and that for me is fundamentally what makes the difference is that actually if I am choosing to disclose something it's because I'm wanting somebody else to know that you're not alone- I've had a similar experience to this, our experience is not the same but I can understand, I can empathise better. I get where you're coming from […] (Danny, LE8).

6.2.2 Boundaries

As alluded to above, the data identified professional boundaries as being a key issue for all of the staff with lived experience, particularly those who had freedom of disclosure. The overall situation, with only one exception, was that all of the interviewees were professionals, and consequently very aware of their professional boundaries, having addressed that in their training.

However, Ava, whose professional training was more educational than clinical, asserted that her personal psychiatrist influenced the defining of her personal boundaries as he role modelled appropriate boundaries:

> Dr B looked after me from day one… and so from day one I mirrored- I knew what a productive, successful and positive therapeutic relationship looked like (Ava, LE5).

Boundaries were generally seen as being there to protect both the staff member and the patient as an understandable part of the professional identity. They are an integral part of the therapeutic relationship and are something Alex believed was particularly important for staff with lived experience of mental health problems:

> We make them [service users] aware that obviously we're there to support their recovery and it's hard letting them know that friendship which we build with them I suppose is therapeutic and we're not there to be their friend, we are there to support their recovery, but it's not going to be something which is going to be long-term… letting the people know what those boundaries are I suppose, puts us in a better position to be able to get the best from that relationship (Alex, LE4).

Naomi elaborated on the topic of boundaries. She recounted how she had used her professional skills to maintain boundaries with a patient who, following a therapeutic self-disclosure, constantly wanted to know how she personally dealt with issues relating to her mental health problems.

> Somebody wanted to ask about my experience all the time after I'd self-disclosed: 'what did you do when you felt like this?' and 'what did you do in this situation?' That made it harder because I was trying to focus on them so it wasn't a case of going all psychodynamic and [saying] 'that's not appropriate, we're here to talk about you', you know blank screen on them, but it was about having to turn it round and not… going into great detail about me because that's not always relevant. […] So, it's the same that if they ask me 'when were you last depressed?' 'How long did it last? 'And if they went on into great detail, I'd have to say I don't know how much this would help you because my experience is going to be very different from yours' so… it's just a case of handling it in the normal therapeutic way (Naomi, LE2).

Despite all of the interviewees agreeing that professional boundaries were essential, not everyone agreed that the way the organisation enforced boundaries was entirely appropriate. In fact, two of the interviewees felt that sometimes boundaries were unnecessarily imposed, a blanket instruction that did not always benefit patients, other staff and the interviewees themselves. The underlying message that these interviewees believed, was that lived experience was something to be hidden away and be ashamed of; part of their professional identity which had to be secreted away, resulting in them feeling devalued and ultimately powerless.

> They don't know this about me, and you know, I've, I've thought about that, and I've thought how useful it might have been to them to know that their psychiatrist actually had, also had issues. I don't think this organisation could cope with that though. That this organisation would firstly

> view that as un-boundaried […] and probably more about me being inadequate. […] They're not benefiting from knowing that their psychiatrist has also been that, you know in that position…

When asked why she thought the organisation's boundaries around staff disclosure were so robust, Aisha responded:

> Because management couldn't cope with it, not because the patients couldn't cope with it because management have a certain, I mean where I work we have policies about patients giving you gifts. I mean you have to have policies, but you know er don't tell me that I can't take erm a little house that somebody made out of lollipop sticks as a, as a, as a gift you know […] I'm told I shouldn't accept that because it's a boundary you know, we have this rule […] Modelling "normal" human behaviour is to disclose and to give gifts- but we don't model that where I work: we model boundaries and they're somebody else's boundaries 'cause they're not mine […] they're boundaries imposed on me by, by the management structure actually (Aisha, LE11).

Ava, although happy to openly disclose her mental health problems to those she meets, also asserted that she is restricted from doing so in the workplace with patients, due to imposed boundaries, which she finds frustrating. She looks forward to the day when this may be possible:

> They won't let me talk about my lived experience in my job at [X Site]… [But if they did] I think it would be great (Ava, LE5).

When asked for the rationale as to why her self-disclosure is prohibited with patients she stated:

> Because people are too frightened; transference, boundaries being blurred. They don't think it can be done safely and that is underpinned by the fact that they don't trust people with mental health problems because they're working in a profession that doesn't trust people with mental health problems (Ava, LE5).

Duncan, a psychologist, supported this view:

> I think it's very difficult because when you are working in mental health… you are part of the system. You are part of a system that can section people… (Duncan, LE10).

This suggests that being able to normalise mental health problems is valued by staff with experience of mental health problems, but in some settings is unattainable due to organisationally imposed practices and lack of trust, something which disempowers them. However, this is in opposition to Glen Forest's ethos whereby people with lived experience are being actively recruited to work in the organisation simply because they have this lived experience.

This need for caution is shared by another of the staff members, based on his own personal experiences:

> I'm all for it [laughs]. I did it [laughs][…] I think people can bring and enrich and look from a different perspective having lived with it, as well as their professional competency. I think it's about actually ensuring that the support mechanisms are in place to ensure that they are able to do that safely and

> ensuring that their mental health is protected throughout that process, like mine unfortunately wasn't (Danny, LE8).

For others however, maintaining boundaries is an essential part of their professional identity; a necessary framework that helps protect them and others. Referring specifically to peer workers, Betty, emphasises the positivity, but warns of the need for personal and professional responsibility (boundaries):

> I think it needs to be… used wisely that position and not for personal gains… you just need to constantly reflect on what you're doing and what you're saying as a peer and why you are doing it. […] I think the other thing that can sometimes happen is a sort of competition like 'what you've only been admitted once? I've been admitted three times'. Or 'how many times did you try to kill yourself? I tried to kill myself this…' or 'I've tried fifty medications' and [sighs] it creates hierarchy in what should be a really mutual relationship (Betty, LE7).

This section examined how the impact of disclosure and the idea of 'boundary work' on the experiences of interviewees in the workplace, in addition to how the enforcement of such boundaries are enacted through organisational policies and practices. It reinforced the finding that staff with lived experience often self-determine how much of their personal experiences they utilise in their clinical work, and how often this is on a case-by-case basis, in the knowledge that this is an organisation that, by the very nature of its policies and practices, frowns on self-disclosure, and in doing so strengthens the notion of strict professional boundaries. The staff that feel able to disclose are clear in the need to only use it for the benefit of others. Those unable to share their lived

experience with others refrain for varying reasons: self-preservation and to protect the professional persona for fear of being judged and seen as "less than", thereby further disempowering them. One can therefore conclude that boundaries, although in place to protect both patients and staff, are an organisational tool that can, if used inappropriately, render staff with lived experience powerless; consequently, denying them the opportunity to use the power that their lived experience brings.

6.3 Conclusion

This chapter highlighted the findings of the semi-structured interviews and the PSW focus group and provides an overview and discussion on the interpretations made during data analysis in relation to the dialectic themes of power and powerlessness. In doing so, it explored the participants' understanding of power and powerlessness and how these impact on their experiences in the workplace. It then focused on how organisational policies and practices in relation to disclosure and boundaries affected them both personally and professionally, before drawing to the conclusion that clinicians with lived experience of mental health problems, even when they feel empowered by the value their lived experience brings to an organisation that encourages people with lived experience to apply, are disempowered by the very policies and procedures that are put in place that are deemed to protect them and others. Using the Foucauldian concept of power, one can conclude that power, as experienced by these staff with lived experience, is a double-edged sword; one that can be positive or negative, can both restrain and enable, but ultimately within an organisational context imposes itself on its staff.

In the following chapter, the main findings of this study will be summarised, followed by a discussion and conclusion that focuses on the interpretation of how clinical staff with lived experience of mental health problems experience working for an NHS trust; and how that same trust supports these staff to do their job to the best of their abilities.

Chapter 7: Discussion and Conclusions

7.0 Introduction

The primary aim of this study was to explore the workplace experiences of staff employed by a mental health trust who have lived experience of mental health problems and to identify the extent to which the organisation supported them. Accordingly, this thesis has presented a case study exploring the voices of clinical staff with lived experience of mental health problems and policy makers employed by Glen Forest, a mental health trust. In the previous chapters, the findings have been portrayed as three definitive overarching vertical themes; Fulfilling the Organisational Narrative: Practicing What We Preach? (Chapter 4), A Balancing Act: How Staff with Lived Experience Negotiate their Identity (Chapter 5) and Wielding the Double-Edged Sword of Power and Powerlessness (Chapter 6). Although these themes were presented as individual entities it is important to emphasise that they are interrelated, and the aim of this chapter is to present a critical analysis of the rich data evident in these themes to address the research questions. This chapter achieves this by interpreting and summarising the key findings from each of the data chapters, then shows the relationships in the form of cross cutting arguments within the context of the academic literature (Figure 5).

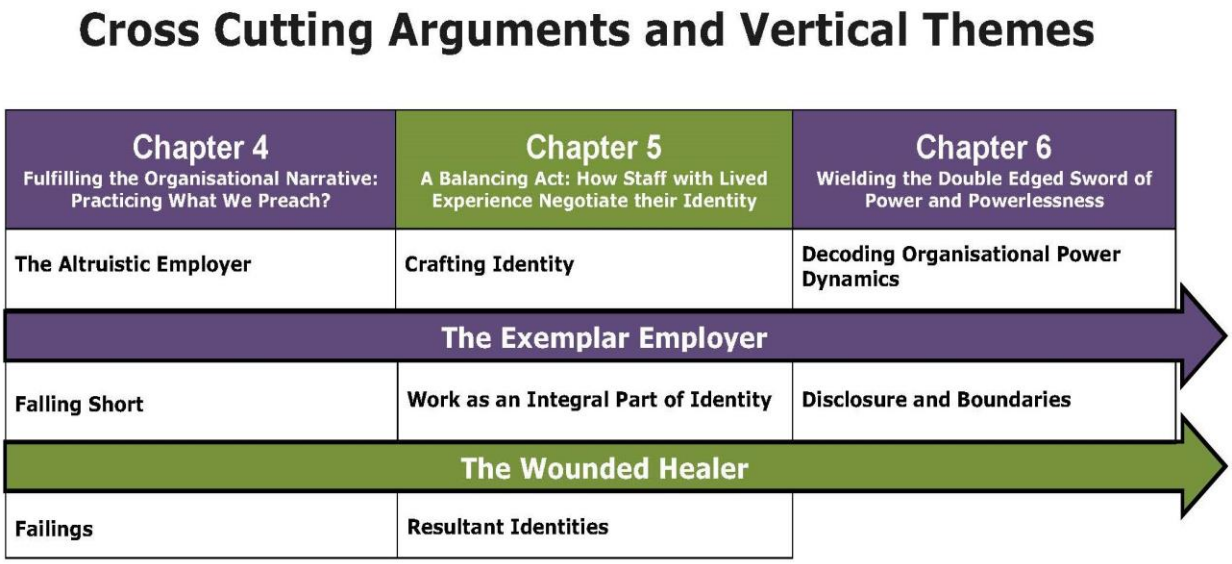


Figure 5: Stage 3- Cross Cutting Arguments and Vertical Themes

7.1 Chapter Road Map

This final chapter begins by re-capping the main aims of this thesis. This is followed by a discussion based on the analysis of each of the three findings chapters in this study (Chapters 4, 5 and 6), where the research questions are provisionally addressed. This is supported by a final discussion section that critically analyses and interprets the three vertical themes to generate two cross cutting themes, offering an enhanced level of interpretation and abstraction within the context of the current academic literature.

The contribution of this thesis is to challenge the dominant discourse presented in the mental health in the workplace literature. It will specifically contribute to enhancing the understanding of the experiences of clinical staff with lived experience of severe and enduring mental health problems, where a significant gap has been identified. In acknowledgement of the value I afford reflexivity, I will then explore how my own views and understanding of staff with lived experience of mental health problems were enriched during my research journey. Based on the findings, the chapter will conclude by making recommendations for

organisational policy, practice, education, and academic research within mental health services, with the anticipation that they will be considered and applied as an alternative narrative to enhance the workplace experiences of all staff with lived experience of mental health problems. Finally, this chapter will provide a reflection on the study limitations and highlight potential areas for further research before closing with a short conclusion.

7.2 Summary and Discussion of Findings Chapter 4: Fulfilling the Organisational Narrative: Practicing What We Preach?

The purpose of this chapter was to offer context to the study and position the organisational narrative that underpins the case study organisation's culture through the voices of its senior leaders, identified in this thesis as policy makers. The term policy makers was chosen to categorise this cohort as each of the individuals interviewed had considerable responsibility for determining organisational policy and how it was enacted. This served to provide a framework through which to understand the case study organisation's ambition in relation to the recruitment and retention of staff with lived experience of mental health problems, how senior leaders notionally sought to capitalise on that experience to improve services and enhance clinical outcomes for patients, and how the organisation then supported these staff.

Within the academic literature there is a growing body of writing about employing people with lived experience within mental health trusts, however the majority of these relate to Peer Support Workers (PSWs) or individuals in voluntary advisory roles as service user champions, with the specific aim of influencing policy change and practices within services. Few academic works focus on

NHS staff with lived experience of mental health problems beyond the PSW role, and those that do largely concentrate on primary mental health conditions, such as low-level anxiety, depression, and burnout, mainly in acute hospitals, as opposed to mental health trusts. Such paucity of information means that there are very few comparable studies, however collectively those that do exist contain some useful overarching principles.

By examining the relationship between mental health and employment from multiple perspectives this study contributes to a better understanding of how these two factors interact and impact on each other within a mental health trust. Furthermore, the study's unique approach to data collection and analysis provides a fresh perspective on the subject, offering insights that were previously unexplored. Accordingly, it has key implications in terms of policy formulation, education and guidance, for mental health trusts as well as other NHS trusts and health and social care employers.

Central to the findings was the collective belief that staff with lived experience of severe and enduring mental health problems can and do successfully deliver clinical care to others within a secondary mental healthcare setting, provided that they themselves are given the right support, treated with compassion and made to feel valued; something which policy makers identified was lacking in places.

Whilst there is limited research on the value of clinical staff with lived experience working for a mental health trust, beyond the PSW role, studies suggest that with proper support, individuals with lived experience can indeed thrive and succeed. This is supported by a plethora of authors such as Fisher (1994), Perkins and Rinaldi

(2002), Wheeler (2002), Seebohm and Grove (2006); Hogg and Kemp, 2020; von Hippel at al., (2022); Stuetzle et al. (2023); and King et al. (2023). Policy makers were keen to emphasise that despite the added burden often placed upon them in terms of managing such staff, this and any additional risks were worth it. These staff, they asserted, contributed an added dimension to the workplace, through their insight, authenticity and empathy. This is supported in the literature by writers such as Jung (1951/1985), Hall (1996, 1997), Conti-O'Hare (1998), Brandon (1999a), Cain (2000), Mander (2004), Kottsieper (2009), MacCulloch and Shattell (2009), Kundra and Salzer (2019), von Hippel et al. (2022), and Stuetzle et al., (2023), who identify the clinician's lived experience as an essential and powerful component in the healing process, not a weakness, or as Kottsieper (2009, p. 174) describes it, "an additional competence"; where individuals use the power of their own wounds to help heal others.

Consequently, policy makers claimed that in a well-managed and supportive team all staff, including individuals with lived experience, would feel valued. The team would work around each other's strengths and challenges, and unique skills and differences would be recognised and celebrated. This is in line with the aspirations of the 'Exemplar Employer' report entitled 'Leading by Example: Making the NHS an Exemplar Employer of People with Mental Health Problems' (Seebohm and Grove, 2006), which reminds UK mental health trusts that they have a duty to support the health and wellbeing needs of the thousands of staff they employ with lived experience of mental health problems. The report provides practical advice and guidance for managers both within the NHS and beyond on how to be 'Exemplar Employers', one of which includes signing up to the 'Mindful Employer' Charter,

a commitment to a number of identified standards. The case study organisation is a Mindful Employer signatory.

Contrarily, such experiences were identified by policy makers as rare within the organisation, a conclusion mirrored in the aforementioned academic literature and in the findings of the interviews with staff with lived experience. Inconsistency of support across the organisation resulted in an inequity of experience for staff with lived experience, with numerous examples given of managers rejecting the skills and the corresponding 'added value' such staff bring; all of which were wrapped up in demonstrations of personal and professional stigma, and an ensuing lack of compassion. This had an impact on the workplace experiences of staff with lived experience and, as asserted in the findings, their ability to realise their career potential. In conclusion, an organisation that was on the whole failing to meet the needs of its staff with lived experience. Studies by researchers such as Crawford et al., (2013), Jeffrey (2016), Sinclair et al., (2016), Sinclair et al., (2017) and Stuetzle et al., (2023), confirm a similar gap in compassion and understanding amongst healthcare professionals, including managers.

Such a conclusion was deemed oxymoronic to many of the policy makers, who highlighted that as a mental health trust the organisation was not "practicing what it preached" (Christine, PM23); that it should be exemplar in its performance, in spite of management pressures and the changing face of the NHS. This reinforces the assertion of Paynter and Rivers (2015, p. 149) who wrote:

> Inside these statistics stands a deep irony; that mental health trusts- organisations whose bread-and-butter activity is diagnosing mental illness and actively supporting recovery, which have so much expertise and knowledge about mental health, recovery and illness – have so little to say about the mental health of their workforce and about the people with lived experience who work within them. This silence sets up a paradox for those with lived experience working in mental health services, as narratives of health and wellbeing, recovery and therapeutic optimism are undermined by the lack of overt support for, and presence of staff with lived experience providing mental healthcare and support.

For Paynter and Rivers (2015) the organisation should be an exemplar to others and its staff should naturally excel in supporting both its patients and the staff who care for them, as that is their professional role. This claim however suggests a challenge to the validity of one of the assertions in this study, namely that training is needed to up skill managers to enable them to better support staff with lived experience; the rationale being that managing staff with lived experience was different and often more complex than patients, something that Paynter and Rivers emphatically refute.

The need for enhanced guidance and support for staff with lived experience was also an important finding from this chapter, particularly around disclosure and boundaries. This supports the literature, which highlights the importance of reflexivity for therapists, perhaps enhanced within the confidential confines of clinical supervision following personal psychiatric disclosure (Cain, 2000; Laskowski and Pellicore, 2002; Canfield, 2005; Arnaud, 2017; King et al., 2023).

Chapter 4 concluded that the organisational narrative, through the eyes of its policy makers, did not reflect the workplace experiences of staff with lived experience and that as a whole the organisation failed to meet their needs. That despite their hopes, lived experience was not fully valued as a professional credential, something that they felt powerless to remedy. The next two chapters changed the focus, exploring this from the perspectives of staff with lived experience, through the two intertwined themes of: negotiating identities; and the double-edged sword of power and powerlessness.

7.3 Summary and Discussion of Findings Chapter 5: A Balancing Act: How Staff with Lived Experience Negotiate their Identity

This chapter sought to interpret the findings in terms of how staff with lived experience experienced the workplace. Despite their occupation being highlighted as integral to identity formulation, it introduced the concept of staff who found their resultant identity to be in one of perpetual liminality: a place of limbo where they neither belonged to the world of patient or clinician, sometimes even fluctuating between the two; at times conflicting in an uncomfortable, chaotic dance. This concurs with the writings of Richards et al., (2016, p. 1) who described this as "unintegrated identities". Those who did identify primarily with one world more than the other still did not inhabit the whole of that world, regardless of how hard they tried, resulting in personal and professional tensions.

The data also implied that the identity formulation, and subsequent identity regulation, of staff with lived experience were heavily influenced by societal stigma, often exacerbated by professional

stigma within the workplace. It was highlighted that staff were a microcosm of the wider society in which they lived; a society that Tajfel and Turner (1986) asserted shaped their self-identity; defined by Tajfel, earlier in 1981 (p. 255) as:

> …that part of an individual's self-concept which derives from his knowledge of his membership of a social group together with the value and emotional significance attached to that membership.

It noteworthy, however, that a mixed methods study conducted by Stuetzle et al., (2023) in Germany, which explored stigma among 182 mental health professionals with lived experience, revealed minimal levels of self-stigma among the participants. Whilst the authors recognised the need for further research on this subject, they proposed that individuals who closely identify with their lived experience are less inclined to self-stigmatize, contrary to the findings in this study.

The approach adopted by Tajfel and Turner (1986) to social identity theory influenced the writings of later social psychologists such as Ashmore, Deaux, and McLaughlin-Volpe (2004) and Ruble et al., (2004) who focused on the wider societal influences on identity in the form of collective identity as opposed to personal identity. This was confirmed in the present study's findings where for some staff it meant hiding their lived experience, for fear of being 'othered' and separated into an 'us and them' category. The result was that they felt destined to suffer in silence, afraid that if they did not they would be "culled" once out of the herd (Ted, LE3). Of particular interest was that this was also true for many of the Peer Support Workers, where lived experience of mental health problems was an essential criterion of the role. This staff group,

despite having their own collective 'peer identity', one based on mutual support, shared experiences and the desire to be a unique entity, did not always feel able to be themselves at work, sometimes fearful of the repercussions, and at other times powerless to affect change.

Chapter 5 concluded that clinicians with lived experience of mental health problems, regardless of how they personally identified, worked within a system that did not fully value their lived experience. Identity, it was asserted, was so heavily regulated that staff often felt unable to formally use their 'wounds' to help others, often resulting in them using them informally and in secret. The next chapter focused on the second key theme that was identified by staff with lived experience, namely the double-edged sword of power and powerlessness; one that was clearly intertwined with negotiating identities.

7.4 Summary and Discussion of Findings Chapter 6: Wielding the Double-Edged Sword of Power and Powerlessness

As with Chapter 5, the ambition of this chapter was to interpret the findings to understand how staff with lived experience encountered the workplace. Exploring the second overarching theme that emerged from the data, namely the dialectical opposites of power and powerlessness, this chapter concluded that lived experience, when wielded, was a double-edged sword for the majority of the interviewees and their colleagues. Their lived experience sometimes had a positive impact on their working lives and at other times negative. It was a tool that could both enable and disable, but always one that was imposed on them, which they had little or no control over. This confirmed Foucault's assertion that

power and powerlessness is influenced by material, social and normative factors and dependent on the contexts individuals found themselves in (Broer et al., 2014). Other authors such as Rafael (1996), Widder (2004), Collinson (2005), and D'Cruz and Noronha (2013) have found utility in using these Foucauldian principles to understand the dialectics of power and powerlessness within organisations and wider society. As Widder (2004, p. 412) wrote, when addressing the works of Foucault:

> Power operates to impose identities on its subjects and that resistance, which may itself be considered a form of power, works to oppose this first power and thereby dissolve or deconstruct power's identity formations.

Furthermore, key to these chapter findings was that staff with lived experience, despite being encouraged to join the organisation because of their lived experience of mental health problems, were constrained from sharing such experiences. Organisational policies and procedures, particularly those concerning boundaries and disclosure often censored them, rendering them helpless and unable to ask for support, thereby relegating them to suffer in silence.

Conversely in scenarios where individuals were able to use their lived experience to help others, the outcomes were described in words such as "profound" (Alice, PSW5), "it lights a fire" (Betty, LE7), "it makes me more compassionate" (Aisha, LE11), "I'm a better psychologist because of my experiences" (Duncan, LE10), and "it made me a better nurse" (Danny, LE8).

Lived experience, it was concluded, was simply tolerated, and used tokenistically by policy makers and managers when the situation

dictated it, and the potential power that Paynter and Rivers (2015, p.148) described "as the silent (and invisible) conduit through which the shift from ill health to health is achieved" was not fully understood or realised.

However, in spite of such rebuffs, staff with lived experience still chose to work for the organisation, perhaps a testament to the strength of their conviction to help and heal others.

7.5 Overall Discussion

Having summarised the key findings of each of the three preceding chapters, this chapter will now consider the contributions of these findings in relation to the research questions and the related literature presented in Chapter 2, within the context of the case study organisation:

'How does a mental health trust support clinical staff with lived experience of mental health problems; and how do these staff experience work, in light of their mental health problems?'

Two horizontal arguments (see Figure 5) emerged from the findings of the interviews with staff with lived experience and policy makers, both of which are corroborated by the academic literature. The first is the notion of the Exemplar Employer, the gold standard expected of NHS mental health trusts by the government and the staff who work for them (The Standard). This theme frames the case study organisation and other NHS trusts within the national policy context and helps determine whether the experiences and expectations of staff with lived experience are synonymous with The Standard. The second horizontal argument is that of the value of lived experience; the concept of the wounded healer, namely the

staff member with lived experience of mental health problems, who within a supportive environment, such as that identified in The Standard, can use their wounds to heal others.

7.5.1 Practicing What We Preach: The Exemplar Employer

As identified in Chapter 3.2.1.1 the Case Study Employer is a signatory of the Mindful Employer Charter, a key requirement of all exemplar organisations, as defined by Seebohm and Grove (2006) in the report 'Leading by Example: Making the NHS an Exemplar Employer of People with Mental Health Problems'. This report clearly states that NHS organisations, particularly mental health trusts, have a duty to support the health and wellbeing needs of the many staff they employ with lived experience of mental health problems. Boorman (2009a, p.6) supports this in his report on the health and wellbeing of NHS staff, where he asserts that the NHS in particular "has an opportunity to lead by example".

The term used to define NHS trusts that demonstrate 'gold standard' support for staff with lived experience is described in the grey literature as the 'Exemplar Employer'.

7.5.1.1 The Exemplar Employer

The concept of the Exemplar Employer is not new to employment practice. Perkins et al., (1997) allude to it via the concept of exemplars when referring to a number of NHS trusts who had introduced policies aimed at tackling employment discrimination and were demonstrating good practice through the provision of supported employment. Sayce and Boardman (2003) also make reference to it in an article outlining the crucial role psychiatrists have in "enabling the NHS to become an exemplar in employing people with mental health problems" (p. 403).

The term 'Exemplar Employer' is formally recognised in Seebohm and Grove's aforementioned 2006 report, published by the Sainsbury Centre for Mental Health. The basic premise of this report is that mental health trusts across the UK employ thousands of people with lived experience of mental health problems and that they have a duty to support the health and wellbeing needs of these staff. It also encourages NHS trusts and other public sector employers to see the many benefits, both moral and business-led that employing and supporting the employment of such individuals can bring. The report provides practical advice and guidance for managers both within the NHS and beyond on how to be 'Exemplar Employers' using case studies to highlight key messages and offering practical tools to support the work, one of which includes signing up to the 'Mindful Employer' Charter, a commitment to a number of identified standards.

Seebohm and Grove highlight the potential of a previous successful project in relation to supporting staff with serious mental health problems. It recounts that between 1995-2005, the 'User Employment Programme' at South West London and St. George's Mental Health NHS Trust (SWLSTG) effectively supported 126 people in jobs within the organisation, 80% of whom had an admission to a psychiatric hospital and 43% of whom had a diagnosis of psychosis (Seebohm and Grove, 2006, p. 64). What it does not provide however is an interpretation of the specific health needs of clinicians with serious mental health problems and examples of ways in which they can be best supported to succeed within the working environment, one of the two main questions in this thesis. Whilst they did make recommendations these were only general and did not specifically relate to the needs of clinicians with mental health problems, unlike the cohort in this case study.

The term 'Exemplar Employer' is next identified in the report 'Mental Health and Employment in the NHS' (Department of Health, 2008), again drawing upon the exemplary practice demonstrated by the User Employment Programme at SWLSTG. The 2008 report highlights this workplace programme's success, through its provision of support for staff with mental health problems and its active encouragement of past service users in applying for posts within the Trust. This, the report suggests, sets the standard of expectation for all NHS trusts, drawing on the point that the NHS as a major employer should be setting an example and leading the way.

Steven Boorman, in his foreword to the 'NHS Health and Wellbeing: Final Report' (2009b) reinforces this expectation, underlining the importance of the NHS practicing what it preaches in relation to looking after staff health and wellbeing. Not only do his words clearly identify that there is an expectation on the NHS to model good practice, but a suggestion in his final words that NHS staff deserve better: "the cobbler's children do not deserve bad shoes" (p. 3).

Such an approach is contrary to the academic literature (Fisher, 1994; Perkins and Rinaldi, 2002; Wheeler, 2002), which places the onus on the individual with lived experience to make the necessary changes, for example focusing on ensuring they are well, that their wounds are healed, that they do not breach boundaries, and that they personally and proactively seek appropriate support. Instead, Boorman (2009b) places a responsibility on the organisation, in partnership with the individual staff member, something that is confirmed in the findings of the interviews with policy makers, and indeed staff with lived experience.

Of particular significance is that when interrogated, the data suggest that the policy makers had an assumed power, one that the majority of them implied that they did not in fact possess. All but one of the interviewees recognised that the organisation was falling short and/or failing staff with lived experience, but despite their overwhelming desire to improve the workplace experiences of these staff they reported feeling impotent to challenge and thus achieve the necessary change; shackled by the very policies and practices they had wittingly endorsed. Furthermore, none of the policy makers offered insight as to how they as leaders could effect change and improve staff experience. This suggests that they, in spite of having inferred organisational power, felt powerless to influence change, in a similar way to those staff members with lived experience whose findings were highlighted in Chapter 6. This implies the presence of ingrained organisational structures that, in spite of positive leadership intent, suppressed progress. This highlighted the paradox of senior leaders with the ability to effect change, but who were constrained as they did not possess any real power. This postulates that policy makers did not believe that the organisation practiced what it preached and fell short of the standards required of an Exemplar Employer, one where they as senior leaders had the authority to influence and implement positive change.

This finding can be situated in the writings of academics such as Fayol (1949) and Weber (1958) whose works explore organisational bureaucracy. Weber defined organisational bureaucracy as the administrative functioning of an organisation, whereby its policy makers are necessitated to develop a structured approach to decision making, which involves the application of established rules and precedents (policies, procedures and practices) to ensure fairness, consistency, and accountability

(Lutzker, 1982, p. 121).

However, Weber argued that bureaucracy was a double-edged sword (King and Lawley, 2019, p. 44) as it, with its emphasis on rules, hierarchy, and efficiency, had the potential to become an "iron cage" that confined individuals due to its rigidity (Weber, 1958, p. 181). Furthermore, he asserted that as bureaucracy grows in complexity, it becomes increasingly rule-bound and disconnected from individual needs and desires (Weber, 1958). This supports the study finding detailed above, by suggesting a shift in focus by policy makers from human interaction and innovation to the strict following of rules and procedures. This, according to Weber (1958) can lead to a loss of flexibility and adaptability, as decision-making becomes slow and weighed down by endless red tape.

Consequently, as is illustrated the case study data, individual autonomy and creativity are stifled, as employees are expected to conform to established protocols rather than take initiative, think creatively or take even the most benign risks. This had a particular impact on the organisational understanding, acceptance and support of staff with lived experience of mental health problems. This postulates that bureaucracy was the most likely reason behind the inaction of those policy makers interviewed, as opposed to powerlessness. For as Buchanan and Badham (2020, p. 4) citing Keltner (2017, p. 10) state, "powerlessness means having little control over one's life, which is caused by poverty, inequality, [racism], and gender bias". None of the policy makers met the criteria of being powerless, but their testimony suggests that they were bound by bureaucracy and a desire to maintain the status quo. Furthermore, it is suggested that the policy makers interviewed, simply went through the motions and obeyed the

organisational rules and practices, but with an apathy as opposed to a genuine commitment. (Wastell et al., 2010; Waring, 2014; Waring et al., 2023).

It is worthy of note that there has been no reference to the Exemplar Employer organisation in the grey literature or the academic literature since 2013. This suggests that within a relatively short period of time this initiative was no longer a governmental priority. Consequently, without this national drive and the resulting oversight it fostered, this NHS directive fell into abeyance within the case study organisation. Glen Forest NHS Foundation Trust, like its comparators, was no longer being held to account, therefore indifference crept in, and inaction pervaded. Consequently, the findings suggested that staff with lived experience of mental health problems did not believe that the organisation met the stipulated standards of an Exemplar Employer in terms of supporting their needs. The organisational narrative did not match their experiences and coupled with the societal stigma that manifested itself in the workplace in the form of personal and professional stigma, the majority of interviewees with lived experience found themselves caught in a precarious position between the role of staff and patient. Consequently, the experiences they recounted did not epitomise the type of organisational culture described by Seebohm and Grove (2006) as belonging to that of an Exemplar Employer; the liminal space that they occupied was not the expected comfortable and nurturing environment (Croft et al., 2015).

7.5.1.2 Occupying the Liminal Space

The findings highlighted that the liminal space staff with lived experience occupied was not the comfortable space one might infer to be the best of both worlds. Instead, it felt unsafe, precarious,

and unstable, as opposed to feeling one had two feet firmly planted on the ground. They inhabited a space at the top of the precipice between their two worlds, struggling to maintain their balance and teetering on the edge- unsure if and when they would fall, due to variable levels of support, sometimes adequate, at other times not. It was a place where lived experience was not fully valued as a professional credential and staff could not bring their whole selves to work, contrary to the expectations of what an Exemplar Employer should be like (Paynter and Rivers, 2015).

It is suggested that this may be due to the fact that all of the interviewees worked in an environment that is heavily regulated. Even staff employed in peer roles, who are appointed due to their lived experience, are constantly urged to regulate their identities and align with that of the professional. The work of Sveningsson and Alvesson (2003 p. 1188) corroborates this finding, defining the metaphor of personal identity within the organisational context as "a struggle".

This assertion suggests that when an individual's sense of self is challenged or disrupted, negative emotions such as tension, anxiety, shame, or guilt may arise. Additionally, if efforts to restore and maintain one's identity are unsuccessful, it can lead to increased tension and may even result in a breakdown in relationships. The work of Alvesson and Willmott (2002) and Croft et al., (2015) support this view by highlighting the importance of identity work and the consequences of its failure.

Bringing one's whole self to work is encouraged in theory but has not modernised sufficiently to make this their experience. This further supports the work of Sveningsson and Alvesson (2003) who argue that the modification of professional identity has become a

significant area of focus in professional and organisational studies. The authors reference Du Gay (1996), who suggests that such reforms have aimed to modulate and at times control the professional identity of individuals working in the public sector. This implies that these reforms have sought to redefine and shape how professionals in the public sector see themselves and their roles.

The resounding organisational message is that staff should be empathetic not sympathetic, in line with the Medical Model in which psychiatry is still firmly grounded (Moulding, 2015; Byrne et al., 2016; Huda, 2019). Furthermore, staff with lived experience, despite being encouraged to work for the organisation and to bring their authentic self, are being instructed not to talk about their own thoughts, feelings and experiences when at work; and to leave these at the door when they cross the workplace threshold, as not to do so is deemed unprofessional. This is consistent with the findings of Dunlop et al., (2022), Stuetzle et al., (2023), and King et al., (2023), whose research identified that the beliefs and practices of some professionals were not in line with current professional and organisational guidelines. This, as one would anticipate, has a negative impact on the staff member's way of working and therefore their resultant identity. It also engenders a sense of powerlessness, which was explored in Chapter 6. This can be explained in theoretical terms as a constant interplay between identity formation and the rhetoric of identity regulation. This, as described, has implications for job satisfaction, moral distress, health and wellbeing, and from an organisational perspective, staff retention. This is illustrated using Alvesson and Willmott's model of 'Identity regulation, identity work and self-identity' (Figure 6), which outlines the complex and dynamic nature of identity regulation.

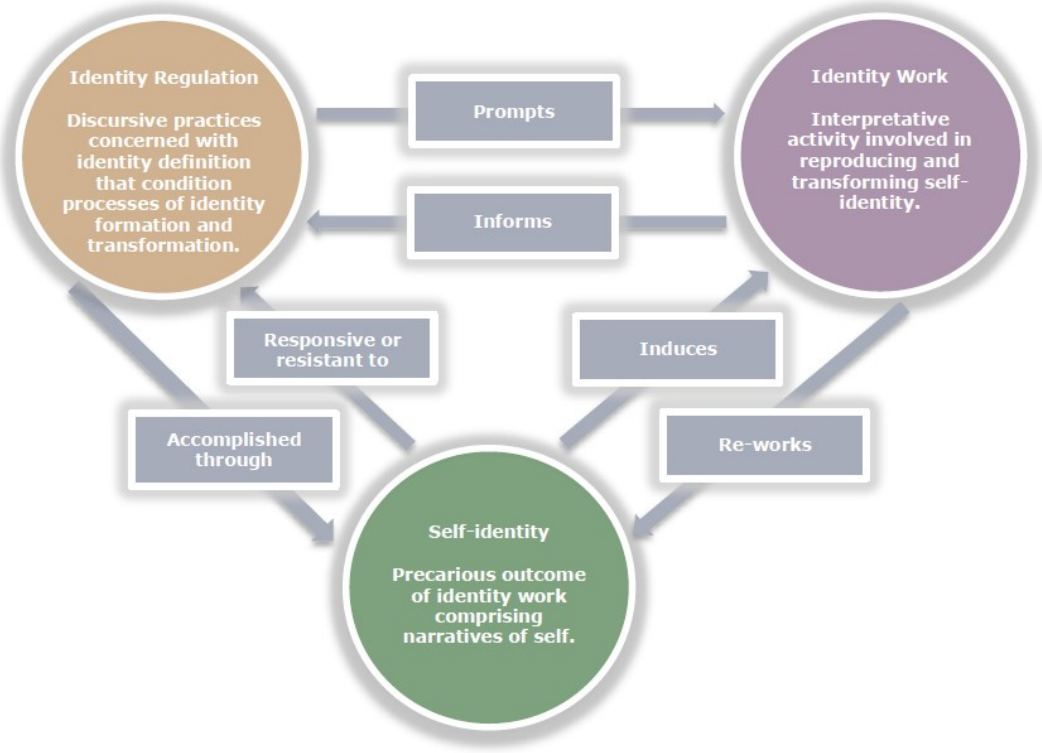


Figure 6: Identity Regulation, Identity Work and Self-Identity (Adapted from Alvesson and Willmott, 2002, p. 627)

It emphasises the interplay between external factors and internal processes in shaping and re-fashioning self-identity and in doing so contributes to our understanding of how individuals navigate and negotiate their identities within social and organisational contexts. This conceptualisation aligns with Giddens' (1991, p. 53) theory of reflexive modernity, which suggests that individuals actively shape their identities in response to social and cultural contexts.

> Self-identity is not a distinctive trait, or even a collection of traits possessed by the individual. It is the self as reflexively understood by the person in terms of her or his biography. Identity here still presumes continuity across time and space: but self-identity is such continuity as interpreted reflexively by the agent.

In order to support and retain these staff, Glen Forest NHS Foundation Trust and other NHS organisations need to ensure that there are effective support mechanisms in place, such as mentoring programs, debriefing sessions, and access to counselling services, to assist employees in managing these conflicts and maintaining their wellbeing.

Furthermore, the findings suggested that support often depended on the manager, so while they may have felt comfortable and safe with their current manager (harmonious identity), that could alter suddenly should their manager change. The hallowed, fully inclusive space would be one where they could be themselves in the workplace should they choose to do so, where they were not ashamed or embarrassed about their lived experience, and could use it to help others, should they choose. Consequently, there was a need for perpetual liminality to be eradicated and for hybrid functionality to exist. A hybrid space, which entails the best of both worlds and enables them to bring their whole selves to work and recognises their unique identities a workplace that matches that of an Exemplar Employer (Seebohm and Grove, 2006; Jeffrey, 2016; and King et al., 2020). This is consistent with the findings of Richards et al., (2016, p. 8), however they describe the hybrid space in terms of an "integrated identity". This term however does not adequately convey the complexity of the hybrid identity and suggests assimilation rather than celebration.

It is noteworthy that these staff, despite their inferred powerlessness, chose to work in healthcare. Individuals who at times have straddled two often conflicting identities, each with resultant power dynamics, but who still chose to work there; to allow themselves to be vulnerable and use their lived experience to help others (Wolgien and Coady, 1997; Gilbert and Stickley, 2012;

Stuetzle et al., 2023). Each of these staff could have chosen to work in a different profession, in an environment where they did not need to give as much of their personal self and face the difficult experiences they often encountered, but instead chose to work in a mental health trust; one that they suggested did not meet their needs and consequently the required standard of an Exemplar Employer (Perkins et al., 2009; Perkins, 2010). Appropriately, the second horizontal argument identified through this study relates to those staff, who despite the many challenges encountered, are drawn to work in those caring professions, couched in the espoused ideals of the NHS. Individuals, who due to an inherent understanding of the value of lived experience have an overwhelming desire to use their own experience of mental health problems to help others (Fisher, 1994; Kottsieper, 2009; MacCulloch and Shattell, 2009; Sanchez-Moscona and Eiroa-Orosa, 2021; von Hippel et al., 2022). Such altruistic intent personifies the concept of the wounded healer and through their workplace experiences enhances our understanding of lived experience and the resulting body of academic knowledge (Conchar and Repper, 2014).

This study sought to understand the voices of staff with lived experience, and by highlighting their struggles to raise awareness that would incite the necessary change. As Sveningsson and Alvesson (2003, p. 1190) wrote:

> In order to understand identity in depth we need to listen carefully to the stories of those we claim to understand and to study their interactions, the discourses and roles they are constituted by or resist – and to do so with sensitivity for context. We […] would encourage more open-minded efforts to explore the more vital aspects how people define and re-

> define themselves. We can ask how do people see themselves in organisations, as part of and/or in addition to how do they perceive and identify/ disidentify with organisational identity and/or distinct social groups.

7.5.2 The Wounded Healer

The archetypal image of the 'Wounded Healer' has permeated societal thought since the beginning of time. Most writings on the subject attribute the concept to the Greek myth of Chiron, with other writers identifying later parallels in many different cultures (Jackson, 2001; Benziman et al., 2012). According to mythology, Chiron was a centaur with healing powers who was accidently wounded by a poisoned arrow from the bow of Hercules, resulting in a painful and incurable wound. As a consequence of his wound and his devotion to the healing of others he was designated as the epitome of a wounded healer (Jackson, 2001).

It is clear from Jung's writings (1963, 1951/1985) that he personally attributed the notion of 'wounded healer' to the myth of Chiron, developing the concept into a metaphor, which influenced his early 20th century psychoanalysis and analytical psychology work. Jung (1951/1985, p. 116) writes:

> A good half of every treatment that probes at all deeply consists in the doctor examining himself, for only what he can put right in himself he can hope to put right in the patient… it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician.

The application of the metaphor was then extended by Henri Nouwen in 1972 in relation to pastoral ministry (Nolte and Dreyer,

2010) and later by others such as White (2000), Jackson (2001) and Kirmayer (2003), to include other helping professions such as nursing, rehabilitation medicine, psychotherapy, chronic-illness support groups, and Alcoholics Anonymous and the self-help movement.

7.5.2.1 Using Wounds for Healing

As identified in Chapter 5, the majority of staff with lived experience suggested that they used their own experiences, or wounds, to help heal their patients. Often this work was covert, for reasons including a fear of being seen as crossing boundaries and being deemed unprofessional. Habitually this acquired competency was unconsciously assimilated into their practice, an integral part of who they were and who they had become as a consequence of their lived experience; something which also frightened some of the interviewees on reflection for fear of this being discovered. This was not the case for Peer Support Workers (PSWs), whose lived experience was a pre-requisite for their role. However, despite this, PSWs experienced many of the same challenges encountered by staff with lived experience as a whole and, as described in the findings chapters, a few that were unique to their cohort.

7.5.2.2 The Motivations of a Wounded Healer: The Good Samaritan or Self-Rescue?

Central to the concept of the Wounded Healer are the reasons why individuals with lived experience of mental health problems choose to work within mental health services (Conchar and Repper, 2014). According to von Hippel et al., (2022, p. 1004), "… a history of mental health issues appears to draw people to work in the mental health sector". Awareness of the rationale for people's motivations helps us to better understand the needs of staff with lived experience in the workplace and how to best support them.

The academic literature that focuses on clinicians using their own personal experiences within the healing professions suggests that the second most common reason for such staff entering the mental health profession is to protect others from the feelings and abuses that they, and others, have experienced as patients (Deegan, 1995; Adame, 2011). Adame (2011) introduced the concept of 'survivor-therapist'; an individual who has lived experience of mental health problems but who also practices as a counsellor/ clinical psychologist. Outlining the stories of a number of survivor-therapists who have had very negative experiences of the mental health system, from human rights abuses to being devalued as therapists, Adame illustrates their determination and resolve to make a difference. Recounting the story of the survivor-therapist Pat Deegan, who has been given a diagnosis of chronic schizophrenia, Adame writes that Deegan's resolve was to leave hospital and become a psychologist with the aim of preventing others from experiencing the things that she had there. This is however an over-simplification of Deegan's ambition, for as she herself more emphatically writes:

> I was so outraged at the things that had been done to me against my will in the hospital as well as the things I saw happen to other people, that I decided that I wanted to get a powerful degree and have enough credentials to run a healing place myself (Deegan, 1995).

This was consistent with the findings of this study where three of the interviewees alluded to a similar motivation for entering the therapeutic professions. As Naomi stated:

> I think the whole reason I got into therapy was because I'd had such a bad experience of therapy, so it motivated me to

> be there and listen to people and actually offer something concrete that would make the whole process feel worthwhile, [and]… it's influenced my… style of therapy (Naomi, LE2).

Similarly, Betty recounted:

> I definitely went to peer support in order to… give something back and to create… a service that I didn't receive myself, and to be a part of a positive change rather than just being angry (Betty, LE7).

The literature also suggests that a number of people enter the therapeutic professions as a mark of respect to someone in such a profession. Garry Walter (2003) believed he became a psychiatrist simply because he was influenced by the kindness a revered psychiatrist showed to his father while his grandparents were imprisoned in Nazi occupied Austria. This was a view shared by two of the interviewees in this study. Ted became a psychiatric nursing assistant to pay back the kindness he received from a nurse who gave him a home during a difficult period of his life; someone he described who had shown him "complete unconditional regard" (Ted, LE3). For Ava it was her admiration of a psychiatrist who cared for her in a truly person centred way:

> From day one […] I knew what a productive, successful, and positive therapeutic relationship looked like (Ava, LE5).

By far the most common theme that emerges from academic research is the individual's need to self-heal. Richard (2012, p. 132) writes: "Like many amongst us, I believe, I became a therapist to heal myself". This is a view shared by Mona Shattell, a psychiatric nurse, who defines herself as a wounded healer having

'confessed' to using mental health services (MacCulloch and Shattell, 2009). Shattell (p. 135) asserts that she was naturally drawn to the profession as she believed that she would potentially find within it "both understanding and cure". This resonates with Maeder (1989, p. 37) who rather tersely writes:

> The helping professions, notably psychotherapy and the ministry, appear to attract more than their share of the emotionally unstable wounded healers.

What is interesting is that none of the interviewees in this study, despite gentle probing, talked about entering the therapeutic professions to heal themselves. A possible exception to this was Jake (LE6), a self-confessed service avoider, who agreed that while helping others was therapeutic to him, he still had not figured out how to best look after himself. A possible explanation for this not appearing as an area of note in this study is that all of the interviewees had reached a position of maturity in their lived experience, where the need for self-healing was no longer a focus of their agenda. An alternative response is that individuals, believing that admitting to entering the profession to self-heal would be viewed as an anathema, did not mention it. However, the latter seems unlikely due to the high level of detail and disclosure that they all shared in the interviews.

This supports the supposition of Benatar (2000, p.23), who in a paper aiming to identify and explain issues around transference and countertransference in the therapeutic relationship between survivors of sexual abuse and their therapist, alleged:

> Experience seems to be an important mediating factor in defining vulnerability. Vulnerable therapists hopefully have

> selected themselves out of the field, or made themselves substantially less vulnerable through further training, supervision and their own personal psychotherapy.

Noteworthy is that this assertion also suggests an assumption that vulnerable staff are aware of their frailties and take action to increase their resilience, and additionally a view that the onus is on the individual to seek support and be healed, and not the employing organisation.

Without exception, all of the staff with lived experience interviewed asserted that they entered the caring professions due to an innate desire to use their lived experience of mental health problems to help heal others and not to heal themselves. This is best exemplified in an anecdote shared by Iain (LE9) at the end of the study interview, once the tape was switched off and we were exiting the room. He mentioned that when he was unwell, he invented stories of superheroes to get him through the difficult times; he would be the superhero helping others through their dilemmas, in spite of his own wounds being open. This reminded me of those who, having suffered adversity, use that experience to help others despite their own personal pain, whether it is physical and/or mental. This suggests that the wounded healer does not always need to be whole; a key area of contention within the wounded healer discourse (Conchar and Repper, 2014). An alternative explanation is that by donning a disguise, an individual can hide their true self from the outside world and do things they may not feel confident in doing as themself, instead pretending they are someone else.

7.5.2.3 The Power of the Healer's Wounds

> Now the most skilful physicians are those who, from their youth upwards, have combined with the knowledge of their art the greatest experience of disease; and should have had all manner of diseases in their own persons (Plato, Republic 3.4081, Jowett, (1937), p. 673).

As identified earlier, all interviewees alluded to the concept of the wounded healer. All of the participants identified the impact their lived experience of mental health problems had on themselves and their patients. They described 'lived experience' as a strength, something that could enhance professional practice and improve patient care, thereby turning negative experiences into positives (Elise, PSW3). However, a small number of the interviewees also highlighted areas where it could be viewed as a weakness, mainly looking through the stigmatising lens of self and others who advocated that clinicians must always appear strong (Stuetzle et al., 2023). Consequently, Sarah was quick to point out the importance of those with lived experience resolving their own problems before offering support to others:

> I worked in a children's home [...] I always wanted to work in that environment because I felt I'd got a lot to offer, but because I hadn't addressed my own issues it made me unwell (Sarah, LE12/PSW2).

Clear parallels exist between staff with lived experience of mental health problems working in therapeutic care and those who work in alcohol and substance misuse rehabilitation. In fact, Repper and Carter (2010) allege that these very roles can be seen as the precursor for formalised Peer Support. The wounded healer concept

initially developed within the alcohol rehabilitation setting in the 1930s and later became known as Alcoholics Anonymous (AA). In its simplest terms, AA can be described as a 12-step programme, whereby the mentors as recovering alcoholics (having completed the 12 steps) provide empathic support and guidance to other alcoholics. This association is often referred to as 'sponsorship'. As Jackson (2001, p. 28) writes:

> It is a recovery programme in which the sufferers are all alcoholics, and the healers are all alcoholics.

The mentors' "woundedness" is used to help heal the sufferer and in doing so motivates and encourages them to stay sober, noting that:

> Nothing will so much ensure immunity from drinking as intensive work with other alcoholics (AA, 2001 p. 89).

In fact, Naomi, one of the staff members with lived experience of mental health problems, explained how the wounded healer concept applied to her clinical work using the analogy of the AA's sister sobriety movement Narcotics Anonymous:

> It's like when we have ex-drug users working in drug services, they can say 'I've been there', 'I know how difficult it is' (Naomi, LE2).

This is closely aligned to one of the findings in Chapter 5, that highlighted that all of the staff with lived experience agreed that only those who have been personally wounded could "truly heal" others (Naomi, LE2). This assertion is supported by Cain (2000), who claims that the benefits that lived experience of mental health

problems brings to the profession is essential, particularly since little is still known about the causes of and treatments for key mental health problems. Similarly, Sedgwick (1994) is clear that Jung intended the term wounded healer to apply to those therapists who bring into their practice their vulnerabilities and testing life experiences. Consequently, he believes that it is the "wholeness rather than 'clean hands' perfection", which enables the therapist to heal others (Sedgwick 1994, p. 15). This is supported by Gilroy et al.'s (2001) study, which determined that the majority of female psychotherapists who had undertaken personal therapy for depression specified that the experience had positively influenced their personal practice as a therapist, developing skills including empathy and a sense of affiliation. Cain (2000) added to her earlier assertion by suggesting that the innate ability of wounded healers to offer empathy, based on their own lived experience, enhanced the possibilities of therapeutic success for their patients.

However, Davis (2009) disagrees, believing that empathy is all that is required, something that he feels can be cultivated by all clinicians if need be. Despite recognising that personal experiences can be a valuable resource in fostering empathy, he suggests that utilising one's own personal wounds can be potentially dangerous, therefore a measure of "compassionate detachment" (p. 77) is necessary to avoid countertransference of the clinician's issues to the patient. Consequently, by following his interpretation of the writings of Carl Jung, Davis claims that the patient's treatment is adversely impacted by the therapist's clinical judgment, which is clouded by their personal experiences. Furthermore, Davis's interpretation of the term 'empathy' within the clinical environment, suggests no more than the skill of active listening as opposed to true understanding, which is what he alleges Jung

(1963, p. 134) intended when he wrote "only the wounded physician heals".

It is therefore not surprising that the concept of the wounded healer is an area of great contention, particularly within psychiatry literature, for as Biering (1998, p. 334) writes:

> To transform into personal growth behaviours that were awakened by […] distress contradicts the basic assumptions Western psychiatry holds about mental suffering. Psychiatry does not expect the wound to promote growth, let alone foster healing potentials.

Cain (2000), referring to the work of academics such as Dickstein and Hinz (1992), Fink and Tasman (1992) and Fisher (1994), effectively sums this up in her work exploring countertransference in 'Psychotherapists with Personal Histories of Hospitalisation'. She concluded: "the mental health profession seems wary of wounded healers within its ranks" Cain (2000, p.22). This finding is clearly evidenced throughout the interviews involving staff with lived experience who, as Betty (LE7) described, were seen to be "flawed or weak," thereby reinforcing the concept emanating from societal stigma of 'us and them'.

7.5.2.4 Summary

This study reinforces the findings of the 'survivor movement' literature and challenges the dominant psychiatric discourse, emphasising that wounds are a strength that NHS trusts should actively exploit, not deny. Furthermore, by reinforcing the concept of the wounded healer, as outlined in the academic literature, it adds to this body of knowledge by asserting that it is unhealthy for staff with lived experience to be forced to renounce that integral

part of themselves. Many of the staff with lived experience that were part of this study expressed that they felt deprived of the freedom to bring their whole self to work due to restrictions inferred by organisational policies and practices, despite the organisational narrative to the contrary. In addition to perpetuating stigma and discrimination, such behaviours left staff with lived experience feeling devalued and estranged from their colleagues and patients. This is contrary to the expectations of an Exemplar Employer.

In addition, the findings of this thesis and the surrounding academic literature suggest that the archetypal image of the wounded healer and its application to medicine is as applicable now as it was throughout history. Accordingly, there are some suggestions that clinicians with mental health problems should be treated differently from the general population in light of the additional barriers they face. It is however unclear whether this is based on the stigma which remains unchallenged by many of the professional bodies, who fear that harm may come upon the patients of clinicians with lived experience, or as part of a genuine desire to help and support individuals. This is particularly pertinent, as until recently 'the old establishment' viewed the employment of people to whom it provided services as a conflict of interest; and indeed, as alluded to, many still do.

7.6 Concluding Thoughts

The findings from this chapter agree with previous research that individuals with lived experience encounter additional barriers and challenges in employment. In spite of this one might question why, if it is so bad, do so many staff with lived experience continue to work in the NHS, surrounded by a culture of secrecy that

undermines them? And why do policy makers perceive themselves as powerless to make change, in spite of their altruistic aspirations? Despite a variable collective experience, such a finding suggests that there is something about the NHS and other caring professions that draws such individuals to work within it: compassion, the desire to care for others, acknowledgement of the value the enhanced competency and insight lived experience brings, and hope; and for those who also have lived experience the desire to openly use their own experiences to help others.

However, creating a supportive working environment for all staff members with lived experience requires a multifaceted approach and should not solely rely on Peer Support Workers. While they play a crucial role in modelling how to use lived experience to help others, they cannot champion a culture of open-ness and acceptance on their own, nor should they be expected to. It is important that staff across the entire organisation, including policy makers and others with lived experience, play their part.

The interview data, supported by the academic literature, make it clear that there are several key issues that need to be addressed in order to create a more supportive workplace for individuals with lived experience; one where staff at all levels and in all professions can use and feel encouraged to use their own wounds to heal those of others; an environment where staff are able to be themselves at work should they choose to do so.

Firstly, policy makers need to prioritise and actively promote a culture that values and embraces diversity, including lived experience. This can be achieved through organisational policies that clearly state the commitment to creating an inclusive workplace free from discrimination and unfair treatment, as well as

leadership actions that demonstrate this commitment. This includes implementing inclusion policies and ensuring that non-discriminatory practices are adhered to throughout the Trust. Staff members should feel safe and supported in coming forward with their lived experience, without fear of negative repercussions. Access to mental health services, reasonable adjustments and flexible working practices should also be clearly visible in these policies to support individuals' mental health needs.

Secondly, it is important to create a culture of support and inclusivity within the workplace. There is a need for greater awareness and education surrounding mental health and lived experience, which can be achieved through awareness campaigns, professional development opportunities and mental health initiatives. Many individuals still face stigma and discrimination when it comes to disclosing and/or using their mental health challenges at work. Accordingly, it is suggested that Glen Forest NHS Foundation Trust needs to prioritise mental health training and resources to ensure that all staff members, including those with lived experience, are treated with respect and understanding. By actively promoting a supportive environment, the organisation can encourage open dialogue and ensure that staff members feel comfortable seeking help and support when needed. For this reason, it is important that the employee network, established to support staff with lived experience, is supported and resourced by the organisation and not relying on the good-will of members to facilitate in their own time. It is recommended that Peer Support Workers or other clinicians with lived experience, who understand the unique challenges faced by staff with lived experience, facilitate this group.

7.7 Reflections, Study Limitations and Potential Avenues for Further Research

The research work contained in this thesis has been structured around two distinct staff groups, presented in Chapters 4, 5 and 6, namely Policy Makers and Staff with Lived Experience of Mental Health Problems. These data were collected over a 16-month period while the author worked in the case study organisation in a senior management role. This section provides a reflection on the process and the methodology, which includes a brief consideration of its strengths and limitations and makes a set of recommendations to other researchers for future studies.

7.7.1 Reflecting on the Methodology

In Chapter 3, some critiques around the methodology of this study were noted, namely the case study approach (Campbell and Stanley (1963); Hartley, (1994, 2004)) and responded to using the arguments of qualitative researchers such as Flyvbjerg (2006), Hancock et al. (2007), Stake (2010), Tight (2017) and Thomas (2021). This section will provide a brief overview of why the single case study approach was an appropriate methodology for this study and how it resulted in the creation of a large body of rich and valuable data. It will also demonstrate how the author took great care in interpreting the findings for this study.

The main benefit of focusing on a single case study organisation was that it enabled the author to look at an individual organisation in detail and investigate it thoroughly. Over sixty hours of rich data were produced from the transcribed semi-structured interviews with thirty-six participants (twenty-four policy makers and twelve staff with lived experience) and the Peer Support Worker focus group (five staff). While it is accepted that the findings cannot be

generalised for direct application to other NHS trusts, there is an acknowledgment that the ideas and recommendations that have emerged from this study may be transferrable in a given context and be of value to other NHS and social care employers (Polit and Beck, 2010). As alluded to by Flyvbjerg (2006), policy makers within these aforementioned organisations, with the detailed information laid out before them, can decide whether it is appropriate to apply the findings to their own organisation.

On reflection, whilst the data collected were rich and varied, it might be argued that it was too much for one study. Although the author does not regret the time spent with any of the interviewees, it is important to acknowledge that this made writing this thesis more difficult than necessary due to the huge volume of information. However, had a data saturation marker been deployed this would have had no impact on the volume of data produced as it was not until the final interview with a psychiatrist with lived experience that data saturation had been reached. Despite this, on reflection, it is unlikely that any changes to the number of interviews conducted would have been made, as the findings show the necessary depth that is characteristic of the case study approach; one which enables triangulation of data to ensure trustworthiness and authenticity (Hamilton, 2011; Amin et al., 2020).

If more direct questions had been asked this would likely have cut down the amount of data collected, however doing so would possibly have steered the story in the wrong direction, namely the author's direction. It was better to be led by the interviewee.

The decision to conduct a Peer Support Worker (PSW) focus group, as stated in Chapter 3, was both deliberate and very effective, for

reasons that included safety in numbers as well as the intention to encourage discussion and debate. In fact, Chapter 5 postulated that PSWs were so comfortable in each other's company that they often finished each other's sentences during the interview. Furthermore, they described themselves in words that suggested a collective, to the exclusion of others, as if it was 'them against the rest of the world'. Although it is acknowledged that interviewing PSWs individually may have produced additional insights, this study suggests that the evidence of the 'pack mentality' that existed between PSWs would not have been evident in individual interviews.

As a result of the huge body of rich data collected, I initially struggled with writing the findings chapters. This was not only due to the overwhelming volume of data, but my personal investment. I wanted to ensure that everybody's voice was represented, so faced the dilemma of what information to leave in or take out. However, as a result of this immersion I gained a better understanding of staff with lived experience and was determined to ensure that their stories were heard. This made deciding which quotes to use and not use challenging. Through self-reflection and discussions with my supervisors I learned that often a few words can paint a powerful picture, and this is what I aimed to achieve- my interpretation of the case study organisation through the voices of its staff.

7.7.2 Engagement with Study Volunteers

It is important to acknowledge that as in all social interactions, the author's engagement with the participants shaped the data captured. Had another researcher analysed the interview data, their interpretations would likely differ from that of the author. Moreover, an interpretive researcher's presence cannot be

separated from the study (Gouldner, 2004; Davies, 2012), something that was particularly compelling since I was employed as a senior manager by the case study organisation, so in many ways was also part of the study.

Prior to the interviews, I was concerned that my role in the organisation could influence the outcomes of the interviews, for example, staff would perhaps not tell me the full extent of their experiences or simply tell me what they thought I wanted to hear (Flores, 2016; Blee 2019). In order to address this, I kept field notes (Appendices 10 and 11), which captured my reflections and observations before, during and after the interviews. I was fastidious in keeping the notes up to date noting any perceptions, possible biases, my interpretations of what was said and what was not said, inflections in voice, descriptions of body language, interruptions and so forth. As highlighted in Chapter 3, interviews with staff with lived experience were brokered through the Workplace Recovery Lead, to ensure staff felt safe and cognisant that their participation was voluntary. Psychological support was made available to any who required it through the Let's Talk Wellbeing Service or the Staff Counselling Service, as well as the Workforce Recovery Lead. To minimise any bias, I met regularly with my supervisors to discuss my findings, identify any concerns that had arisen and plan for future interviews.

As mentioned in Chapter 1, my profession is within Equality, Diversity, and Inclusion therefore I am used to working with 'seldom heard' groups, doing in depth work, such as casework, investigations and service audits. This is coupled with my background and training in Human Resources as well as my qualification and experience as a mediator. These skills and experiences I believe helped obtain the depth of interview that I

did, and the rich, quality data that ensued. It is clear from the transcripts of the data provided that interviewees felt able to open up to me and share very personal information, especially in relation to mental health disclosure, some of which included very personal details around self-harm and incomplete suicide attempts. I reflected in my field notes that at least ten of the staff with lived experience and five policy makers commented that they valued the study and the rationale I had for doing it, primarily because they saw it as an avenue for potential change (see Appendices 10 and 11). They invested their trust in me and saw it as an opportunity to have their voices, which had hitherto been suppressed, heard. This can be exemplified by quotes from two of the interviewees, a member of staff with lived experience and a policy maker:

> I'm a bit emotional actually but I feel blessed that I've been able to talk… openly, honestly and candidly […] I do feel quite honoured that I've been asked to do this […] and hopefully taking part in this'll make some changes (Victor, LE1).

> I think it's a fascinating topic that you've chosen to research into, and I'd be interested to look at it afterwards and see the different views […] I've always been able to identify people who I felt at times when I've needed support and things like that I've been able to go to and they have enhanced my mental health tremendously. And as I say people who make me smile, such as yourself, I have to say…. That's all that matters. That's all that matters. We all make the whole then (Lyn, PM10).

All of the interviewees stated that they were really keen to see the findings of this study once available, but more importantly witness

the changes that they hoped the recommendations would bring. I recognise the responsibility that comes with this trust and will endeavour to ensure that this study's findings are shared and disseminated effectively, ensuring that policy makers, staff with lived experience and other relevant stakeholders are made aware of the issues raised by staff with lived experience. This in itself can lead to meaningful discussions and actions aimed at creating a more supportive and inclusive workplace.

Having worked in Equality, Diversity, and Inclusion for over 20 years at the time of the interviews, and although not a trained counsellor or therapist I had developed a number of skills including, as highlighted above, the ability to self-reflect. It was a privilege to hear staff with lived experience openly share their stories with me, and while I was committed to ensuring my own self-care, I was blindsided by the effects their trauma had on my own personal health and wellbeing. Consequently, I spoke to my supervisors as soon as I realised this and procured the help of a clinical psychologist colleague to support me through clinical supervision.

This experience reinforced in me the importance of self-care and taught me about self-awareness and how critical it was to seek support from others when I needed it. I was however very aware that I was in a privileged position; I had resources, a supportive family, a senior role in a mental health trust where I knew people who could help when I needed it, and perhaps more importantly, did not have a diagnosed mental health problem. This served to change how I viewed staff with lived experience. Possibly for the first time I saw the real strength, tenacity and bravery exhibited by those staff with lived experience that I interviewed. I was shocked when I heard some of their personal and professional experiences,

yet careful not to convey this emotion to them. The time for acknowledgement and guided reflection was with my supervisors and clinical supervisor; not just in terms of countertransference, but also to ensure I did not overstep my role as researcher and become the saviour in search of justice.

7.7.3 Writing a PhD as an Employee of the Case Study Organisation

As identified in 7.7.2, I concluded that my employment as a senior manager in the case study organisation benefited this study. It gave me a unique position and perhaps meant that interviewees were more forthcoming than they may have been with an external researcher, particularly around such a personal subject; one where the conclusions did not always reflect positively on the organisation. Sharing such personal stories, ones where each interviewee's honesty and frankness may have had a detrimental impact on their employment status, required a high level of trust; something that an external researcher is unlikely to have built in such a short time. This contradicts the initial assertion of Ergun and Erdemir (2010, p. 17) who suggest that the 'inside researcher' may be deemed untrustworthy by stakeholders due to prior knowledge of those involved in the study, their connections, and their role within the case study organisation; a perspective supported by Wolf (2018). However, Ergun and Erdemir (2010) offset their earlier statement by acknowledging that being an insider has the potential to enhance the perceived trustworthiness of the researcher, as participants may feel more comfortable and willing to share their experiences, opinions, and personal information with someone who belongs to their community. This they suggest can lead to richer and more comprehensive data collection, enabling the researcher to gain a deeper understanding of the subject matter. Such polarisation of opinion as to whether the insider or

outsider researcher is the preferred position is, common within the academic literature (Merton, 1972, Burgess, 1984; Naples, 1996; Kusow, 2003), however there is a consensus of opinion amongst some writers (Naples, 1996; Allen, 2004; Bryman, 2016; Britton, 2020; Bukamal, 2022) that being an insider or an outsider is mutable. As Allen (2004, p .4.) writes:

> Situations are neither totally familiar nor totally strange and the researcher's insider-outsider status changes at different points in a research project and is different with different groups and different individuals.

While it is acknowledged that an external researcher may have received different responses, it was clear through the quality and quantity of the data that interviewees felt comfortable and safe to share their experiences with me. Interviews with policy makers ranged from 46 minutes to 2 hours and 12 minutes, an average of 1 hour 27 minutes per interview. Those involving staff with lived experience went from 1 hour 36 minutes to 3 hours 22 minutes, an average of 1 hour 58 minutes. The PSW focus group lasted 2 hours 11 minutes. All of the interviewees were participant led, as is evident from the transcripts.

Nonetheless, being an 'inside researcher' presented unique ethical challenges that an outsider may not have encountered. It required a heightened awareness of potential biases, conflicts of interest, and responsibilities to maintain confidentiality and objectivity. I had to strike a balance between my duties and responsibilities as an employee of Glen Forest and my responsibility to impartially report the findings (Allen, 2004; Ergun and Erdemir, 2010; Bukamal, 2022). An example of this was my frustration about having to maintain the role of observer at all times when

conducting this study. I was unable to take action to improve the reported experiences of staff with lived experience, despite knowing that things could be done to help improve their experiences but were not. This included revising training on disclosure and boundaries and teaching staff the skills needed to share their lived experience appropriately. Likewise, the much-needed formal protocol to support staff in urgent need of secondary mental health care was never developed. Instead, the practice of an informal "gentleman's agreement" (Christine, PM23; Jayne, PM6; Danny, LE8; Duncan, LE10) with other NHS trusts in the region, known only to some senior psychiatrists, remained. Overall, it remained an organisation where sharing details of one's mental health was still largely taboo, due to fear of reprisals, being seen as weak, and other associated workplace stigma and discrimination such as not being trusted to do one's job. To requote Danny's then manager:

> I'm not signing that because we're not having some mental health nutter signing prescriptions (Danny, LE8).

This required careful navigation to maintain ethical standards and avoid compromising the integrity of the research in the face of internal pressures and dilemmas thereby ensuring the validity and reliability of my findings (Allen, 2004; Yin, 2014; Bukamal, 2022). A high level of reflexivity, via detailed field notes (both reflective and descriptive) and discussions with my supervisors, was therefore key to navigating these challenges, as is instructed within qualitative methodology (Koch and Harrington, 1998; Brown, 2008).

7.7.4 Personal Reflections

Undertaking a PhD is a challenge for any student; it requires

commitment, dedication and considerable effort (Churchill and Sanders, 2007; Woolston 2019; Harvey et al., 2021). However, it may be suggested that such challenges are amplified during significant global events such as the COVID pandemic (Börgeson et al., 2021), which, according to official records, swept across the UK between March 2020 and December 2021 (Institute for Government, 2022). Certainly, this was my experience. As an NHS professional the working environment during this time was arduous and intense, despite the fact that I was deemed non-clinical facing. My workload intensified exponentially during this time as staff constantly needed my support, often outside of standard working hours. They shared their fears about not feeling able to keep themselves, their patients and their families safe; concerns about personal protective equipment and vaccine hesitancy; anxieties relating to health inequalities due to the disproportionate impact of the virus on people of colour, disabled people, patients with learning disabilities and so forth. At the same time, I found myself grappling with personal concerns about how the pandemic would affect not just me and my spouse, but my elderly mother who lived nearly 300 miles away in a rural village in Scotland. Consequently, during this period, I was unable to engage with my PhD, which I found incredibly disheartening. Around January/ February 2022, the time period when things were judged to be 'getting back to normal', I, like the majority of my colleagues remained physically and emotionally depleted due to the toll the pandemic had on us. I have always maintained a steadfast commitment to completing this research, however in the first few months of re-engaging with this work progress was extremely slow and I again became overwhelmed with the huge volume of data I had collected, and its emotionally challenging content. Though it required immense determination, I managed to refamiliarise myself with the material, and I truly feel privileged to be able to share a story that is crucial

to be heard.

7.7.5 Recommendations for Future Research

As highlighted in Chapter 3 the findings of this study, through the use a case study approach, cannot be generalised (Hartley 1994, 2004; Seymour and Sandiford, 2005), which as explained is not the intent of this methodology (Hancock et al., 2007). Whilst some of the recommendations that emerge from the findings may be transferrable to comparable organisations, it would be prudent to study the experience of staff with lived experience of mental health problems in other mental health trusts to determine if this is accurate, as is my proposition. The outputs of this work can then be used to further develop best practice and share across the health and social care sector and beyond.

Another potential area to expand this research would be to focus on governmental policy, with a view to providing recommendations for change that address key questions such as: How do we continue to change societal perceptions of people living with and working with mental health problems? This study highlighted that the staff employed by the case study organisation, like all workplaces, are a microcosm of the society from which they belong. Staff enter the caring professions, but they are not value free and bring with them their own influences and experiences. Once in the workplace they have it instilled into them about appropriate boundaries between professionals and patients and yet they are presented with peer workers and peer support workers. This may cause uncertainties as they do not really know how or where that sits within the profession. It would be beneficial to explore where that does sit within the context of professionalisation. Does the view of policy managers change when they move into managerial positions and do not spend their days

on the wards? Arguably policy makers are very different people to staff on the wards and have different priorities. It is also noteworthy that only two of the staff with lived experience in this study identified as Black and Minority Ethnic (BME). Extending the parameters of this study to identify if other intersectionalities such as race, sexual orientation, social class, gender, and disability influenced the workplace experiences of staff invested in this study would be worthy of investigation.

A further possible area of research based on the findings of this study links to the change in how mental health support for patients is provided. Mike Slade, a clinical psychologist and researcher, whose work focuses on transforming clinical care pathways to focus on recovery, advocates that psychiatry is not the right approach for everyone with mental health problems. When interviewed about his team's research into what people with their own lived experience of mental health problems identify as important in their recovery journey he responded:

> The key message [is] that psychiatry, and the wider mental health system, is hugely helpful for some people, but not helpful or even damaging for others. We need to move towards a rights-based system in which choice and control by the individual, not the system, are the default setting. This means clinicians being open to the reality that, for some people, their recovery journey takes place partly or wholly outside of mental health services (Institute of Mental Health, 2023).

This is a similar viewpoint to that of Betty (LE7) in Chapter 6, who described psychiatry as a "tyranny". If there is a fundamental shift towards giving patients control over their care, including the choice

of the environment in which they are cared for and supported, how would this impact on staff with lived experience who are part of that system? One could suggest that for some it might be welcome and liberating, but for others invested in the Medical Model, challenging and difficult to accept.

Lastly, due to the limitations of this study it was not possible to answer some of the questions that arose from the findings. These too would benefit from further investigation, particularly in relation to organisational power dynamics and ascertaining who holds the power. Policy makers suggested that they did not have the power to make the necessary changes and offered little insight into who had this power and how they as leaders could claim it and use it collectively to effect change and improve the experiences of their staff. Similarly, the literature suggests that the national government do not have the power to make the necessary changes as, despite a number of formally commissioned reports and pieces of statutory guidance, the literature and the conclusions of this study suggest that little has changed in the eyes of staff with lived experience. Is change therefore in the hands of those staff with lived experience that are brave enough and confident enough to put their heads above the parapet? And if so, how do they through their activism generate the necessary power to force change?

While this reflexive account focuses mainly on the limitations of this study it also highlights the strengths of this work within the confines of its parameters. Consequently, this study provides a valuable contribution to research and offers a number of recommendations for consideration.

7.8 Contributions to Research

This study challenges the dominant discourse and has offered new insights into the lived experience of staff with mental health problems within the mental health setting. In doing so, this research not only critically explores the needs of this 'seldom heard' group but suggests broader implications for understanding the mental health needs of all employees, and for society in general.

Despite there being a growing body of evidence on the impact of societal stigma on people with lived experience both at work and in wider society, it was identified that missing from academic research was an appreciation of how mental health clinicians with their own lived experience, experience mental health stigma in the workplace. Accordingly, the present study sought to explore this and in doing so filled a void. Furthermore, it is advocated that if Glen Forest NHS Foundation Trust, as part of a wider organisational cultural change strategy, adopt the recommendations laid out in this thesis, the workplace experience of all staff will be enhanced, not only those with lived experience of mental health problems. Through education to improve awareness and understanding, better processes and resources to support staff with lived experience and their managers, and role modeling of the requisite values and behaviours from policy makers, the staff will feel confident, supported, and equipped to challenge stigma around mental health. This in turn, with sustained action, will help Glen Forest Trust to be the Exemplar Employer that it aspires to be; a place where staff feel valued and that they belong, where they can bring their whole selves to work and where appropriate use their lived experience to benefit the patients they serve. (Kline, 2014)

Although this study produced a wealth of rich data there is, as highlighted earlier, an acknowledgement that the findings cannot be directly generalised and applied to other organisations (Hartley 1994, 2004; Seymour and Sandiford, 2005; Hancock et al., 2007). However, with that said it is asserted that the key findings are likely be similar to those of other mental health trusts throughout the UK, and while the workplace experiences of staff with lived experience may be different, there is sufficient commonality to determine that many of the findings and corresponding recommendations can be considered by policy makers for application to their own organisation.

Above all, this research has offered new insights, which provides impetus for further postgraduate study.

7.9 Recommendations for the Case Study Organisation, Other Mental Health Trusts and External Bodies

This study explored the perspectives of staff with lived experience of mental health problems and also policy makers within a mental health trust. It highlighted that staff with mental health problems often do not feel valued and supported in the organisation, with a variation in experiences reported depending on the understanding of the manager. It also confirmed that despite being a Mindful Employer signatory, action needs to be taken to ensure that the case study organisation fulfils the requirements of the Exemplar Employer organisation that it pledges to be. Consequently, based on the findings of this study and the literature reviewed, a number of key recommendations have been identified.

7.9.1 Recommendations for External Organisations and Governing Bodies

1. **Government action** is needed to support organisations to improve their workplace practices and hold them to account for their behaviours. Mental health is a moral and economic issue, which impacts on the whole of society in terms of belonging, self-value, worklessness/benefits, absence from work, and so forth. Furthermore, the NHS Constitution (DHSC, 2021) states that the purpose of the NHS is to ensure citizens are supported to be mentally and physically well, and that includes its staff. When staff are given the support they need they provide better care, which impacts on patient outcomes and experience. In spite of active campaigns by healthcare scholars, activism by staff with lived experience and large-scale reviews such as the Boorman Report (2009a, 2009b), it is only relatively recently that the NHS has acknowledged the value of staff experience and personal wellbeing. It is recommended that HM Government review its policies and approaches to workplace mental health and convene the necessary working groups, which include representation from NHS staff with lived experience, to take this forward. This, it is suggested, should provide national oversight, and ensure commitment, accountability and action within organisations. Furthermore, it is suggested that the government mandate Disability Pay Gap reporting in line with current Gender Pay Gap reporting (EHRC, 2018) and that this be differentiated between physical and mental health disabilities.
2. **The Role of Universities and Colleges in Building Resilience in Nursing, Medical, and Counselling Students:** There are a growing number of authors (Roth et

al., 2000; Skovholt, 2001; Tully, 2004; Morrisette, 2004; Mander, 2004; Trusty et al., 2005; Graves, 2008; Wallace, 2012; Cohen et al, 2016; Thomas et al., 2019) who in their academic writings urge universities and colleges to provide better training in self-care, self-reflection, self-awareness and personal resilience for nursing, medical and counselling students. For Skovholt (2001) the key skill that trainers should teach above all others is the ability to self-reflect; a skill which will prove valuable throughout the student's professional career. These skills will provide members of the healing professions with much needed capabilities such as the ability to look after one's own mental health, to formulate coping strategies when faced by challenges and to develop individual responsibility. If managed appropriately, it will also help reduce the stigma and barriers often faced by people with mental health problems, both within the healing professions and the wider community (Wallace, 2012; Cohen et al, 2016). Furthermore, it is recommended that educators take the time to discuss with students the concept of the wounded healer, and by explaining its significance, help to normalise this phenomenon and by doing so aid students' self-awareness and sense of personal value to the profession (Trusty et al., 2005). This work, it is recommended, should be developed in collaboration with staff with lived experience and supported by the professional colleges and governing bodies, such as the Royal College of Nursing, the Royal College of Psychiatrists, the British Psychological Society, and the Health and Care Professions Council. Each should ensure that staff membership revalidation requires evidence of a comprehensive understanding of mental health in the workplace, including an awareness of the unique abilities and added value that staff with lived experience bring to

healthcare and wider society (Hogg and Kemp, 2020; King et al., 2023), reflection on personal identity, self-care and boundaries, and knowledge of signposting and support for self and others.

7.9.2 Recommendations the Case Study Organisation and Potentially Other Mental Health Trusts

1. The NHS is losing staff faster than it can recruit due to issues around belonging, low wages, lack of perceived flexibility, and so forth (NHS England, 2022). Some of the staff entering the case study organisation are trained in mental health, but not all. Many support staff have their first experiences of the mental health environment when they undertake their first shift on the ward. Furthermore, staff trained in mental health do not, as highlighted above, always have the necessary skills to recognise the needs of and support their colleagues. For these reasons it is recommended that:
    a. All current and future employees are required to complete a module on understanding mental health in the workplace. This should be developed and delivered in collaboration with staff with lived experience and include clear examples of the difference between clinical and personal recovery (Slade et al., 2008; Watts and Higgins, 2016; Lim et al., 2017). Furthermore, it should be approached from a strengths model, which first and foremost highlights the unique abilities and added value that individuals with lived experience bring, as well as the unique challenges (Rapp and Goscha, 2011; Ibrahim et al, 2014; Pullman et al, 2023). Additionally, it is advised that a statement be included in every job description, emphasising the need for employees to possess a comprehensive

understanding of mental health and wellbeing principles and to integrate them into all their work-related responsibilities. This will not only show the organisation's intent and commitment to improvement but will be a step towards normalising mental health problems, and distinguishing staff with mental health problems and the patients they care for as at different ends of the spectrum.

b. All non-registered mental health staff undertake an 'introduction to mental health' induction module, which explains what a mental health problem is, the requirements of a section under the Mental Health Act (2007), and an overview of key mental health problems such as anxiety, personality disorder, schizophrenia, and so forth; to destigmatise these conditions through awareness and understanding.
c. Job advertisements for roles in the organisation not only make it clear that applications from people with lived experience of mental health problems are both welcome and encouraged, but that training and support will be provided. Furthermore, that colleagues will have received this training as a demonstration of the organisation's commitment as a Mindful Employer. Such statements are also likely to encourage members of the general public to consider a career in mental health.
d. The organisation utilises the skills and experiences of its staff with lived experience by setting up a school/ college/university education programme where learning can be shared with children and young people in an effort to educate and help combat societal stigma of mental health problems. This will also serve to

encourage young people to consider a career in the NHS.

e. A career pathway be developed, which supports the distinct needs of all staff with lived experience, particularly Peer Support Workers (Stirrup et al., 2022). Sharing one's lived experience of mental health problems on a daily basis is not sustainable for many and can lead to burnout (Clossey et al., 2018). It is suggested that the availability of a menu of short and long-term alternative work placements for staff with lived experience, provided in partnership between Human Resources, Occupational Health, and the organisation's Employee Support Service, could reduce burnout and in doing so lower incidences of staff absence and increase retention rates. This, it is suggested, may have a positive impact on staffing shortages within the NHS. It is further suggested that the Employee Support Service is given a more active role in supporting staff with lived experience at all levels of the organisation in relation to employment matters, as opposed to mainly those in entry-level roles.

f. A reciprocal mentoring scheme be introduced with two principal aims: to provide support and development opportunities for staff with lived experience; and to help policy makers understand the specific needs of staff with lived experience from a personal perspective (Sarsah et al., 2022). This would also send a clear message throughout the organisation that lived experience is valued.

2. Another clear recommendation based on the findings is the need for improved information and guidance within the

organisation, both to support staff with mental health problems and improve the understanding and awareness of colleagues and managers. To this end it is recommended that:

a. A policy be developed, in collaboration with staff with lived experience, which aims to address the specific needs of staff with lived experience of mental health problems, in particularly those with severe and enduring mental health conditions such as schizophrenia, severe depression/anxiety disorders, personality disorders, bipolar affective disorder etc. This includes developing a formal agreement with another mental health trust in the region so that staff who become unwell have a clear care pathway. This should also include the development of an advanced directive form so that staff with mental health problems can decide where they want to be treated should they need hospitalisation, namely a neighbouring trust or the organisation in which they are employed. This policy should be centrally monitored to ensure that managers act fairly and consistently, are supportive and being supported, and are not as described in Chapter 7 (7.5.1.1) "shackled by the very policies and practices they had wittingly endorsed". Consideration should also be given to developing a fast-track system for staff with lived experience should they begin to experience a decline in their mental health. This would be similar to the existing fast-track scheme for staff experiencing musculoskeletal problems.
b. Resources and guidance for staff with lived experience, developed in collaboration with current staff with lived experience, be made available and accessible prior to

them commencing work with the organisation. This should include guidance on boundaries and disclosure (Dunlop et al., 2022; King et al., 2023), signposting to relevant policies and support plans, details of expected behaviours, how to access training and support mechanisms, the role of their management and clinical supervisors, details of the Disabled Staff Network, how to access a peer buddy, and so forth. In addition, communication and signposting to this information should be improved for existing staff making it easy to access on the organisation's staff intranet pages. The availability of this information should also be highlighted at both Trust and local site inductions, as well as in staff management supervisions.

3. Enhanced training is provided for all managers as part of the core leadership offer. This should include understanding the needs of supporting staff with mental health problems, managing diverse teams, understanding disabilities and the importance of reasonable adjustments, and so forth. This would include ensuring managers have the necessary skills to support team members in making a decision on important issues such as 'what to tell colleagues if they are unwell' or 'how to explain their absence when meeting their psychiatrist'. It is suggested that the 'Managing Minds at Work' digital training programme for line-managers (Blake et al., 2022) be considered for this purpose. Moreover, management training should include how to provide effective management supervision to all members of their diverse teams, including staff with lived experience.
4. Enhanced opportunities for staff with lived experience to meet to offer each other peer support be encouraged and

supported. This should be under the auspices of the Disabled Staff Network.

5. All staff with lived experience of mental health problems, not only Peer Support Workers, be encouraged and supported to share their experiences with colleagues in psychologically safe spaces. This would serve as a means to educate and inform and contribute towards de-stigmatizing mental health problems within the organisation and beyond; helping break down the barriers between 'us and them' (King et al., 2023).
6. A 'Looking After Your Mental Health Campaign' is established. All staff should be encouraged to take regular breaks, have time for rest and reflection and a space away from the ward or their office to recharge. This would send a positive message to all that mental health and wellbeing is prized by the organisation and that it values its staff. Consideration should also be given to incorporating 're-charging' spaces into clinical areas, as opposed to focusing solely on break rooms. These spaces are likely to be easier for staff to access in-between patients and could be used by staff for tasks that do not require direct patient care such as updating patient notes or sending e-mails. This is also a recommendation made by Halford and Leonard (2003) in their study on the impact of stress on the working lives of nurses. It is also suggested that 'stress control' workshops be made available to all staff, particularly when experiencing organisational change.
7. A task and finish group comprised of key stakeholders, including staff with lived experience, be established to conduct an audit on the support available to these staff. This group should have full support of the Trust Board and the findings reported in line with Glen Forest's Board Governance Structure.

Chapter 8: Conclusion

This thesis has explored how the case study organisation, a mental health trust, supports its clinical staff with lived experience of mental health problems, and how those staff experience working for the organisation. It challenges the dominant narrative within the 'mental health and the workplace' literature, by emphasising that clinical staff with severe and enduring mental health problems can and do successfully provide effective patient care. It also highlights the value these individuals can bring to an organisation by virtue of their lived experience. However, their ability to contribute effectively relies on them receiving adequate support and having a workplace that fosters a sense of belonging and allows them to bring their whole selves to work.

This study explored the organisational values and practices from the perspective of policy makers, namely senior managers, and other staff with key policy roles within the organisation, **and** staff with lived experience. It concluded that despite evidence of positive staff experiences in parts of the organisation, Glen Forest NHS Foundation Trust was essentially failing to meet the needs of its staff with lived experience, regardless of its positive intent. Due to societal stigma that permeated the workplace, clinical staff with lived experience felt unable to openly use their valuable lived experiences to help patients, and as a consequence were forced to regulate their identities into one that denied their lived experience. This was substantiated by claims from the policy makers, who revealed that they did not believe that the organisation's narrative aligned with the actual experiences of these employees. They asserted that the organisation, as a whole, had failed to adequately address the needs of these employees, yet they, in spite of their positional power felt helpless to take direct action. Consequently, it

was established that Glen Forest did not meet the standards required to be the Exemplar Employer that it aspired to be.

Through presentation of staff experiences, supported by academic literature and theory, this research aims to affect future change and contribute to filling the identified knowledge gap within the existing literature. By virtue of its findings and recommendations, this research makes a significant contribution to both the academic literature, and the development of organisational policies and practices that can better understand and support the workplace needs of clinical staff with lived experience working in the NHS and beyond. Overall, this research informs the study of organisational development through the documentation and promotion of positive workplace cultures. It does so by identifying actions that if implemented will effectively enhance the support systems and workplace experiences of clinical staff with lived experience of mental health problems.

In conclusion, it is anticipated that this study, as well as future research, will stimulate additional investigations into the significance of lived experience of mental health problems within the workplace, particularly in mental health settings. Moreover, it is hoped that these findings will serve as a foundation for enhancing the workplace experiences of staff members with lived experience, and that the case study organisation and other NHS trusts, with concerted support from key partners such as Central Government, universities and professional bodies, will be both obligated and motivated to 'practice what they preach'.

8.1 Final Thoughts

Integral to this thesis are the hitherto 'seldom heard' voices of staff with lived experience, which when heard and interpreted within the context of organisational policy, practice, and theory are amplified, and convey a single resounding voice that appeals for change. By listening to and addressing the concerns and experiences of employees who have faced mental health challenges, organisations can create an environment that values and supports all individuals.

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Appendices

Please note: The name of the case study/sponsoring organisation, and any specific details attributable to it, including its logo, have been removed/redacted from the appendices to further protect the anonymity of the participants.

Appendix 1: Participant Information Sheet- Policy Makers: Individual Interviews

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Participant Information Sheet for 1 to 1 Interviews - Policy Makers and Managers
(Final version 4.0: 1 June 2015)

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

Name of Researcher(s): Professor Patrick Callaghan- Chief Investigator
Dr Shelia Greatrex-White- Co Investigator
Ms Catherine Conchar- Co Investigator/Principal Researcher

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

The one to one interview, which you have been invited to participate in, is one part of a larger study that has several parts to it. In addition to one to one interviews with policy makers and managers there will be one to one interviews with staff with lived experience of mental health problems, as well as two focus groups. One focus group will be made up of Peers Support Workers and the other members of the Trust's Disability Equality Steering Group. It is expected that forty-eight people in total will take part in this study either in a one to one interview or as part of a focus group.

What is the purpose of the study?

The overall purpose of this study is to determine whether mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems. In doing so this research aims to identify and explore those organisational values and practices, which can effectively support staff with experience of mental health problems.

The purpose of this study is also to partly support the requirements for the degree of PhD in Health Studies.

Why have I been invited?

You are being invited to take part because you have been identified as a policy maker and/or manager within X NHS Trust. It is believed that your involvement will bring with it your particular expertise in Trust policy and practices and ensure a cross-organisational/cross-discipline response from within the organisation. If you choose to be part of the study you would be 1 of 22 participants like you taking part in a one to one interview.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to participate in this study, you will be asked to be interviewed by Catherine Conchar on a one to one basis about your experiences and beliefs around the employment of people who have lived experience of mental health problems within a mental healthcare environment.

The interview session will be audio recorded to ensure that all information is accurately documented. All information collected by the researcher will be kept confidential.

You will be required to attend only one session which should last between 60-90 minutes. These will be held at X or X Hospital at a pre-agreed date and time.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks or discomforts associated with the interviews, nonetheless it is possible that some individuals may find the questions asked potentially distressing. This participant information sheet is accompanied with a copy of the interview guide containing the main questions that will be asked in the interview to help you to decide whether or not to take part.

Psychological/ therapeutic support will be made available, as required, via the Let's Talk Wellbeing Service. It is however important that you consider if you are well enough before participating in this study. The researcher will be very happy to discuss this with you at any time in the process.

What are the possible benefits of taking part?

Due to the nature of this study X NHS Trust is mostly likely to benefit from this research as opposed to individual participants. It is however hoped that any benefits will in time filter down to individual employees and that the information we get from this study may help improve the support available to staff with personal experience of mental health problems in the workplace.

What happens when the research study stops?

Once you your participation in an interview is over you will not be asked to engage any further in the study. Once the research study ends you will be able to decide whether or not you would like to be kept informed of the research outcomes.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting X, Service Liaison Manager, Service Liaison Department, XXX. Email: complaints@xxx.nhs.uk Tel: XXXX XXXXXXX.

Will my taking part in the study be kept confidential?

The researchers will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database and encrypted data stick. Any information about you which leaves the Trust will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (work address, telephone number) will be kept for 3 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 5 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information will still be used in the study.

What will happen to the results of the research study?

The results of the study will be written up and will be used to form part of the requirements of a PhD Thesis in Health Studies. The results of the study may also be written up for publication in a journal. You will not be identified or identifiable in any report or publication, however anonymised quotes from you and others interviewed will be used in both the thesis and any research publications. The only exception to this rule is the Chief Executive and the Trust Chair from whom direct quotations will be sought due to their organisational role, providing specific, informed and prior consent has been given. Only those quotations that have been deemed by the research team to be valuable to this study will be used.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by X NHS Trust as part of a PhD thesis in Health Studies.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NHS Research Ethics Committee London-Surrey Borders.

Further information and contact details:

Chief investigator:

Professor Patrick Callaghan
Professor of Mental Health Nursing
Faculty of Medicine and Health Sciences
University of Nottingham, Room 1977, A Floor,
Queen's Medical Centre, Nottingham, NG7 2UH

Phone: 0115 8230812
Email: patrick.callaghan@nottingham.ac.uk

Co-investigators:

Dr Sheila Greatrex-White
Assistant Professor
Faculty of Medicine and Health Sciences
University of Nottingham, Room B62, B Floor,
Queen's Medical Centre, Nottingham, NG7 2UH

Phone: 0115 8230960
Email: sheila.greatrex-white@nottingham.ac.uk

Ms Catherine Conchar
PhD Student- Faculty of Medicine and Health Sciences,
University of Nottingham/ XX NHS Trust, Room X, XXX,

Phone: XXXX XXXXXXX
Email: ntxcc3@nottingham.ac.uk

Appendix 2: Interview Guide for Policy Makers: Individual Interviews

The University of Nottingham

Interview Guide for Policy Makers and Managers.

1. Do you currently or have you in the past had management responsibility for staff who have used secondary mental healthcare services?
2. Has a staff member ever disclosed a mental health problem to you? What was your response?
3. What experiences do you believe staff with mental health problems have in your organisation?
4. Have you witnessed staff with mental health problems being stigmatized or discriminated against at work due to their mental health problem?
5. What do you believe to be the Trust's approach to staff with mental health problems? (perceptions of organisational culture/commitment towards a positive working environment, notably in relation to issues such as stress, anxiety and burnout, support for staff with mental health problems)
6. Please describe your knowledge and experience of the Trust's supportive policies and working practices in relation to staff who declare they have a mental health problem. What are they? Have you used them with staff? How supportive are they for you as a manager? (e.g. implementation of reasonable adjustments, disability leave, employee assistance etc.)
7. Please describe the self-management techniques and formal and informal processes you are aware of to support staff with mental health problems. How have you shared these with staff who declare they have a mental health problem?
8. What do you believe lived experience of mental health problems contributes to clinical practice?
9. What are your personal views of staff with lived experience of mental health problems providing mental health care?
10. How do you think your colleagues view people with lived experience of mental health problems in the workplace?
11. What do you think the views of your friends and family are about staff who have/have had a mental health problem working in mental health care?
12. Please describe the impact that the views of the general public about people with mental health problems working in healthcare have on you.
13. I am interested to hear of other views on this issue you have…

Interview Guide for Policy Makers and Managers. Final Version 1.0: 24 July 2014.

Appendix 3: Participant Consent Form- Policy Makers: Excluding CEO and Chair: Individual Interviews

The University of Nottingham

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

REC ref: 14/LO/1523

Name of Investigators: Prof Patrick Callaghan, Dr Sheila Greatrex-White, Ms Catherine Conchar.

Consent Form for 1 to 1 Interviews- Policy Makers and Managers: excluding CEO and Chair v3 010615

Please read this form and sign it once one of the above named investigators has explained fully the aims and procedures of the study to you.

Please initial box

1. I voluntarily agree to take part in this study. ☐
2. I confirm that I have been given a full explanation by one of the above named investigators and that I have read and understand the information sheet given to me which is attached. ☐
3. I have been given the opportunity to ask questions and discuss the study with one of the above investigators on all aspects of the study and have understood the advice and information given as a result. ☐
4. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published. ☐
5. I agree to the interview in which I participate being audio recorded and the recording retained for the purpose of the research study. ☐
6. I understand that anonymous direct quotes from my interview will be used in the study reports. ☐
7. I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing and that any information collected so far cannot be erased and will still be used in the study. ☐

Name: ……

Address: ……

Telephone number: ……

Signature: …… **Date:** ……

Consent Form for 1 to 1 Interviews- Policy Makers and Managers-excluding CEO and Chair v3 010615

I confirm that I have fully explained the purpose of the study and what is involved to:

……

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: …… **Date**: ……

Investigators Name:……

Study Volunteer Number: ……

2 copies: 1 for participant and 1 for the project file.

Consent Form for 1 to 1 Interviews- Policy Makers and Managers-excluding CEO and Chair v3 010615

Appendix 4: Participant Consent Form- Policy Makers: CEO and Chair: Individual Interviews

The University of Nottingham

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

REC ref: 14/LO/1523

Name of Investigators: Prof Patrick Callaghan, Dr Sheila Greatrex-White, Ms Catherine Conchar.

Consent Form for 1 to 1 Interviews- Policy Makers and Managers: CEO and Chair v3 010615

Please read this form and sign it once one of the above named investigators has explained fully the aims and procedures of the study to you.

Please initial box

1. I voluntarily agree to take part in this study. ☐
2. I confirm that I have been given a full explanation by one of the above named investigators and that I have read and understand the information sheet given to me which is attached. ☐
3. I have been given the opportunity to ask questions and discuss the study with one of the above investigators on all aspects of the study and have understood the advice and information given as a result. ☐
4. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published. ☐
5. I agree to the interview in which I participate being audio recorded and the recording retained for the purpose of the research study. ☐
6. I agree that as Chief Executive or Trust Chair **identifiable direct quotes** from my interview will be used in the study reports. ☐
7. I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing and that any information collected so far cannot be erased and will still be used in the study. ☐

Name: ……

Address: ……

Telephone number: ……

Signature: …… **Date:** ……

Consent Form for 1 to 1 Interviews- Policy Makers and Managers: CEO and Chair v3 010615

I confirm that I have fully explained the purpose of the study and what is involved to:

……

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: …… **Date**: ……

Investigators Name:……

Study Volunteer Number: ……

2 copies: 1 for participant and 1 for the project file.

Consent Form for 1 to 1 Interviews- Policy Makers and Managers: CEO and Chair v3 010615

Appendix 5: Participant Information Sheet- Staff with Lived Experience: Individual Interviews

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Participant Information Sheet for 1 to 1 Interviews- Staff with Lived Experience of Mental Health Problems (Final version 3.0: 1 June 2015)

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

Name of Researcher(s): Professor Patrick Callaghan- Chief Investigator
Dr Shelia Greatrex-White- Co Investigator
Ms Catherine Conchar- Co Investigator/Principal Researcher

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

The one to one interview that you have been invited to participate in is one part of a larger study which has several parts to it. In addition to one to one interviews with staff with lived experience of mental health problems there will be one to one interviews with policy makers and managers, as well as two focus groups. One focus group will be made up of Peers Support Workers and the other members of the Trust's Disability Equality Steering Group. It is expected that forty-eight people in total will take part in this study either in a one to one interview or as part of a focus group.

What is the purpose of the study?

The overall purpose of this study is to determine whether mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems. In doing so this research aims to identify and explore those organisational values and practices, which can effectively support staff with experience of mental health problems.

The purpose of this study is also to partly support the requirements for the degree of PhD in Health Studies.

Why have I been invited?

You are being invited to take part because you are a Peer Support Worker and/or a member of the Living in Both Worlds Group and have therefore identified that you have lived experience of mental health problems. As this study seeks to identify if staff with lived experience of mental health problems feel supported at work it is important to talk to people like you. If you choose to be part of the study you would be 1 of 10 participants like you taking part in a one to one interview.

Please note that individuals who take part must be willing to share their personal experiences as to how they perceive their mental health problem to impact/have impacted on their work.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to participate in this study, you will be asked to be interviewed by Catherine Conchar on a one to one basis about your experiences and beliefs of being an employee with lived experience of mental health problems within a mental healthcare environment.

Individuals who take part must be willing to share their personal experiences as to how they perceive their mental health problem to impact/have impacted on their work.

The interview session will be audio recorded to ensure that all information is accurately documented. All information collected by the researcher will be kept confidential.

You will be required to attend only one session which should last between 60-90 minutes. This will be held at X or X Hospital at a pre-agreed date and time.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks or discomforts associated with the interviews, nonetheless it is possible that some individuals may find the questions asked potentially distressing. This participant information sheet is accompanied with a copy of the interview guide containing the main questions that will be asked in the interview to help you to decide whether or not to take part.

Psychological/ therapeutic support will therefore be made available, as required, via the Let's Talk Wellbeing Service. It is however important that you consider if you are well enough before participating in this study. The researcher will be very happy to discuss this with you at any time in the process.

What are the possible benefits of taking part?

Due to the nature of this study X NHS Trust is mostly likely to benefit from this research as opposed to individual participants. It is however hoped that any benefits will in time filter down to individual employees and that the information we get from this study may help improve the support available to staff with personal experience of mental health problems in the workplace.

What happens when the research study stops?

Once you your participation in the interview is over, you will not be asked to engage any further in the study. Once the research study ends you will be able to decide whether or not you would like to be kept informed of the research outcomes.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting X, Service Liaison Manager, Service Liaison Department, XXX. Email: complaints@xxx.nhs.uk Tel: XXXX XXXXXXX.

Will my taking part in the study be kept confidential?

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups, where information and experiences are openly shared, prevents the researchers from guaranteeing confidentiality. The researchers will ensure that ground rules are set at the beginning of the session, including securing confirmation that "all participants agree to assure the confidentiality of other group members". This however relies on the professionalism and integrity of individuals and consequently the researchers cannot guarantee confidentiality.

The researchers will follow ethical and legal practice and all information about you will be handled in confidence. If you agree to join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database and encrypted data stick. Any information about you which leaves the Trust will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (work address, telephone number) will be kept for 3 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 5 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information will still be used in the study.

What will happen to the results of the research study?

The results of the study will be written up and will be used to form part of the requirements of a PhD Thesis in Health Studies. The results of the study may also be written up for publication in a journal. You will not be identified or identifiable in any report or publication, however anonymised quotes from you and others interviewed will be used in both the thesis and any research publications.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by X NHS Trust as part of a PhD thesis in Health Studies.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NHS Research Ethics Committee London-Surrey Borders.

Further information and contact details

Chief investigator:

Professor Patrick Callaghan
Professor of Mental Health Nursing
Faculty of Medicine and Health Sciences, University of Nottingham, Room 1977, A Floor, Queen's Medical Centre, Nottingham, NG7 2UH

Phone: 0115 8230812
Email: patrick.callaghan@nottingham.ac.uk

Co-investigators:

Dr Sheila Greatrex-White
Assistant Professor
Faculty of Medicine and Health Sciences
University of Nottingham, Room B62, B Floor, Queen's Medical Centre, Nottingham, NG7 2UH

Phone: 0115 8230960
Email: sheila.greatrex-white@nottingham.ac.uk

Ms Catherine Conchar
PhD Student- Faculty of Medicine and Health Sciences, University of Nottingham/ XX NHS Trust, Room X, XXX,

Phone: XXXX XXXXXXX
Email: ntxcc3@nottingham.ac.uk

Appendix 6: Participant Consent Form- Staff with Lived Experience: Individual Interviews

The University of Nottingham

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

REC ref: 14/LO/1523

Name of Investigators: Prof Patrick Callaghan, Dr Sheila Greatrex-White, Ms Catherine Conchar.

Consent Form for 1 to 1 Interviews- Staff with Lived Experience of Mental Health Problems v3 010615

Please read this form and sign it once one of the above named investigators has explained fully the aims and procedures of the study to you.

Please initial box

1. I voluntarily agree to take part in this study. ☐
2. I confirm that I have been given a full explanation by one of the above named investigators and that I have read and understand the information sheet given to me which is attached. ☐
3. I have been given the opportunity to ask questions and discuss the study with one of the above investigators on all aspects of the study and have understood the advice and information given as a result. ☐
4. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published. ☐
5. I agree to the interview in which I participate being audio recorded and the recording retained for the purpose of the research study. ☐
6. I understand that anonymous direct quotes from the interview will be used in the study reports. ☐
7. I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing and that any information collected so far cannot be erased and will still be used in the study. ☐

Name: ……

Address: ……

Telephone number: ……

Signature: …… **Date:** ……

Consent Form for 1 to 1 Interviews- Staff with Lived Experience of Mental Health Problems v3 010615

I confirm that I have fully explained the purpose of the study and what is involved to:

……

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: …… **Date**: ……

Investigators Name:……

Study Volunteer Number: ……

2 copies: 1 for participant and 1 for the project file.

Consent Form for 1 to 1 Interviews- Staff with Lived Experience of Mental Health Problems v3 010615

Appendix 7: Participant Information Sheet- Staff with Lived Experience: Peer Support Worker Focus Group

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Participant Information Sheet for Focus Group- Peer Support Workers: Staff with Lived Experience of Mental Health Problems (Final version 3.0: 1 June 2015)

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

Name of Researcher(s): Professor Patrick Callaghan- Chief Investigator
Dr Shelia Greatrex-White- Co Investigator
Ms Catherine Conchar- Co Investigator/Principal Researcher

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

The Peer Support Worker focus group, which you have been invited to participate in, is one part of a larger study that has several parts to it. In addition there will be another focus group with members of the Trust's Disability Equality Steering Group as well as one to one interviews with staff with lived experience of mental health problems and one to one interviews with policy makers and managers. It is expected that forty eight people in total will take part in this study either in a one to one interview or as part of a focus group.

What is the purpose of the study?

The overall purpose of this study is to determine whether mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems. In doing so this research aims to identify and explore those organisational values and practices, which can effectively support staff with experience of mental health problems.

The purpose of this study is also to partly support the requirements for the degree of PhD in Health Studies.

Why have I been invited?

You are being invited to take part because you are a Peer Support Worker and have therefore identified on applying for this job role that you have lived experience of mental health problems. If you choose to be part of the study you would be 1 of 8 Peer Support Workers taking part in a focus group.

Please note that individuals who take part must be willing to share their personal experiences as to how they perceive their mental health problem to impact/have impacted on their work.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to participate in this study, you will be asked to be part of a focus group with 7 other Peer Support Workers looking at personal experiences and beliefs of being an employee with lived experience of mental health problems within a mental healthcare environment.

Individuals who take part must be willing to share their personal experiences as to how they perceive their mental health problem to impact/have impacted on their work.

The focus group will be audio recorded to ensure that all information is accurately documented. All information collected by the researcher will be kept confidential, however it cannot be guaranteed that if you participate in a focus group session other members will do so.

You will be required to attend only one session which should last between 60-90 minutes. This will be held at X or X Hospital at a pre-agreed date and time.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks or discomforts associated with the focus group discussions, nonetheless it is possible that some individuals may find the questions asked or answers provided by others within the focus groups potentially distressing. This participant information sheet is accompanied with a copy of the interview guide containing the main questions that will be asked in the focus group to help you to decide whether or not to take part.

Psychological/ therapeutic support will therefore be made available, as required, via the Let's Talk Wellbeing Service. It is however important that you consider if you are well enough before participating in this study. The researcher will be very happy to discuss this with you at any time in the process.

It is also acknowledged that some people may feel uncomfortable voicing opinions in front of others or having their point of view challenged. It will be up to subjects how much they wish to take part and they will be free to discontinue involvement at any time by notifying the researcher.

What are the possible benefits of taking part?

Due to the nature of this study X NHS Trust is mostly likely to benefit from this research as opposed to individual participants. It is however hoped that any benefits will in time filter down to individual employees and that the information we get from this study may help improve the support available to staff with personal experience of mental health problems in the workplace.

What happens when the research study stops?

Once you your participation in an interview or focus group is over, you will not be asked to engage any further in the study. Once the research study ends you will be able to decide whether or not you would like to be kept informed of the research outcomes.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting X, Service Liaison Manager, Service Liaison Department, XXX. Email: complaints@xxx.nhs.uk Tel: XXXX XXXXXXX.

Will my taking part in the study be kept confidential?

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality. The researchers will ensure that ground rules are set at the beginning of the session, including securing confirmation that "all participants agree to assure the confidentiality of other group members". This however relies on the professionalism and integrity of individuals and consequently the researchers cannot guarantee confidentiality.

The researchers will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database and encrypted data stick. Any information about you which leaves the Trust will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (work address, telephone number) will be kept for 3 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 5 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Please note however that should you disclose anything to us in the focus group which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information will still be used in the study.

What will happen to the results of the research study?

The results of the study will be written up and will be used to form part of the requirements of a PhD Thesis in Health Studies. The results of the study may also be written up for publication in a journal. You will not be identified or identifiable in any report or publication, however anonymised quotes from you and others in the focus group will be used in both the thesis and any research publications.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by X NHS Trust as part of a PhD thesis in Health Studies.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NHS Research Ethics Committee London-Surrey Borders.

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Appendix 8: Participant Consent Form- Staff with Lived Experience: Peer Support Worker Focus Group

The University of Nottingham

Title of Study: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?

REC ref: 14/LO/1523

Name of Investigators: Prof Patrick Callaghan, Dr Sheila Greatrex-White, Ms Catherine Conchar.

Consent Form for Focus Groups- Peer Support Workers:
Staff with Lived Experience of Mental Health Problems v3 010615

Please read this form and sign it once one of the above named investigators has explained fully the aims and procedures of the study to you.

Please initial box

1. I voluntarily agree to take part in this study. ☐
2. I confirm that I have been given a full explanation by one of the above named investigators and that I have read and understand the information sheet given to me which is attached. ☐
3. I have been given the opportunity to ask questions and discuss the study with one of the above investigators on all aspects of the study and have understood the advice and information given as a result. ☐
4. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published. ☐
5. I agree to the focus group in which I participate being audio recorded and the recording retained for the purpose of the research study. ☐
6. I understand that that anonymous direct quotes from the focus group will be used in the study reports. ☐
7. I agree to maintain the confidentiality of the information discussed by all participants and researchers during the focus group session. ☐
8. I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing and that any information collected so far cannot be erased and will still be used in the study. ☐

Name: ……

Address: ……

Telephone number: ……

Signature: …… **Date:** ……

Consent Form for Focus Group- Peer Support Workers: Staff with Lived Experience of Mental Health Problems v3 010615

I confirm that I have fully explained the purpose of the study and what is involved to:

……

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: …… **Date**: ……

Investigators Name:……

Study Volunteer Number: ……

2 copies: 1 for participant and 1 for the project file.

Consent Form for Focus Group- Peer Support Workers: Staff with Lived Experience of Mental Health Problems
v3 010615

Appendix 9: Interview Guide for Staff with Lived Experience: Individual Interviews and PSW Focus Group

The University of Nottingham

Interview Guide for Staff with Lived Experience of Mental Health Problems.

1. Are you a mental health practitioner?
2. Are you currently, or have you in the past, used secondary mental healthcare services?
3. What age were you when a mental health problem was diagnosed? (in order to determine if age has an impact on experience) Was this before or after you began working in mental health care?
4. Have you ever disclosed your mental health problem to your manager(s) and/or work colleagues? If so when and at what point was this in your career?
5. What was your experience of disclosing this information? What barriers did you face? If none why do you believe this to be the case?
6. Please describe your experience in relation to stigma and/or discrimination at work as a result of your mental health problem.
7. What do you believe to be the Trust's approach to staff with mental health problems? (perceptions of organisational culture/commitment towards a positive working environment, notably in relation to issues such as stress, anxiety and burnout, support for staff with mental health problems)
8. Please describe your knowledge and experience of the Trust's supportive policies and working practices? What are they? Have you used them? How supportive are they for you? (e.g. implementation of reasonable adjustments, disability leave, employee assistance etc.)
9. Please share with me what self-management techniques you have used to keep you well at work.
10. Please describe the formal and informal processes you have used for support.
11. Please describe how your lived experience of mental health problems contributes to clinical practice.
12. What are your views of staff with lived experience of mental health problems providing mental health care?
13. How do you think your colleagues view people with lived experience of mental health problems in the workplace?
14. What do you think the views of your friends and family are about you having/having had a mental health problem working in mental health care?
15. Please describe the impact that the views of the general public about people with mental health problems working in healthcare have on you.
16. Please share with me anything else you would like to add…

Interview Guide for Staff with Lived Experience of Mental Health Problems. Final Version 1.0: 24 July 2014.

Appendix 10: Field Notes Examples: Policy Makers

10.1 PM1

Reflections Prior to Interview

This was my first PhD interview and despite it being [X] I was relatively relaxed, although a bit apprehensive should I not perform to his high standards. It was necessary that this interview was the first conducted as he was leaving the organisation soon. Furthermore, he was instrumental in my decision to undertake this study due to his open-ness and transparency about his own personal experience of mental health problems.

As part of my Equality and Diversity role I am committed to help create a workforce that is representative of the people it serves; to include protected characteristics such as race, mental health, other disabilities, sexual orientation etc. I believe strongly in the phrase "People cannot be what they cannot see" and for this reason I often seek out and publicise role models who are feel safe enough and confident to do so. I was therefore very keen to highlight [X] as a role model for people with secondary mental health issues. A provider of mental health services with [X] on the Board who it appears role modelled the vision for the organisation also illustrates the fact that people with secondary mental health problems, indeed any mental health problem, can and do succeed.

The Interview

My biggest concern was being able to manage the interview appropriately and in the 75-minute time slot allocated, as [X] is known for being quite intolerant about being interrupted. I therefore practiced ways of steering the conversation without interruption, both prior to and during the interview, utilising periods of natural pauses, to probe and elicit further information. I had also carefully developed the questions so that they would elicit reflection and an exploration of the areas I was interested in. Using a semi-structured interview format meant that I was able to use the questions as a source of guidance as opposed to specific questioning,

allowing the interviewee to share their personal experience in line with the approach I had originally intended.

The interview lasted approximately 70 minutes and it was clear at the end of it that [X] had given me as much time as he was prepared to for this purpose. Throughout the interview he was relaxed, leaning back on his chair and reflective. His answers were carefully considered, he was open and honest and needed little if any prompting. He gave examples to illustrate his points and was clearly well versed in the mental health and recovery agendas.

After the interview he gave me a number of useful booklets that he had been involved in developing, a few of which had relevance to the study. He also asked me more about the study and wished me well, thanking me for all the work I had undertaken for staff, patients, and diverse communities. I was very touched and pleased to accept his thanks.

Post Interview Reflections

In terms of the interview itself I believed that despite [X] stating that he had gone off track a couple of times, that I had managed to steer the interview appropriately to elicit appropriate information from him. On reflection and via feedback/discussions with my supervisor I interviewed more like a therapist than a professional researcher, in that I reframed, rephrased and acknowledged as opposed to probing deeply e.g. asking the interviewee what particular words they had used meant to them i.e. stigma, recovery etc., and not asking them to reflect on what that experience looked like and felt for them.

I have also reflected that I was rather over polite on occasion with the interviewee, mostly likely because he was a Board member, had a busy diary and was leaving the organisation soon, so had lots to do before he left. I was simply aiming to encourage him to talk as he often seeks that

encouragement but may have sugar-coated it too much- thanking him profusely for his time on several occasions, when in fact he had already blocked this time out for me. Certainly, something I have reflected on and have learned from. On further reflection however I put forward that this type of thanks, encouragement etc. would not only have been welcomed by him but expected. I did however respond to his statement about the high number of loans from the Human Library (people meet with a person to learn their story as opposed to taking out a book) with the word 'wow', which although positive may not be seen as an impartial word- a learning experience.

Despite this I was pleased that it was a satisfactory first interview, though acknowledged that improvement was needed. I was also pleased that since it was [X] who had inspired me to undertake this research that he acknowledged that it was valuable and would be of significant importance to the organisation going forward.

Interview held in interviewee's office.

10.2 PM5

Reflections Prior to Interview

The interviewee works as a manager in the Trust's [X] healthcare division. I had approached her for interview for a number of reasons. 1. She is very knowledgeable about the work of the NHS and how organisations such as the Trust work 2. She is well respected by her direct reports as a fair and supportive manager 3. I wished to get the views from a cross section of managers across the organisation in terms of divisions/clinical disciplines 4. We are both equivalent levels, yet even if this were not so, I am sure that she would tell me her true thoughts and not what she wants me to hear- she calls 'a spade a spade' and is widely known for doing so. Keen to improve my technique based on my frustrations of the previous interview, I prepared as normal through reflection on the subject matter

and reading the transcripts of previous interviews. I particularly focused on the last interview and reflected on where I could have probed further and how to rephrase questions to make them open not closed.

The Interview

The interviewee was very relaxed and open and honest, so much so that she felt able to discuss her own experiences of mental health and how that had impacted on her as an individual, as a manager and as a clinician. She used clear examples throughout to illustrate her point and pointed to the humour often used in clinical environments to deal with issues such as mental health. She was so relaxed that she often used [local] colloquialisms (which are highlighted in the transcript). Her body language was open, she had very good eye contact and used her hands to express herself throughout the interview.

It is important to note that I was genuinely surprised to hear (very much from the heart) the level of value and commitment that the individual had to her staff and to their mental health and wellbeing. It is important to clarify this point- I had heard that this individual was an excellent manager and very supportive of her staff. What surprised me was the level and commitment to mental health care of her staff and the knowledge of this subject, the innovation that she herself had developed due to what she believed to be the lack of corporate support available to her as a manager etc. I believe this was particularly surprising to me not just because her career history is that of a physical healthcare nurse, who as a profession reputedly know little or want to know little about mental health, but because she had a better understanding of the subject than some of the mental health professionals I know. How wrong I was. As an experienced interviewer (recruitment), I was easily able to keep any surprise from my voice and explore the subject deeper with very satisfying results. The interviewee was also clear as to the benefits that

staff members with personal experience of mental health problems can bring to clinical care, the wider team and indeed the profession.

Post Interview Reflections

On further reflection I believe that I may have spoken too much in the interview at the beginning. Having checked the transcripts however it seems that on several of the occasions, it was because I never had the chance to complete the question before she answered- occasionally on a tangent- therefore I had to bring it back to the main question which required contextualization and further clarification.

After the interview I was very happy with the outcome, believing that I had elicited very valuable information from a specific arm of the organisation. I had expected it to be valuable, but not quite as much as it was. Post interview reflection and re-reading of the transcript has only confirmed this in my opinion.

Post interview I was able to source the Mind checklist that the interviewee had used, in what she described as "successfully", with her staff.

Interview held in neutral office.

10.3 PM11

Reflections Prior to Interview

I really welcomed the opportunity to interview this manager as I was keen to add a social care perspective to this study and believed that the interviewee was the best person for this purpose- she had the experience and the seniority to be able to tell me as it is- no embellishments just the truth as determined by her experiences. I was however concerned as the interviewee is often quiet spoken and hadn't spoken a great deal in any meetings that I had attended. I was confident that she would openly

share her views but concerned that they would be short and to the point and would require considerable probing.

Interview and Post Interview Reflections

This was my favourite interview to date. The interviewee had clearly reflected on her thoughts and experiences and was able to recount them with such clarity and detail. Her social work training she later stated was a key influence in developing reflective practice. It was also my longest interview to date and neither of us had realised how much time had elapsed.

I had never heard the interviewee speak about issues at any length in the past, let alone issues that she was passionate about. She had a very pragmatic approach- one that was supportive but also firm, but fair. She was very clear about her view that people with mental health problems should be able to work in the Trust- in most places (and do)- however there were some places where it was inappropriate in her experience e.g. within the forensic setting.

Through probing I was able to expand on what she said. She talked about social responsibility, about vulnerability as a strength, about the impact of stigma on staff and the importance of Trust managers and staff having time to care for themselves and others.

I was aware throughout that the interviewee held many of the beliefs and views that I did, however I was careful to ensure that I did not seek out answers that reinforced my beliefs/opinions, only those of the interviewee based on her knowledge and experiences. This I did by reflecting on my questions before asking them to ensure that they were not loaded i.e. that they were open questions and neutral- seeking her views and experiences.

Throughout the interview her speech was very confident, clearly had been thought through and reflected on and her body language was open and positive, with very good eye contact.

At the end of the interview, she commented that the interview really made her think- which I was pleased to learn.

It was interesting to note that in the last 20 minutes or so of the interview, the interviewee commenced tapping on the table- almost as if to emphasize her point. This seemed to be rhythmic, in time with each phrase that she was speaking/sounding out.

Interview held in Interviewee's office.

Appendix 11: Field Notes Examples: Staff with Lived Experience, Including PSW Focus Group

11.1 LE5

Reflections Prior to Interview

I met the interviewee on their first day of work at the Trust staff induction. I had just co-delivered the mandatory Equality and Diversity training session to c.100 new starters. As normal I- as part of my presentation highlighted the Equality and Diversity steering groups and forums in the Trust which all staff are eligible to become part of. One of these groups is Living in Both Worlds (LIBW)- a group for staff who have lived experience of using mental health services themselves (and who provide mental health services to patients). At the end of our session there was a lunch break, and the individual approached me and thanked me for an enjoyable presentation. She asked me for more information on the LIBW Group and during the conversation voluntarily disclosed that she had personal experience of mental health problems and had used secondary services. She was energetic, enthusiastic, and bubbly and we talked for about 10 minutes. I gave her the name of the staff member who runs the LIBW group, however she asked that I provide the group facilitator with her name so that she could make contact, to which I agreed.

My only other interaction with the interviewee was in relation to a mentoring scheme that I was involved in as a mentor. I attended the introductory 'meet and greet' session at which the individual was present. I was not her assigned mentor.

My reflections prior to the interview therefore only related to information I came across during brief contacts with the individual, at which time I had not formed an opinion of her in any way. I was however careful about ensuring that the individual was well enough to be interviewed as she had informed me that she had only come out of "an episode" a month previously. I therefore wanted to ensure that she was well enough to be

interviewed- she had been able to continue working through her episode but with additional supervision sessions due to her hyperactivity/mania and assured me that she was well enough. I did however wish to remain cautious and vigilant to ensure that any questions did not distress her, however she ensured me that due to her 'episode' which was manic that would never happen as that was not how it affected her. Adding to my piece of mind, her manager called me and told that me that she had contacted him stating that she had volunteered to be interviewed by me. He confirmed that she was well enough from his perspective to be interviewed. He did, however, wait outside the interview room in a nearby café should she need him. This was not required, although she later reported that they did debrief afterwards.

I was also pleased that this interviewee worked in the Trust's X Division, where based on my knowledge and experience- as well as the testimony of other interviewees (both policy makers and staff with lived experience) was an area of the Trust where the sharing of lived experience was viewed as having more serious implications and associations. Risk/fear of the risk allegedly made it more difficult for staff within this division to disclose their mental health problems at work- to other staff, let alone patients.

The Interview

The interview went very well from my perspective from start to finish. The interviewee was very open and opted to share her lived experience in some detail even though I highlighted that this was not necessary. Her response was that she trusted me and that understanding her illness would better inform my understanding of experiences as a member of staff working for the Trust.

Throughout the interviewee the individual maintained good eye contact, as well as positive, open body language. She used hand gestures to express herself. Her speaking voice was very relaxed and engaging however physically she was very animated and kept changing leg positions (legs under her, reverse crossing etc.) every 10 minutes or so, which seemed to convey hyperactivity/ lots of energy. She did comment at one point that she had 4 types of medication prior to the interview, one of which I knew to be a sedative, and laughed as she asked if I could imagine how animated she would have been had she not taken them.
I was very careful throughout the interview to ensure that the questions I used were appropriate- ones that were sufficiently probing, but only relevant to the study- just as I would do with any interviewee, however perhaps I was more aware of it in this case, ensuring that she was safe and well.

It was interesting that the interviewee on several occasions asked me if she was on the right track, needing me to acknowledge that she was. I didn't see this as a lack of confidence or uncertainty on her part but instead her personally checking that she was not veering off the subject, having acknowledged that she had a tendency to ramble as part of her very nature.

Although the individual was aware of a number of policies and confirmed that she had a very supportive manager who had put in place a number of reasonable adjustments to help support her in work and keep her well, she had no knowledge of the Trust's Disability Leave Policy, which allows staff [X] hours to attend hospital appointments, therapy sessions etc. related to their disability. Instead, her manager had been very flexible allowing her the time, but she felt that it would have been better if she had known that it was there- an entitlement- and not just her manager making exceptions for her.

The interviewee also highlighted that she had used Trust services as a patient and recounted how supportive one of the psychiatrists had been in particular, and how he had inspired her to work in the NHS and help others, who many in society did not accept and understand. She was however concerned that as she had used Trust services her personal records were available for all of her colleagues to see should they choose to access them. These records detailed psychiatric states, hospital admissions, sectioning etc. which could result in inappropriate personal information being known about her. She suggested a separate database where the details for Trust staff that used services could be recorded that only key personnel could access. As she was a staff user of the patient record database, I asked her how practical that would be. She reflected that this would not be possible for a number of reasons. Instead, she suggested that staff with lived experience could be recorded under pseudonyms, only know to the psychiatrist and other personnel who may need the information for treatment purposes.

The interviewee had also had her essay published, which recounted her experiences as a staff member with personal experiences of mental health problems and offered to send me a copy. I agreed that this would be helpful. She has since sent me the journal link.

Post Interview Reflections

I was very pleased with the outcome of this interview and believe that the information I elicited from the interview was both highly relevant and very valuable to this study. I believe that my research interviewing skills have developed considerably, and I have developed a more investigative approach, while remaining within the strict ethical boundaries I identified in my application for ethical approval.

Interview held in interviewer's office.

11.2 LE9

Reflections Prior to Interview

The interviewee is a member of the Trust's Disabled Staff Network, however, has not attended meetings for several years. I understand that this may be to do with work commitments. I have therefore not had any interaction with him for several years and was therefore pleased that he responded to my interview request- sent out to members of the Living in Both Worlds group by the group facilitator.

My recollection of him at meetings was that he was often quiet and thoughtful but certainly spoke what was on his mind when they time was appropriate for him- particularly in relation to issues that were important to him such as mental health. I am aware that he had personal experience of using secondary mental health services- as he mentioned it in one of the meetings several years back and I believe that he is still a Community Psychiatric Nurse (CPN). I am therefore looking forward to this interview as I believe that his experiences will add a further dimension to the study – both as a CPN and as a staff member who I believe has not disclosed his personal experiences of mental health problems to many people in the Trust- particularly to those in the services where he works.

The Interview

The interview was rescheduled twice due to the individual's work commitments: On the first occasion for a tribunal, which he was required to attend, and on the second to attend a funeral. From this I understood that he was having a particularly busy and perhaps stressful time at work, so I wanted to make sure that he was in the right place to be interviewed. He confirmed by e-mail that he was happy to be interviewed and was looking forward to it.

Prior to the interview commencing we had a 10-minute chat about how the funeral went and discussed his hobbies. I wanted to do this to build rapport with him and to help us both relax as it had been several years since we'd last met. This worked well as throughout the interview he was very relaxed, leaning on the table in a relaxed manner and maintaining good eye contact throughout the interview. His body language was open the majority of the time and he used hand gestures to express himself, at times leaning in to emphasize a point. He was certainly not as quiet as I had anticipated and in fact spoke at length on his experiences and his view of the organisations support mechanisms for staff with personal experiences of mental health problems. Furthermore, his responses were well though through and he sounded confident- despite confidence or indeed lack of it being one of his self-identified 'problems'. The challenge for me therefore was to ensure that I delved deep enough to get the key information for the study whilst guiding him gently to enable us to progress through the interview in the allocated time. However, all of the information he was giving me was relevant as it was based on his considerable experiences and was interesting to hear.

He was, I believe, very honest, sharing many of his experiences of working for the Trust, including being assaulted at work on several occasions and suffering from consequent PTSD. He was reflective at times thinking about his experiences, but I believe at no time tried to sanitize them as he shared with me some very persona information, which he later said he had never shared with colleagues or indeed his family i.e. in relation to self-harm. I felt privileged that he was comfortable enough and trusted me enough to share this information and I acknowledged this appropriately. He was so assured in the confidential nature of this study that he mentioned his own name several times, and also the colleagues/ managers who had supported him. It is interesting to note that he at no

time mentioned the names of those managers who he deemed as unsupportive, simply referring to them by job title.

He also talked to me openly about how he had met with a specialist in trauma for the Trust called [X] and for the first time was able to get real and meaningful help for his PTSD. He talked about [X] using a technique which he couldn't remember the name of, but it sounded to me like EMDR (Eye Movement Desensitization and Reprocessing) Therapy.

The interviewee shared some of the techniques that he had been trained in to support the needs of others i.e. his clients- but which he found useful personally e.g. Relapse signature work- where an individual tries to identify their relapse signatures i.e. patterns of thinking and behaviour that can signal the onset of episodes or additional episodes (usually of depression); and also Formulation- i.e. the process of making sense of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them (a bit like a narrative that a professional draws up with an individual and in some cases their family/carers). He also mentioned that despite being a Community Psychiatric Nurse (CPN) he constantly reminded himself to identify as a Community Mental Health Nurse due to the stigma created in the community and indeed the Trust around the word 'psychiatric' and our need to identify people by their diagnosis as opposed to the fact that they (as with all of the population) have a mental health issue- only in the case of patients and clients there is at the far end of the spectrum. He also shared self-management techniques that he personally used e.g. reading, sport, mindfulness, relapse signature plan, making lists etc.

At the end of the interview, he was keen to remind me that if I ever needed any help or information regarding my study to contact him as he would be very pleased to help. It genuinely felt good to be doing this

study and that I was being supported to do this by staff who had personal experiences of mental health problems who worked for the Trust.

Post Interview Reflections

After the interview was over, when the tape was switched off, he remembered that he had forgotten to say that he made up stories in his head to get himself through difficult times and would progress and add to these stories sometimes for weeks on end. In these stories he was always a superhero. This made me think of people who have suffered adversity but who use that experience to try and help others despite the personal pain that it can put them through (both physical and mental).

I was very pleased with the way the interview had gone and firmly believe that my skills as a researcher continue to develop well. I was able to encourage the interviewee to share his experiences and probe deeply into them/his understanding of the impact of them while gently progressing the discussion to ensure that all aspects were addressed. He was very open and honest and shared a number of personal experiences -relative to the study- and it was clear that he wanted to help progress this work- perhaps making up for the time that he alluded earlier in the interview- where he had not dedicated any time recently to the work of Living in Both Worlds because of work commitments. He was clear that the LIBW group needed the support of people like him and other staff with lived experience in order to help the Trust make a difference to the working experiences and therefore lives of staff with personal experience of mental health problems. I believe that some very rich and valuable data was elicited from the interview that will be of considerable importance to my study. Furthermore, I enjoyed this interview and on reflection have identified that it has been of personal value to me in that I have developed a deeper understanding of yet another staff member who works for the Trust and who is bravely committed to sharing his

experiences with others -where appropriate- to aid/support their recovery.

Recommendations:

- At a previous Trust he worked- CPNs used to go into schools as part of their role to raise awareness of mental health issues, but more importantly to help young people problem solve e.g. using examples of arguments with peers- getting them to explore the issues and develop problem solving skills that would improve their emotional resilience.
- Change the designations of Community Psychiatric Nurses to Community Mental Health Nurses.

Interview held in neutral office.

11.3 PSW Focus Group: PSW 1-5

Reflections Prior to Interview

The invite to interview was e-mailed to all of the Peer Workers and Peer Support Workers by the Peer Development Lead. Eight PSWs responded to say that they wished to be part of a focus group.

I knew five of the eight volunteers to an extent in that I had had brief conversations with them at events. Another I had done a little work with as she had a second job in the [X] Team. Beyond that I knew little about them personally except that they were all staff employed because of their lived experience of mental health problems, due to the benefit it was believed such experience could have on patient recovery. I was unaware that they regularly met for peer development sessions, and due to the nature of their role had already shared a number of their personal experiences with each other at these development sessions or prior to that when some of them trained together to be PSWs.

I was really looking forward to the interview and hearing of the experiences of PSWs, having only heard sound bites about them from other staff with lived experience, and policy makers. I do not believe that I had any particular expectations from the group beyond them sharing their experience, something it seemed they were all eager to do from the e-mails they sent me volunteering to be part of the focus group. I am experienced in conducting focus groups in relation to service audits, staff opinion etc. so wasn't concerned about this aspect.

As with all of the interviews conducted, I ensured that participants had access to drinks etc., however as I would with any small gathering of people who had volunteered to be part of something I bought 2 boxes of cakes for attendees to eat. Not only is this my normal behaviour but something I read as good practice in a Guide to Conducting Focus Groups (Duke University, North Carolina) and the Omni Guide to Focus Groups (recommended by St. Olaf College Minnesota).

In order to ensure that the interview was a. appropriate for PSWs and b. that there was a focus on the most important areas I re-ordered and rephrased some of the questions on the interview guide and also left the questions more open to enable participants to tell me of their experience.

The Interview

On the day there were five PSWs interviewed, as two individuals were off work sick and the other was unable to participate. Having had a discussion with one of my PhD supervisors a few weeks prior to the interview she had suggested that my target of eight people was quite high as this could be difficult to manager- suggesting a good number for a focus group of this type was between four and six. I was therefore happy that five participants were present and keen to be interviewed.

The room itself was a perfect size for the six of us. In the one-to-one interviews I had used two digital recorders, however as I had five participants, I opted for three, one of which was attached to a larger microphone. I had trialled its effectiveness at a previous meeting and was happy with the outcome. I wanted to ensure that I captured everyone's experiences and am really glad that I opted for three recorders as two of the participants were quiet spoken. Prior to the interview commencing I went through the participant information sheet. We agreed on ground rules and individuals were happy to complete and sign their consent forms. I explained that while I could ensure confidentiality, I could not guarantee that for others in the room. All attendees were happy that 'anything said in this room should stay in this room' was one of the ground rules, however, as mentioned, it was clear from the interview that they had all shared much deeper and more sensitive experiences/ information with each other and appeared really quite unconcerned with this ground rule.

After the initial explanation of the project (Participant Information Sheet) and agreement of the ground rules, one of the individuals asked if it was a convenient time for her to go and check on domestic arrangements to enable her to stay the full course of the focus group. I was happy to agree to this even though she had arrived later than the 2pm agreed start time. When she left to make a few phone calls it was clear that there were some 'interesting' group dynamics, which were also observable in the focus group.

All of the participants were eager to speak, however for some reason- perhaps because of the ground rules- were very polite and allowed each other their time and space to share their experiences. It was therefore quite slow to begin with, but really gathered momentum after the first 30-40 minutes or so. As mentioned, a couple of the participants were quiet

spoken so I was glad that I had three voice recorders even in a small room. At the beginning i.e. the first 30 minutes or so individuals looked at me when sharing their experiences, however after that time they started to respond to each other, looking at each other and picking up cues from their colleagues, nodding and agreeing, but also politely agreeing in a way that said 'I respect and accept your experience but mine's is different'. The reassurance that they had initially sought from me they were getting from each other. All of the interviewees were relaxed, had a drink in front of them, a few nibbled at cakes and had open body language. One of the participants part-way through the interview had what she described as "jittery arms", but it seems that is quite normal for her on occasion and may or may not have had something to do with the large can of energy drink that she was drinking.

I believe that all the interviewees were very open and honest in their accounts and prepared to share their experiences. It seemed they had a common aim to help improve the workplace experiences of staff with lived experience of mental health issues, but perhaps more so themselves i.e. PSWs. It was clear that each of them had had good and bad experiences within their teams, particularly in relation to support and feeling valued. However, it was clear that the role of PSW was not in their opinion fully understood within the organisation, that there wasn't enough of them despite promises, that there were tensions with other staff (HCAs), often misunderstandings about their role (sometimes with ward managers e.g. being asked to make beds). Two of them believed that they had to continuously fight to maintain their existence, and that there was no career path. Examples were also given of how they were often excluded, which they acknowledged was perhaps seen by others as a protection e.g. a poor PSW shouldn't see or hear of a really unwell patient in case it causes them distress. This they all found frustrating, although only two of the five participants gave examples of such personal experiences. Others

however agreed that at times colleagues tip toed around them for fear of upsetting them, rather than treating them like an equal who had developed levels of resilience based on these very experiences. One interviewee pointed out that any member of staff could be affected by an incident or become poorly at any time.

I understood that PSWs were supernumerary to the staff on the ward and asked if individuals felt a valid member of the team. A number of experiences were shared, however it was clear that they didn't want to be part of the ward numbers e.g. one of the two staff that had to be present for example, to ensure safe staffing levels. They were adamant that they were and should be supernumerary and in fact one individual recounted how every time she is on the ward, she has to rub her name off of the dry-wipe board. They are keen to be seen as different from staff and see this as very important, particularly to the patients. If they get involved in making beds, doing observations, giving out medications or restraining patients the dynamic changes as does the trust patients have in them as peers- helping out at breakfast one day was seen however as acceptable.

Only two of the interviewees had heard of the Disability Leave guidance, however most were aware of and had used other support mechanisms including supervision, though perhaps more so the support they each gave each other as PSWs. I realized at this point that the aforementioned group dynamics I mentioned earlier were similar to a family situation, where the perpetually busy colleague, whom they rolled their eyes about, was seen as the naughty, but much-loved little sister.

Another service, mentioned for the first time in this Focus Group, was the Occupational Therapy Team. The phrase "if anyone gets the role of PSWs it's them" was used. Not only had PSWs found support with Occupational Therapy colleagues but a mutual respect and value. Furthermore, they

found Occupational Therapy colleagues supportive when needing advice on both personal and patient issues.

The following recommendations were made as to what the Trust can do to improve its support to staff with personal experiences of mental health problems:

1. Enable peer progression- develop a career path for PSWs
2. Give managers the flexibility to lengthen the period of a phased return, especially if the individual concerned has been off for several months
3. Ensure that PSWs are supernumerary to the establishment- not part of the ward numbers
4. Establish a PSW in **every** team
5. Develop an independent network that is available for all staff with personal experience of mental health problems i.e. with flexibility to enable drop ins
6. Ensure that PSWs can be and are supported to be flexible in their roles to meet the needs of patients
7. Raise awareness throughout the organisation about the role of PSWs, the difference in their roles from other staff and how they work differently.

N.B. the majority of these relate specifically to PSWs. This is of interest as when asked if it would work if they were a nurse or a psychologist doing the same interventions, they emphatically stated no. So, despite wanting a career path, they believe that their value is as PSWs. Is this contradictory? Is there a win-win solution?

Post Interview Reflections

Although I have conducted focus groups in the past, this was probably the hardest one- perhaps because I usually have administrative support or someone assisting me, but this time to ensure no undue pressure on the

participants it was only me. On reflection I believe that the focus group was effective, but as the interviewees had so much to tell me one-to-one interviews may have been valuable. Saying that, the interviewees fed off each other's responses- and nodded or shook their heads in agreement with each other- something unfortunately not obtainable from a voice recorder. Most, if not all of them had more to share and would have been happy to have done so individually, however what I would have lost from one-to-one interviews was the group dynamics, the sharing of vocabulary, the shared sense of achievement and injustice. Perhaps I was just being a bit hard on myself an expecting the equivalent of five one-to-one interviews from a 90-minute focus group. Seems silly now when I reflect on it.

I also noted that rather than use the formal semi-structured interview guide, my questions were much more free-flowing and emanated from things the Peers said i.e. more intuitive, less rigid and more "in the moment".

On writing these notes and reflecting it does seem that I may have been expecting too much from a focus group (in terms of breadth) and putting undue pressure on myself after the event. N.B. I was very relaxed in the interview itself and modelled positive behaviour, open body language, good eye contact etc. It now seems clear to me that there was quite a depth of data mined via this focus group which I had not been previously cognisant of until writing it all down- much of which would have been unlikely to have come from individual one-to-one interviews. As with everything in this PhD it is a learning experience and I have learned that a great deal of valuable information can be obtained in a very short time via a focus group such as this, because unlike traditional focus groups which I have conducted based on a particular issue/problem/ concern, the key here is opening up dialogue, exploring experiences and creating new

information through this dialogue/ discussion- not solving it. I therefore am happy with my performance and the outcomes, however plan to work on these skills and develop them further in the future.

Interview held in neutral office.

Post Meeting Note: PSW2 requested to meet me, following my sending out of a generic thank you message to the focus group members. She states that she has more to say, something that was evident from a comment she made at the end of the interview, but which I believe for time reasons she chose to not expand on. I have agreed to meet her to hear what she would like to add.

Appendix 12: Letter of Ethical Approval: NHS Health Research Authority, NRES Committee London - Surrey Borders

NHS
Health Research Authority
NRES Committee London - Surrey Borders
Research Ethics Committee (REC) London Centre
Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 020 797 22561
Fax:020 797 22592

20 August 2014

Professor Patrick Callaghan
Professor of Mental Health Nursing and Head of School of Health Sciences
University of Nottingham
Professor of Mental Health Nursing Head of School of Health Sciences
University of Nottingham, A Floor,
Queens Medical Centre, Nottingham
NG7 2UH

Dear Professor Callaghan

Study title:	**Do Mental Health Services Provide Considered and Progressive Employment Practices that Support the Needs of Staff who have Personal Experiences of Mental health Problems?**
REC reference:	**14/LO/1523**
IRAS project ID:	**159156**

Thank you for your letter of 18 August, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mr Atul Patel, nrescommittee.london-surreyborders@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

Document	*Version*	*Date*
Covering letter on headed paper [Covering letter]	1	05 August 2014
Interview schedules or topic guides for participants [Interview Guide for Staff with Lived Experience of Mental Health Problems v1 240714]	1	24 July 2014
Interview schedules or topic guides for participants [Interview Guide for Policy Makers and Managers v1 240714]	1	24 July 2014
IRAS Checklist XML [Checklist_05082014]		05 August 2014
IRAS Checklist XML [Checklist_18082014]		18 August 2014
Other [Extended Study Protocol v1 240714]	1	24 July 2014
Other [3d. C Conchar PIS for 1 to 1 Interviews Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [Invite to 1 to 1 Interview Policy Makers and Managers exc CEO and Chair v1 160814]	1	16 August 2014
Other [Covering Letter 160814]	1	16 August 2014
Other [4aii. C Conchar Consent Form for 1 to 1 Interviews Policy Makers and Managers CEO and Chair v2 160814]	2	16 August 2014
Other [Invite to Focus Group Disability ES Group v1 160814]	1	16 August 2014
Other [3b. C Conchar PIS for Focus Group Disability ES Group v3 160814]	3	16 August 2014
Other [4c. C Conchar Consent Form for Focus Group PSWs Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [3c. C Conchar PIS for Focus Group PSWs Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [4d. C Conchar Consent Form for 1 to 1 Interviews Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [4ai. C Conchar Consent Form for 1 to 1 Interviews Policy Makers and Managers exc. CEO and Chair v2 160814]	2	16 August 2014
Other [Invite to 1 to 1 Interview Policy Makers and Managers CEO and Chair v1 160814]	1	16 August 2014
Other [3a. C Conchar PIS for 1 to 1 Interviews Policy Makers and Managers v3 160814]	3	16 August 2014
Other [4b. C Conchar Consent Form for Focus Group Disability ES Group v2 160814]	2	16 August 2014
REC Application Form [REC_Form_05082014]		05 August 2014
Referee's report or other scientific critique report [Scientific Critique by Prof. P Crawford]	1	29 July 2014
Research protocol or project proposal [Study Protocol v1 240714]	1	24 July 2014
Summary CV for Chief Investigator (CI) [CV Prof. Patrick Callaghan]	1	24 July 2014
Summary CV for student [CV Ms Catherine F Conchar PhD Student]	1	24 July 2014
Summary CV for supervisor (student research) [6c. Co Investigator & Academic Supervisor J Repper CV]	1	04 August 2014
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Protocol Synopsis v1 240714]	1	24 July 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

14/LO/1523	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp

Sir Adrian Baillie
Chair

Email: nrescommittee.london-surreyborders@nhs.net

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Mrs Shirley Mitchell*

Appendix 13: Letter of Approval from Sponsor

[redacted]

E-mail: [redacted]
Direct Line: [redacted]

Date of NHS Permission: 2 September 2014

Professor Patrick Callaghan
Professor in Mental Health Nursing and Head of School: Health Sciences
University of Nottingham
A Floor
Queens Medical Centre
Nottingham
NG7 2UH

Dear Patrick

Study title: Do mental health services provide considered and progressive employment practices that support the needs of staff who have personal experiences of mental health problems?
Sponsor: [redacted] NHS Trust
IRAS/REC ID: 14/LO/1523
Principal Investigator: Ms Catherine Conchar

Thank you for submitting your project to the [redacted] NHS Trust's R&D Department. The project has now been given NHS permission by:

Dr [redacted]: R & D Director, on behalf of [redacted] NHS Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version	Date
Interview schedules or topic guides for participants [Interview Guide for Staff with Lived Experience of Mental Health Problems v1 240714]	1	24 July 2014
Interview schedules or topic guides for participants [Interview Guide for Policy Makers and Managers v1 240714]	1	24 July 2014
Other [Extended Study Protocol v1 240714]	1	24 July 2014
Other [3d. C Conchar PIS for 1 to 1 Interviews Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [Invite to 1 to 1 Interview Policy Makers and Managers exc CEO and Chair v1 160814]	1	16 August 2014
Other [4aii. C Conchar Consent Form for 1 to 1 Interviews Policy Makers and Managers CEO and Chair v2 160814]	2	16 August 2014
Other [Invite to Focus Group Disability ES Group v1 160814]	1	16 August 2014
Other [3b. C Conchar PIS for Focus Group Disability ES Group v3	3	16 August 2014

160814]		
Other [4c. C Conchar Consent Form for Focus Group PSWs Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [3c. C Conchar PIS for Focus Group PSWs Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [4d. C Conchar Consent Form for 1 to 1 Interviews Staff with Lived Experience of Mental Health Problems v2 160814]	2	16 August 2014
Other [4ai. C Conchar Consent Form for 1 to 1 Interviews Policy Makers and Managers exc. CEO and Chair v2 160814]	2	16 August 2014
Other [Invite to 1 to 1 Interview Policy Makers and Managers CEO and Chair v1 160814]	1	16 August 2014
Other [3a. C Conchar PIS for 1 to 1 Interviews Policy Makers and Managers v3 160814]	3	16 August 2014
Other [4b. C Conchar Consent Form for Focus Group Disability ES Group v2 160814]	2	16 August 2014
Research protocol or project proposal [Study Protocol v1 240714]	1	24 July 2014
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Protocol Synopsis v1 24071	1	24 July 2014

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available: [redacted]

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

[redacted]

Head of Research Management and Governance

cc.

PI: Catherine Conchar

Sponsor: [redacted]