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‘Consumer and carer consultants in mental health: the formation of their role identity’

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Consumer and carer consultants in mental health: the formation of their role identity.

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Abstract

Following the introduction of the first National Mental Health Plan in 1992 consumer participation was and continues to be identified as a key component of the reform of Australia's mental health services. One strategy to achieve participation has been the creation of the role of consumer and carer consultants (CCCs) who have been employed in public mental health services since the early 1990s.

Despite over two decades of service by CCCs there seems to be little consensus between the CCCs and mental health professionals regarding the roles and function of these positions. This qualitative study sought to explore the question of 'what is the role of consultants?' from the perspective of CCCs, focusing in particular on the formation of consumer and carer consultants' role identity. Four themes were identified, namely: Role Motivation; Role Preparation; Role Practice/Focus; and Role Ambiguity/Conflict. This paper explores these themes and their implications, and finally makes recommendations regarding clinical practice.

Background

Mental health services throughout the world have undergone significant policy reform over the past two decades, and Australia is no exception (Parham, 2005; WHO, 2009). Part of this reform has seen the increasing involvement of carers and consumers in the planning, delivery and review of mental health services, and is now a key component of the Federal Government's Mental Health Strategy (Commonwealth of Australia, 2009). One way in which consumers and carers are involved in mental health services is through employment as consultants. Consumer and carer consultants (CCCs) have been engaged in public mental health services in Australia since the first National Mental Health Plan was released in the early 1990s (Commonwealth of Australia, 1992). The most recent Australian figures (for 2004-2005) show a total of 55.3 full time equivalent consumer consultants and 13.5 carer consultants employed across 252 mental health service organisations (Commonwealth of Australia 2007, p. 61). While more recent figures are not available, it is likely that this figure will have increased over the past five years.

Carer consultants are defined as 'work[ing] with mental health staff in developing service responsiveness to the needs of carers and families' (Commonwealth of Australia 2009, p. 84). Consumer consultants are 'employed to advise on and facilitate service responsiveness to people with mental health problems or mental illness and the inclusion of their perspective in all aspects of planning, delivery and evaluation of mental health and other relevant services' (Commonwealth of Australia 2009, p. 84). Consumer and carer consultants are not direct service providers, but work in partnership with mental health staff and occupy diverse roles including:

- building relationships with individual consumers and carers and communicating their needs to health professional staff;
- investigating and advocating areas for improvement to local services, policy and procedures;
- participating in the selection of staff employed in the local services;
- advocating consumer and carer perspectives in the evaluation of local services; and
- contributing to training programs for service delivery staff (Commonwealth of Australia, 2007, p. 61).

Underpinning the consumer and carer consultant role ‘is a view that such participation can empower and inform consumers and carers, destigmatise mental illness and ultimately improve mental health outcomes by promoting a recovery orientation in service delivery’ (Commonwealth of Australia, 2007, p. 59). The notion of ‘recovery’ was introduced by consumer advocacy groups in America in the early 1990’s and is now identified as a key priority of the Australian National Mental Health Plan (Commonwealth of Australia 2009, p. 28). Recovery in relation to mental illness is an ongoing process aimed at achieving quality of life within the limitations of the illness. It is variously defined but generally involves the following: a spirit of unquenchable hope; the ability to define oneself apart from the illness; the ability to cope with symptoms; empowerment; and the ability to establish meaningful social connections (Adams, 2010; Anderson, Carputi and Oades 2010; O’Connor and Delaney, 2007).

While consumer participation at all levels (i.e. policy development, service planning, service delivery and evaluation) is a cornerstone of policy, a plethora of commentators and

researchers have observed that the rhetoric of Australia's mental health policy has not transpired into action (Casey, 2006; Goodwin and Happell, 2006; Hickey and McGorry, 2007; Kidd, Kenny and Endacott, 2007; McAllister and Walsh, 2004; Roper and Happell, 2007; Thornicroft and Tansella, 2005; Whiteford and Buckingham, 2005). Implementation at state and territory level is variable and reliant on 'champions' (Parham, 2005). This has certainly been the case in relation to the involvement of CCCs in mental health service provision, where significant variation has been evident in the employment of CCCs across states and organisations (Commonwealth of Australia, 2007).

Furthermore, a number of researchers and commentators have noted that the CCC role is not well defined, has no career pathway and little evaluation has been undertaken (Casey, 2006, Cleary, Freeman and Walter, 2006; Kemp, 2010; Meehan et al., 2002). This is a significant problem as previous research in other areas (such as nursing) has identified that role conflict and role ambiguity can occur, particularly when roles are not clearly defined and understood, which further contributes to reduced job satisfaction (Tarrant and Sabo, 2010; Wu and Norman, 2006). Role ambiguity is defined as: 'Disagreement on role expectation associated with a lack of clarity of those expectations' (Brookes et al., 2007, p. 149), while role conflict is defined as: 'The focal person perceives existing role expectations as being contrary or mutually exclusive' (Brookes et al., 2007, p. 149).

In order to ensure the effective involvement of CCCs in the provision of mental health services it is important to understand how individuals experience the consultancy role. One way to do this is to explore consumer and carer consultants' experiences and perceptions of their role in relation to the formation of a CCC role identity.

According to identity theory, individuals ‘possess as many identities as they occupy positions (or roles) in networks of social relationships’ (Ng and Feldman, 2007, p. 116). Role identity refers to the way in which identities are fashioned around particular roles (Forbes and Davis, 2008), such as the role of CCC. The development of an identity around a role is an ongoing process that is determined by the ways in which people envision themselves fulfilling the role through practice (Forbes and Davis, 2008). It incorporates their subjective experiences, including their personal history, education and experience (Forbes and Davis, 2008), as well as reflection on other people’s reactions (Schmidt, 2000).

In this paper we report on a small-scale qualitative study that aims to obtain an understanding of consultants’ formation of a role identity in relation to the CCC position.

Method

Participants

Three consumer and two carer consultants from one metropolitan Australian mental health service participated in the study. All five participants were recruited from a group of consultants who were participating in another study involving CCCs teaching in a postgraduate mental health multidisciplinary postgraduate program. While recent figures are not available, according to 2004-5 figures reported in the National Mental Health Report there were 68.8 full-time equivalent consumer consultants employed in Australian mental health services (Commonwealth of Australia, 2007), thus participants in this study represent approximately 7% of the national workforce.

The two carer consultants provided care for family members with mental illness. They had more than 10 years involvement in the consumer movement. The three consumer consultants had personal experience of mental illness and had between 3 and 15 years involvement in the consumer movement. All five CCCs had been employed part time in acute mental health inpatient or rehabilitation units for between 6 and 12-months prior to the interview.

Data collection

The consultants took part in individual semi-structured interviews, which consisted of 13 prompt questions, exploring their experiences as consumer or carer consultants (see Table 1). The interviews were conducted in the consultants' workplace with an average length of 90 minutes. Interviews were audio-taped and transcribed verbatim. Ethics approval was granted by the relevant organisations prior to any data collection taking place.

Semi structured interview questions
1. How long have you been in the consumer movement and in what capacity? 2. How did you come to be in your current role as a CCC? 3. What attracted you to this role? 4. Tell me about your current role as a CCC. 5. What courses, supports or preparation have been provided to you for your role? 6. How is your role different to that of other team members? 7. What are your perceptions of the attitude of the multi-disciplinary towards your role? 8. What do you most value about your role? 9. What are the best and worst aspects of your role? 10. What opportunities do you see for the role of CCCs in the future?

- | |
|---|
| <p>11. What ‘clinical’ supervision do you have?</p> <p>12. How do you manage your own mental health whilst undertaking the role of CC?</p> <p>13. Is there anything else you would like to say?</p> |
|---|

Table 1. Semi-structured interview questions

Analysis

A thematic analysis of the interview transcripts was undertaken following the Thematic Network (TN) model outlined by Attride-Stirling (2001). The TN model is an analytic tool that provides a systematic analytic process allowing rich exploration of the data. The process involves 3 steps, namely: reduction of texts in lower order premises (basic theme); grouping together of basic themes and identification of patterns in the data (organising theme); integration of the organising themes and interpretation of meaning (global theme).

A researcher not involved in the data collection and initial interpretation independently reviewed the analysis and interpretation.

Findings

Texts from the interviews were analysed to identify the ways in which the respondents formed their identity in relation to the CCC role. Data from interviews were manually organised (using MS Word) into basic themes, which were then organised into groups of similar themes under the global theme of ‘Consumer and carer consultants’ role identity’.

Within this global theme four organising themes were identified. These were: Role Motivation; Role Preparation; Role Practice/Focus; and Role Ambiguity/Conflict. The themes are summarised in Figure 1 below.

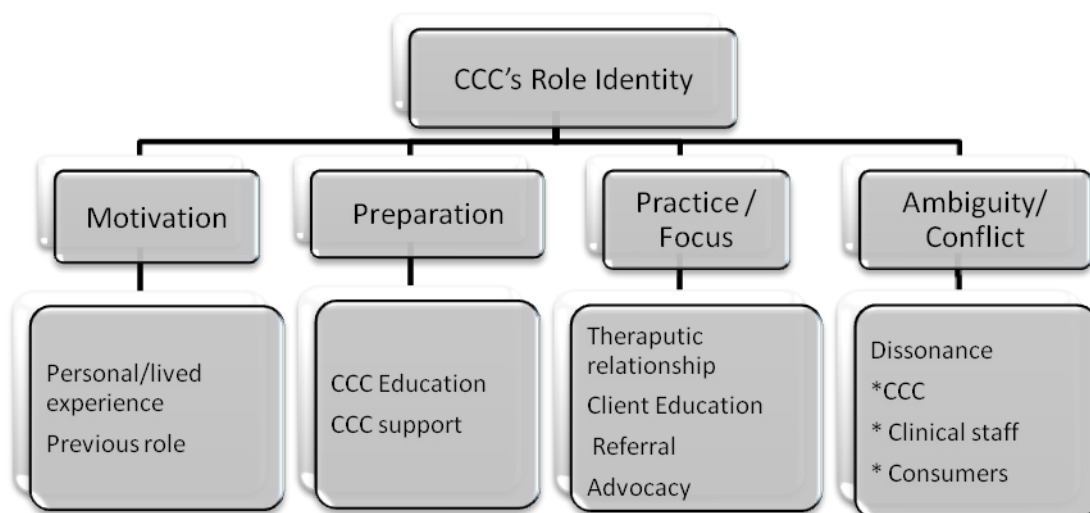


Figure 1. Global, organising and basic themes

Consumer Carer Consultant's Role Identity

The global theme 'Role identity' refers to the ways in which the consumer and carer consultants 'fashion a sense of self' (Forbes and Davis, 2008, p. 911) in relation to the CCC role. As discussed earlier, the development of a CCC role identity relies on the ways in which the CCCs envision themselves fulfilling their role through practice (Forbes and Davis, 2008). According to Forbes and Davis (2008) role identity formation is influenced by experiences in three domains: personal history, education and experience. This is reflected in our study whereby the CCC role identity is developed and maintained through the integration of the CCCs' role motivation (what motivated them to undertake the role – their personal history), their role preparation (the education they undertook to prepare them for the role) and their direct experiences of working in the role (Role practice/focus). Through this process the CCCs develop a role identity that is oriented around the principles of mental health recovery discussed earlier in the paper.

Role motivation

The respondents were motivated by their personal or lived experiences to assist others in similar circumstances to their own, and by the desire to further develop their existing roles within the mental health sector.

Personal/lived experience

The CCCs were motivated to apply for the CCC role by their personal experiences as carers or as consumers experiencing mental health recovery. As a result the CCCs felt the need to use their experiences to help others achieve recovery; thus they were motivated by passion, drive and altruism, and a feeling of responsibility to help others.

Given the differences in their personal experiences, differences in motivation between carers and consumers existed. Carers were motivated by their negative experiences to help other carers to ensure they did not experience the same difficulties, for example not being able to get information or support:

To try and help carers because I wish there'd been somewhere, someone who was a carer there in the years I've had of visiting hospitals with my daughter in there ... and there was no-one to talk carer to carer and you were lucky if anyone told you anything about what was going on. So in that role I think I feel, I hope I can help other carers. (Carer 1)

The consumers, by contrast, drew on their positive experiences of recovery to motivate them to help and support others:

I do know about recovery, what it takes to have a journey of recovery, of maintenance, of wellness. The best thing is I can stand up and walk next to people that may not have had the opportunity but by me being there could inspire them and understand what they can do as well. (Consumer 2)

One of the carers also identified being motivated by a passion to educate health professionals and the general public about what it is like to be a carer/consumer drawing on their personal experiences:

... one of my big passions is really educating everyone about the lived experience of mental illness. I think it's really vital that we know what it's like because you can read books, you can read all sorts and get education about mental illness but until you've actually personally experienced it it's quite a different thing. (Carer 2)

Previous Role

The respondents' drive and passion for helping others had led them to occupy roles in advocacy or working in other roles within the mental health sector. These experiences made them feel that they were capable of fulfilling the CCC role. The decision to apply for the

CCC position was driven by a desire for change, to formalise what they were already doing and get paid for their time and expertise, and because they wanted a challenge. The respondents also felt that the position of CCC was an important and necessary one, and one that had a future as demonstrated in the statements below:

... I guess I really think they do a terrific job so I think it's terrific whatever we can do to keep them going, you know especially in the current climate I think it's just good to have carer consultants there and so I decided that I would apply for one. (Carer 2)

One carer consultant felt that she needed to apply for the job when she saw that an important aspect of the role—service improvement was being overlooked:

... supporting the carers is only one part of the job you've also got to really be constantly encouraging services to work better with families because there's still a lot of carers out there really feeling isolated that they're not included, so I think that that's a big part of our job. (Carer 2)

By taking on the CCC role the respondents were able to strengthen their pre-existing role identity through a more formalised and challenging role.

Role Preparation

The respondents' personal/lived experiences and their previous roles as advocates, volunteers or support workers in the mental health sector facilitated the development of their CCC role identity. This identity was further developed by the education and support the respondents experienced.

CCC Education:

The consumer and carer consultants were undergoing formal preparation for their role by undertaking the Certificate III Mental Health through a Registered Training Organisation (RTO). The course is aimed at people who work in the community service industry providing support services to people with mental health issues, and is oriented around the principles of mental health recovery. One carer had also been to a workshop on recovery, although this was not organised through her place of work.

CCC Support

The respondents furthermore had access to mentors and peer support from meetings with other CCCs. Carer 2 stated:

We have meetings with [the person] who's running this project of carers and care workers once a month where we all go and talk about positives and negatives and issues we've got.

The role preparation for the CCC's has therefore been predominantly through the vocational Certificate III, mentorship and other peers/carers, but little support and preparation has been provided through the mental health organisations where they are employed.

Given that the aim of the CCC role is to apply the principles of mental health recovery it is likely that meetings with mentors and other CCCs would further support this role identity. This means that the orientation of the CCC role identity around the principles of recovery is reinforced by both the participants' previous experiences and their preparation for the CCC role. This is further supported by the focus of the CCC role as experienced and understood by the respondents.

Role Practice/Focus

The participating CCCs experienced varying degrees of structure in their role practice. For three of the respondents (one carer consultant and two consumer consultants) the roles were flexible but not very defined, and these CCCs described themselves as 'autonomous' (Carer 2) and 'flexible' (Consumer 3) in their role. Flexibility can be seen in the following quotes:

I will go with the flow basically, whatever the clients want in that day ... Generally no two days are the same. (Consumer 3)

Consumer 1 experienced less autonomy in terms of being given restrictions on how to practice the CCC role in terms of his ability to approach clients: 'I'm not allowed to be in the client's face' (Consumer 1). However, Carer 1's role was the most defined as one involving preparing families for their relative's discharge, as can be seen in the following quote:

I've been put in here as it turns out to try and convince families that it's going to be a good thing for their family member to be put out of here [discharged]. (Carer 1)

Nevertheless, these respondents were still able to determine how they went about their day-to-day activities.

Given the lack of a pre-defined role respondents were able to construct their role in the way that they determined to be most effective. Carer 1, for example, described participating in family meetings and talking directly to carers and clients. Two of the consumer consultants described running discussion groups and also letting the clients determine what else they might need. For example, Consumer 3 described her work day as follows:

I go to the morning meetings and if I've got a discussion group planned I'll announce that for the day and then I'll run my discussion groups on various topics, recovery or that sort of thing and then I'll go and evaluate the discussion groups and then I will go with the flow basically, whatever the clients want in that day.

Within this flexible and autonomous approach to the CCC role the respondents described the role as being focused on supporting people with mental health problems towards recovery. While both the carer and consumer consultant roles were recovery focussed, the consumer consultants referred to this aspect of their roles more directly. Supporting the recovery process included developing a therapeutic relationship with consumers and their carers, providing information, education and referral, and advocacy.

Therapeutic relationship

Developing a therapeutic relationship with consumers and their carers involved providing them with support, information and partnership. This was contrasted to the role of other staff members which was seen as more clinical and interventionist:

... what I do is I tell them briefly that I'm not a clinician, that I'm there to offer them the personal perspectives, that I've got personal experience with mental illness and so I'm there to support them.
(Carer 2)

Central to the ability of the CCCs to develop therapeutic relationships was having personal experiences as carers and consumers, as articulated by Consumer 3 below:

Well basically I'm relating to the clients from a level which is a bit different [to the clinical staff] because I'm coming from a lived experience. I'm friendly with the clients perhaps, I'm more on their level.

CCCs also saw their role as being available to carers and clients, talking with them about their needs and not being judgemental, which further fostered a therapeutic relationship.

Carer 2 stated:

... telling them about the supports that are around and if you need my help with anything, offering to come to family meetings if that's what they'd like, if they need someone to support them, so

each client is different with things you can offer and also for some people it's just being available and saying I can understand what you're going through so if you just want to chat about it you can do that with me.

An important aspect of the CCCs' therapeutic relationship involved talking with clients and their families about their experiences and aspirations. Through this process the respondents viewed their role as 'positive' (Carer 1) and 'hopeful' (Consumer 2), supporting clients and their carers towards recovery.

Client Education/Information/Referral

A further focus of the CCC role was identified as providing carers and clients with education, information and referrals. The consumer consultants in particular identified providing education around recovery as an important part of their role:

I'm basically an educator... educating groups on mental illness recovery, self esteem, that sort of thing. (Consumer 3)

By contrast, the carer consultants were not involved directly in educating carers; instead they provided information on the facilities and supports that are available in the community for carers and consumers, and also referred carers to other organisations for support and information:

... because of my contacts in the non-government sector I can also help people to link the person when they're discharged with community services as well. (Carer 2)

Advocacy

The final element of the CCC practice focus was identified as advocacy. This was discussed in particular by the carer consultants. For example, Carer 2 talked about the importance of informing carers about their rights and responsibilities within the mental health organisation:

So talking about their rights and their responsibilities and I guess helping them, we advocate, well we're not meant to be advocates you know but to me it is. (Carer 2)

For Carer 2, the advocacy role was seen in her drive to ensure that carers are included in the management plans of the person they support.

Role Ambiguity and Role Conflict

As discussed in the previous sections, the orientation of the CCC role identity around mental health recovery is formed and reinforced through the respondents' role motivation, role preparation and role focus. This is further validated through positive feedback from clients, carers and the multidisciplinary team:

When I'm walking along the street and one of the clients calls out and says 'hey' ... and waves, or chases me up. I guess I've had

really good responses from people I thought didn't take much notice when ... they were in [hospital], but who were keen to make sure that I knew that they were [doing well] ... it's nice.

(Consumer 1)

However, competing expectations and understandings, as well as hostility towards the CCC role were seen to cause the CCCs to experience role ambiguity and role conflict. For example, Carer 2's previous comment about being an advocate, though 'not meant to be'. Respondents' experiences of conflict and ambiguity occurred for a number of reasons. For example, many respondents discussed how they did not feel like they were accepted by or incorporated into the mental health team. Carer 1 stated '... some of the nurses I think would rather we weren't here' and Carer 2 initially experienced exclusion from meetings:

... I've been excluded up until a few weeks ago from the handover meetings, I was not included in them and I'm still not allowed to look at casenotes because I'm non-clinical –which is something strange ... (Carer 2)

However, this lack of acceptance appeared to change over time as the rest of the team gained greater understanding of the CCC role. Carer 1 observed: 'I'd say they're starting to turn round and accept me now but it has been a bit of hard work to explain what I'm doing'. And Consumer 3 stated:

In the beginning it was quite hard because the staff just weren't sure what they were getting themselves into but now that they know me and they've seen that I'm just like them really in a way it's not a problem, they've seen that I've got a valuable role.

Conflict and ambiguity were also the result of the CCCs feeling that other workers, or the organisation itself, were not oriented towards recovery:

... they see themselves as a very clinical service I suppose and ... I could see there was a bit of a resistance to a non-clinical face in being part of their consultations ... (Carer 2)

One respondent identified that she was assigned a role that was out of alignment with her expectations of the role, and this caused great frustration and concern:

... my role is to talk to families about this [discharge] and they're very worried about this and I'm worried because I can't say it's really going to work, I don't know, I hope it will work ... (Carer 1)

For two respondents conflict and ambiguity appeared to result from a lack of autonomy in the role, such as having to wait to be approached by clients, which Consumer 1 stated led to boredom. Carer 2 found it frustrating in the early months of undertaking the CCC role as she was not allowed to choose which carers to approach and had to be given referrals from other staff members, although this has since changed with the increasing acceptance of her role:

... and they give me a piece of paper that's a referral of a family that quite often they've named more a problem family than anything, but now as soon as I went to my very first meeting I had two clients that I picked out myself from the meeting with their permission of course, and just yesterday they just decided I could go for all of them now and I picked up four clients yesterday from the one meeting. (Carer 2)

Role conflict was also identified as resulting from the potential conflict between the CCC role and the roles the respondents' occupy outside of the work environment. For example, Carer 2 discussed the possibility of her job being made full-time and the difficulties this would cause:

... it's very difficult, a full time position and caring for someone with a mental illness is pretty hard for a lot of carers and maybe that's one of the reasons why a lot of carers aren't applying for the jobs (Carer 2)

Other respondents discussed the difficulties they experienced working in the CCC role and managing their own mental health. For example, when asked how she managed her own mental health Carer 2 responded 'not very well' and Consumer 3 stated:

Well I'm actually taking two days off ... I'm thinking that this will help immensely because I'll be able to relax and be away from the

ward and everything. I felt it was time because I started getting symptoms and I felt I might be needing a bit of a break.

Finally, one respondent discussed the problems associated with getting too emotionally involved with clients and being unable to disconnect from her concerns when at home:

The worst thing about my role is being too involved with the client, when we get emotionally involved and you feel like you go home at night thinking ‘oh my God I hope this person isn’t suffering too much’ and you take on their problems and that’s not good. (Consumer 3)

The respondents’ experiences of role conflict and ambiguity caused frustration for the CCCs and impacted negatively on their satisfaction with the CCC role.

Discussion

The aim of this small-scale qualitative study was to explore the ways in which CCCs perceive their role and fashion a sense of self in relation to the role. Findings demonstrate that the respondents’ personal history, role preparation and role practice contributed to the formation of a role identity oriented around the principles of mental health recovery. Role ambiguity and conflict were also experienced and these contributed to a negative perception of, and experience in the role.

The central role of recovery principles in the respondents role identity supports and reinforces the purpose of the consultant role, namely to ‘empower and inform consumers and carers, destigmatise mental illness and ultimately improve mental health outcomes by promoting a recovery orientation in service delivery’ (Commonwealth of Australia, 2007, p. 59). Through their experiences respondents were able to fashion a sense of themselves within the CCC role as making a valuable contribution to mental health service delivery within the recovery framework. Of interest was the finding that carers and consumers had different motivations in undertaking the role. Consumers sought to act as role models for people with mental illness to show them that recovery was possible, whilst carers were motivated by poor personal experiences with mental health services and wanted to improve services for other carers and people with mental illness. This has implications for the recruitment and training of CCCs and is worthy of further exploration.

In addition to personal history, education and experience (Forbes and Davis, 2008), the reaction of others is important in the formation of a person’s role identity (Schmidt, 2000). In this study we found that the ways in which others react to the CCC role had both a positive and a negative effect on the ways respondents saw themselves within their role. Positive responses from consumers, carers and staff reinforced the CCCs’ role identity and their perception of their role as positive, hopeful and helpful. By contrast, negative responses such as hostility and exclusion resulted in role conflict and ambiguity. Difficulties for CCCs in gaining support and acceptance within the organisation have been reported previously (Lawn, Smith and Hunter, 2008; Lloyd and King, 2003; Middleton, Stanton and Renouf, 2004), particularly when the role of the CCC might be perceived as impinging on the traditional roles of clinical staff, such as taking part in ward rounds or staff meetings (McCann et al., 2006). Middleton, Stanton & Renouf (2004, p. 517), for example, identified that ‘some of the

most significant factors that either help or hinder the consumer consultants in their work are the features of the organization'. Bradstreet and Pratt (2010, p. 38) also found that environments in which staff or practices were not recovery focussed posed challenges for the peer support worker. These findings highlights the need to provide appropriate and adequate and support to CCCs in their role, and also to ensure that the members of the multi-disciplinary team understand the recovery approach and appreciate the role of the CCCs and are suitably prepared to be able to work with and alongside them.

Previous research has also identified concerns about a lack of clarity in the CCC role (Casey, 2006; Kemp, 2010; Meehan et al., 2002). This is supported in our study, where role ambiguity and conflict were related to the apparent lack of clarity regarding the function and practice of the CCC role. In particular, it appeared that the respondents who were able to determine for themselves how they would undertake the CCC role were more satisfied, while those who had less autonomy seemed less satisfied and experienced greater ambiguity and conflict in the role. This need for role clarity is echoed in research by Pace (2009, P. 5), where New Zealand Community Mental Health Support Workers were found to be 'struggling to fashion their own scope of practice'.

In addition, consistent with other research some respondents perceived that the organisation and its staff were not oriented towards recovery, a concern that has been raised in previous research (Bradstreet and Pratt, 2010; Cleary et al., 2006; Middleton et al., 2004). For example Bradstreet and Pratt found that 'peer support works best when peers are based in settings that have a pre-existing commitment to the values and principles of recovery' (Bradstreet and Pratt, 2010, page 37) and concluded 'that peers should not be placed in services in which there is little pre-existing commitment to recovery' (Bradstreet and Pratt, 2010, page. 38).

Also, as other commentators have pointed out, within the context of mental health reform the language of recovery is now widely used in mental health policy, services and research, yet the interpretation of the concept varies, particularly between services and service users (Ramon et al., 2007). This variability has a negative impact on the ability of consumer and carer consultants to effectively implement a recovery based approach to their work with people experiencing mental illness, staff and families. There is furthermore the potential for the CCC role to be shifted away from its original intentions as CCCs become 'quasi mental health workers' (Casey, 2006, p.2).

While for the most part the CCCs saw their role as contributing positively to the carers, consumers and staff in the organisation, the experience of role conflict and ambiguity can lead to emotional distress, stress and reduced job satisfaction (Schmidt, 2000). This is particularly salient for CCCs who are personally invested in the CCC role identity through their desire to use their own experiences to help others, and who are often experiencing their own personal stressors (caring for someone with mental health problems or experiencing problems themselves). This highlights the importance of clarifying the CCC role, the need to provide adequate preparation and ongoing support and supervision, and to work with organisations and health professionals to understand, value and support the contribution of CCCs.

Finally, this study has reinforced the view of other researchers and commentators (Hickie and McGorry, 2007; Parham, 2005, Whiteford and Buckingham 2005) that system reform in Australian mental health services still has a way to go in re-orienting to a recovery model.

Recommendations

The findings of this study identify issues that must be addressed if Australia's mental health services are to deliver recovery oriented services, as articulated in policy (Commonwealth of Australia, 2009), and to ensure that the contribution of CCCs in the mental health sector is valued and maximised. Three recommendations are drawn from the findings of this study and are supported by findings from other research. They are:

1. Role clarity

Additional research is required to more clearly define the role and scope of practice of CCCs. The development of a written role description which clarifies the specific functions and responsibilities of the role could empower the CCCs to be more confident and assertive and confirm their place as members of the mental health care team (Casey, 2006; Kemp, 2010; Pace, 2009).

2. Preparation and on-going support for CCCs

Acceptance of the contribution made by CCCs could be expedited by a formal orientation and ongoing support and clinical supervision (Kemp, 2010; Bradstreet and Pratt, 2010). While participants had access to training and development through the RTO, and support from a mentor there wasn't a formal process of orientation into the role. This, along with lack of clarity around the role, contributed to the CCCs initially feeling directionless and not part of the mental health team. Furthermore, the provision of a formal process of ongoing support / supervision could provide professional development and reduce the stress experienced at times by the CCCs.

3. Ongoing staff development for clinical staff working alongside CCCs

Role ambiguity and conflict resulted from different perceptions of the role and the concept of recovery between CCCs and clinical staff. Over time participants were generally accepted by other members of the clinical team. This was most effective in settings operating within a recovery model. Staff development regarding the recovery model and the role of CCCs will facilitate an understanding of the role by the clinical team, and enable the CCCs to be recognised as contributing members of the multi-disciplinary team (Bradstreet and Pratt, 2010; Cleary et al. 2006; Goodwin and Happell, 2006).

Implementing the above recommendations could also contribute to the development of a career pathway for the consumers and carers who take on this role. Importantly, clarification of the role, the provision of a supported transition into the role and ongoing mentorship, support and supervision will help to reduce the ambiguity of the role for the clients, clinical staff and the CCCs and enable the consultants to be more effective.

Limitations

The number of CCCs who participated in the study was small, but did represent the entire cohort of CCCs within the organisation. Therefore this limits the generalisability of the findings to other settings. Nevertheless, the findings are consistent with, and reinforce the conclusions drawn by other commentators and researchers.

Conclusion

In this paper we have described the formation of a CCC role identity from the perspective of the CCCs themselves. Four themes were identified which influenced the CCC's perception of

their role. They were Role Motivation; Role Preparation; Role Practice/Focus; and Role Ambiguity/Conflict. Overall, the participants perceived that their role made a valuable contribution to mental health service delivery. However, they also identified that the clinical staff they worked alongside did not always share this view, and that the role of CCC was not always clearly defined nor understood.

These findings highlight the need to provide appropriate and adequate support to CCCs in their role, and also to ensure that the members of the multi-disciplinary team understand the recovery approach, appreciate the role of the CCCs and are suitably prepared to be able to work with and alongside them. Recommendations to address this have been made and include role clarification, preparation for the role, on-going professional development, support and supervision for CCCs, and staff development for clinical staff to assist them to understand the recovery model and how they can work alongside CCCs to provide recovery oriented care to consumers and their carers.

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