Service User Workforce Development Strategy

for the mental health sector 2005-2010

Published by the
Mental Health Commission
Wellington, New Zealand
2005
ISBN: 0-478-11399-4

Mental Health COMMISSION

Preface

This strategy is an important contribution to mental health workforce development in New Zealand. It links with a whole series of workforce development plans and strategies that have been generated by the Mental Health Workforce Development Programme and its workforce development centres. In particular, this strategy is closely aligned with the planning for the alcohol and other drugs (AOD) consumer workforce development being undertaken by the National Treatment Centre for AOD Workforce Development

This strategy was prepared by the Mental Health Commission with a service user steering group made up of Susie Crooks, Sarah Gordon, Chris Hansen, Iwa Natana, Jacob Read, Peter Ryder, Lina Samu and Debra Wells.

The following people gave responses to the draft strategy – Elizabeth Biddington, Ainsley Brunton, Raewyn Clarke, Caril Cowan, Helen Gilbert, Sonja Goldsack, Toni Gutschlag, Anne Helm, Tim Jackson, Mark Jacobs, Stephen King, Michael Lynch, Vito Malo, Jos van der Pol, Sheriden Pooley, Robyn Priest, Jude Ritchie, Rhonda Robertson, Sarah Scott, Lynere Wilson and Diane Yeldon.

Contents

Introduction

"By 2010 people with experience of mental illness will be a skilled, powerful, pervasive and openly identified part of the mental health workforce in New Zealand."

Over the last decade there has been growing awareness that people with experience of mental illness can be an important part of the workforce in the mental health sector. Recently, *Te Tāhuhu – Improving Mental Health 2005-2015* (Ministry of Health 2005) stated support for the development of a service user workforce. In response to this the Mental Health Workforce Development Programme, with national responsibility for workforce development, has signaled that there is funding available for the development of the service user workforce. This strategy has been developed to ensure that service user workforce development is focused, that funding is used to best effect, and that policy and service development support it.

Experience of mental health problems and the lessons people learn from these can be an important qualification for working in the mental health sector. But this experience is not enough on its own. Additional training and skills are needed to ensure service users are competent at the workforce roles and tasks they take on.

Service user workforce development, and workforce development generally, is part of the jigsaw that needs to be put together to create the services and workforce of the future. *Our Lives in 2014: A Recovery vision from people with experience of mental illness* (Mental Health Commission, 2004) gives a broad brush picture of what service users think services should look like in the future. It describes a fundamental shift to a recovery philosophy where self-determination of service users is paramount, where mental illness is seen as a valid and challenging state of being rather than just an illness, where there is recognition of the multiple determinants of 'madness', where recovery is expected, and where service users are major contributors to their own recoveries. This new philosophy takes us in the direction of the leadership of service users in services, including as part of the workforce. It strongly implies that we need a much broader range of services than is available now, including peer-run services. It puts service users at the heart of their own recovery and the recovery of their peers.

Mental health workforce development includes any initiative directed at the worker, their work or their environment, that improves the ability of the worker to facilitate recovery in people using services. This document begins by defining the service user workforce in the mental health sector. It outlines the major rationale for service user workforce development. It then discusses the current situation of the service user workforce. This leads to a strategy and a high-level action plan for nationally co-ordinated service user workforce development for the mental health sector from 2005-2010.

1. What is the service user workforce?

The service user workforce in the mental health sector is comprised of workers who have current or previous experience of using mental health services. This includes service users working in the specialist mental health system as well as those working with a mental health focus in anti-discrimination, public health and primary health.

The service user workforce can be clustered into two groupings.

Roles designated for service users only, such as:

- consumer advisors and service user policy analysts
- service user representatives, advocates and networkers
- service user researchers and auditors
- service user trainers and consultants
- service user governors on boards
- managers and frontline workers in peer-run services.

Generic roles that can be filled by any qualified people, such as:

- frontline workers, eg support workers, cultural workers, psychiatrists
- service managers, administrators and funders
- central agency policy analysts, planners, advisors, managers
- researchers, auditors, trainers.

2. What is the rationale for service user workforce development?

There are three major rationale that support the development of the service user workforce in the mental health sector. Philosophically it is the ethical thing to do. On a pragmatic level it is a sensible thing to do. On a policy level it is the expected thing to do.

2.1 PHILOSOPHY

Recovery

The recovery philosophy is widely accepted in the mental health sector, though it is not always well understood or implemented. This philosophy requires that services have hope for service users, respect their experience, support their self-determination, provide a much broader range of responses, and promote their social inclusion. By its nature, recovery must be led by service users and informed by the unique expertise derived from their experiences. This leadership needs to be reflected in their roles as service users as well as in the mental health workforce.

Human rights

In western democracies all citizens have the right to participate fully in their communities. In recent times, with the closure of institutions, this right has been fully extended to people with mental illness. Contemporary mental health services are a part of the community and also need to reflect human rights standards in the way they are run, so that they enable service user participation and leadership. Workforce development is one approach to developing service user participation and leadership, as well as contributing to their rights as citizens to work in the open labour market.

Consumerism

Consumerism originates in the commercial sector but has been absorbed into the health sector through contemporary management practices and advocacy from health consumers. Consumerism asserts that the interests of consumers must be paramount to the people and systems that provide them with goods and services. For people using mental health services, this often means receiving services from people who understand their experience, empathise with their struggle and can act as role models for recovery.

Treaty of Waitangi

In the mental health context the Treaty gives Māori the right to work with Government and its agencies to develop programmes and services that meet their needs, rights and aspirations, as much as they do for non-Māori. Service user workforce development sits in this context. This strategy and its implementation, through the development of the Māori service user workforce, must benefit Māori as much as non Māori service users.

Pluralism

New Zealand is an increasingly pluralistic society and the mental health sector is expected to respond to a diverse range of cultures and lifestyles. This diversity needs to be reflected in the workforce, including the service user workforce. For instance, Pacific peoples service users will benefit if there is a well developed Pacific peoples service user workforce.

2.2. PRAGMATISM

Service users have unique areas of effectiveness

Service users must, by definition, fill service user designated roles, but in all roles they may be in a better position than other members of the workforce to offer:

- empathy
- a lived understanding of mental illness, recovery and using services
- a role model for recovery
- a workplace culture more respectful of service users.

People with experience of mental illness working in anti-discrimination can create a double anti-discrimination effect, through their identity as people with mental illness as well as through the content of their work. The exposure of discriminatory groups and individuals to people with mental illness can be a potent anti-discrimination tool.

Service users are an untapped workforce

People with experience of ongoing mental illness have a high unemployment rate. Some have an interest in working in the mental health sector but they remain an untapped resource.

Service users can help to fill workforce shortages

There is an ongoing shortage of workers in the mental health sector. Increasing opportunities for service users to join the mental health workforce should be an important strategy for overcoming workforce shortages.

2.3 POLICY

Over the past decade there has been increasing acknowledgement in policy of the need to develop the service user workforce.

Generic policy

The *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998) is the implementation plan for the mental health strategy. It states: 'There needs to be an expansion of opportunities for people with experience of mental illness to take up roles in the mental health workforce …They can be employed as consumer advisors in clinical roles or support roles'.

Like Minds Like Mine National Plan 2003-2005 (Ministry of Health, 2003) has as its first objective: 'Engage the leadership and participation of individuals and groups of people with experience of mental illness'. The text states that more people with experience of mental illness need to be 'employed or contracted, and remunerated for their skill and contribution'.

National workforce policy

All of the major workforce policy documents over the last decade have mentioned the need for service user workforce development but the Māori, Pacific, and child and youth workforces have been given far greater priority. Virtually no action on consumer workforce development has come out of these documents, which include:

- *Towards Better Mental Health Services* (Ministry of Health, 1996)
- *Developing the Mental Health Workforce* (Mental Health Commission and Ministry of Health, 1999)
- *Tuutahitia te Wero, Meeting the Challenges: Mental health workforce development plan 2000-2005* (Health Funding Authority, 2000)
- *Mental Health (Alcohol and Other Drugs) Workforce Development Framework* (Ministry of Health, 2002).

3. What is the current state of the service user workforce?

The lack of attention given to service user workforce development over the past decade has resulted in a small, underdeveloped and neglected arm of the mental health workforce.

3.1 MAINSTREAM SERVICES

Mainstream services are defined in this strategy as services that are not run by service users. They include District Health Board (DHB), non-government organisation (NGO) and cultural services. Over the last decade there has been a huge increase of service user workers in mainstream mental health services, especially in service user designated roles, as advisors, consultants, auditors and trainers. The proportion of people with experience of mental illness in generic roles in mainstream services is unknown. *Strengthening Our Foundations* (Chris Hansen for Mental Health Commission, 2003) identifies problems service users experience working in mainstream mental health services, such as a lack of consistency and guidelines for service user roles, as well as discrimination and misunderstanding about meeting the needs of all mental health workers with experience of mental illness. The report makes several recommendations that have been reflected in this strategy.

3.2 PEER-RUN SERVICES

Most peer-run services and networks provide support, counselling or advocacy. They tend to be stand-alone services but they can also be integrated into mainstream services. A recent stock-take of peer-run services and networks in the mental health sector in New Zealand showed there are around 40 – *The Effectiveness of Service User-run Services for People with Mental Illness* (Carolyn Doughty and Samson Tse, for Mental Health Commission, 2004). Many are small, unfunded services. There has been very little growth in peer-run services in the last decade despite the massive increase in overall mental health funding; a rough estimate shows that peer-run services and networks use around 0.5 percent to 1 percent of total mental health funding. Several peer-run services and networks have ceased operating due to workforce capacity deficits as well as unsustainable funding.

3.3 ANTI-DISCRIMINATION WORK

The anti-discrimination service user workforce has grown considerably since the Like Minds Like Mine project began in 1996. But there is a long way to go. Many people believe there are still not enough service users in the total anti-discrimination workforce; they lack training opportunities and in many cases adequate remuneration.

3.4 UNMET WORKFORCE DEVELOPMENT NEEDS

Designated service user roles

The roles that can only be taken up by self-identified service users are all relatively new. Many of the workforce needs of people filling these roles are unmet – they lack training, work opportunities, professional associations, well-defined practices and favourable work conditions. These roles have the most urgent need for workforce development.

Generic roles

Many of the workforce needs of people in generic roles are already met through their training, professional associations and well-established practices and work conditions. Therefore this strategy focuses only on the unmet needs that service users in these roles may have in relation to their mental illness, any discrimination they encounter, and the recruitment of more service users into these roles.

4. Where will we be in 2010?

4.1 VISION

By 2010 people with experience of mental illness will be a skilled, powerful, pervasive and openly identified part of the mental health workforce in New Zealand.

4.2 MISSION

Service user workforce development in the mental health sector will thrive through:

- service user leadership
- sector commitment
- a clear vision and strategy
- effective management and co-ordination
- adequate funding.

5. How will we get there?

The actions under the following six objectives are high level; the detail, timing and the agency responsible for completing each one needs to be determined by the organisation that leads this strategy. That organisation will be the Mental Health Workforce Development Programme (MHWD), but it will depend on the involvement of many service users, agencies and sectors to implement this strategy.

5.1 OBJECTIVE 1 – INFRASTRUCTURE

Co-ordinate and lead service user workforce development.

MHWD will co-ordinate and manage service user workforce development in conjunction with its workforce development centres, with the leadership of service users who are active in the workforce, such as consumer advisors, peer support providers and advocacy networks. MHWD will deliver or sub-contract much of the work in this strategy. It will also promote the implementation of this whole strategy by maintaining relationships with key people and agencies involved with MHWD, the mental health sector, the education sector, anti-discrimination projects and service user networks.

ACTIONS	
Co-ordination agency	Establish and co-ordinate service user workforce development, with the leadership of service users. Ensure service user workforce development is adequately resourced and implemented. Establish and maintain relationships with key people and agencies.

5.2 OBJECTIVE 2 – POLICY & FUNDING

Ensure policy & funding supports service user workforce development.

MHWD and other central agencies will promote a policy and funding framework that supports the development of both peer-run services and the service user workforce in general. This strategy must be supported by policy, frameworks, standards and plans

that come out of central agencies such as the Ministry of Health, the Mental Health Commission, and the DHBs.

ACTIONS	
Influencing Policy & Funding	Monitor, advise and respond to ongoing policy & funding developments – national, regional and district.

5.3 OBJECTIVE 3 – ORGANISATIONAL & SERVICE DEVELOPMENT

Promote a culture receptive to the service user workforce and develop peer-run services and projects.

The whole mental health sector will ensure service user needs, rights and aspirations, (including their workforce development) are supported through the embedding of the recovery philosophy. This will create a culture that can enable service users to work in established roles. It will also enable the development of the peer support and advocacy workforce, which must be developed in tandem with the development of peer-run services, teams and projects.

ACTIONS	
Receptive culture	Continue to implement recovery philosophy in the mental health sector.
Peer-run services	Prepare framework and plan for peer-run service development.
	Provide organisational development support for pilot and newly established peer-run services.
National advocacy	Provide organisational development project for new national advocacy projects by and for mental health service users.
Consumer advisors	Evaluate consumer advisor roles and develop an action plan to strengthen their positions.

5.4 OBJECTIVE 4 – RECRUITMENT & RETENTION

Recruit more service users in all roles and improve employment practices to retain them.

MHWD will encourage more service users into the mental health workforce, through working with professional associations, training providers and services, to adopt affirmative action policies and targets. Service users working in all roles will benefit from employers who provide reasonable accommodations and support them if they become unwell. People in roles designated for service users will get more training and support as well as better defined jobs, work conditions and their own professional associations.

ACTIONS	
Guidelines for employers	Prepare guidelines for employers on service user specific roles. Prepare HR guidelines for employers on reasonable accommodations. Implement national consumer advisor employment guidelines.
Recruitment	Work with professional agencies to encourage training/ registration of service users. Develop affirmative action strategies for service users to be employed in all roles. Set and monitor targets for DHBs to employ service users in all roles. Monitor numbers in service user-designated roles.
Retention	Ensure there are career advancement pathways in the education and mental health sectors, especially for designated service user roles.
Professional associations	Develop consumer advisor association. Support the establishment of a generic service user workforce association.

5.5 OBJECTIVE 5 – TRAINING & DEVELOPMENT

Promote, fund or provide training and development for the service user workforce.

The mental health and education sectors will work together to provide training for service users in all the workforce roles they are to fill. Particular attention will be paid to training for service user-designated roles such as consumer advisors, peer support workers, and anti-discrimination workers as well as those who are going into governance and management. All training will be accompanied by training packages on the mental health system and on service user perspectives. Training is defined broadly and can include mentoring and apprenticeships. But training should also be integrated into a pathway through tertiary qualifications for those who want this. A fund for service user-led research will ensure

the development of service user researchers, who will develop service user-generated evidence and approaches to improving services.

ACTIONS	
Consumer advisors	Provide training for consumer advisors.
Service user perspectives	Provide training for service user perspective.
Mental health system	Provide training on mental health system.
Governance & management	Provide training for service users on governance, management and supervision.
Peer support and advocacy	Provide training and apprenticeships for peer support, recovery education and individual and systemic advocacy workers.
Human rights	Train and sustain a network of trainers in human rights with Korowai Whaimana.
Anti-discrimination	Provide training for the service user anti-discrimination and public health workforce.
Additional training	Provide additional training within mainstream courses that targets service users, as needed.
Training awards	Establish and promote awards for service users to undertake courses, training, mentoring, apprenticeships, etc in workforce roles.
Research	Ensure allocation of an ongoing fund for service user-led research.

5.6 OBJECTIVE 6 – RESEARCH & EVALUATION

Ensure service user workforce development is well informed and evaluated.

MHWD will scope the current service user workforce, then define and quantify future service user workforce roles. This will be used as a benchmark for calculating the service user workforce that will be required by 2010 and for measuring progress towards this. The strategy and the work that comes out of it will also be evaluated.

ACTIONS	
Data & planning	Scope existing peer-run services and service user-designated roles. Define and describe the service user workforce roles of the future and estimate the numbers needed. Monitor progress in reaching the numbers needed.
Evaluation	Evaluate individual projects and the overall implementation of the strategy.

6. Who will help to implement the Strategy?

Although the implementation of the strategy will be led by MHWD and service users, there are many types of agencies that need to become involved:

- Wider MHWD workforce development centres and regional coordinators
- Central government health agencies
- Consumer agencies
- DHBs
- Education sector
- Anti-discrimination agencies
- Professional Associations