

Long journey to recovery for Kiwi consumers: Recent developments in mental health policy and practice in New Zealand

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Abstract

Mental health services worldwide are undergoing significant changes in philosophy and direction due to the rising influence of the consumer or service user movement. This paper explores some key developments in the history of social policy, legislative change and funding of mental health services in New Zealand, especially since the landmark 1996 Mason Report. The growth in consumer networks and consumer participation in the aftermath of this report at multiple levels of the mental health service system is examined, with a particular focus on the adoption of the recovery approach as the guiding principle for the nation's mental health strategy. Consumers and carers are now active in contributing to strategy, policy and service development, nationally and locally. Opportunities for advocacy, advice and input into the quality of service provision have increased for many people living with mental illness. However, although government policy and systems are designed to drive services towards consumer empowerment and the recovery approach, there is still a long way to go before a fuller paradigm shift and greater consumer participation are achieved for people living with mental illness in the New Zealand community.

Many of the developmental stages in mental health services outlined by Smith and Gridley (2006) in New South Wales and across Australia were happening simultaneously in Aotearoa: New Zealand. Today, traditional psychiatric hospitals such as Cherry Farm, Lake Alice, Tokanui, Sunnyside and Porirua no longer exist, and psychiatric units have been integrated into general hospitals and the general health system. This significant step in de-stigmatising mental illness has been accompanied since the mid-1990s by increasing changes in the relationship between mental health service consumers and providers.

Mental health consumers and their family or whanau members are exercising their voice, and assuming increasingly crucial roles in policy formulation as well as service design and delivery. This influence is, in turn, helping to shape changes in professional mental health thinking and practice. Today it is generally accepted that service consumers are to be seen as people who have something valid to say about the treatment and care they are given or have to receive, and the services and systems that deliver that care.

The first half of this paper provides an overview of key developments and pressures in New Zealand mental health policy and practice that laid the ground for the watershed 1996 Mason Report and the subsequent increased consumer participation. The second half focuses on the post-Mason Report era, particularly the expansion in consumer activism at multiple levels of the mental health service system, and the adoption of the recovery approach as the guiding principle for the nation's mental health system. We then identify some key challenges to a fuller paradigm shift and greater consumer participation for people living with mental illness in the New Zealand community in the 21st century. (A Table is available on request that summarises some of the major developments in policy, legislation and provision of services for people living with mental illness since early colonial New Zealand. Brunton (1997) offers a very rich and more localised account of the direct impact of these major developments for the West Coast, South Island mental health services since 1872.)

From institutions to community care: The post-World War II journey

As noted by Smith and Gridley (2006), in most Western countries the move from custodial care of people living with mental illness to medical care resulted in a number of new treatments and reforms

in the 1940s and the 1950s. This was a time for patients when

...there wasn't much contact with the world beyond their walls.... Staff tended to stay on for many years and this, combined with the isolation – physical and social – may have contributed to a stagnancy of ideas and

treatment. Mistreatment and even cruelty ...was not uncommon. (Goodwin, 2003, p. 9)

In New Zealand in the 1960s central government devolved responsibility for mental hospitals to local hospital boards, in the hope that it would be a cost-saving measure. But the increased awareness of new technologies of psychiatry as well as psychopharmacology meant that many people were able to be discharged from psychiatric hospitals, whereupon traditional services were found to be insufficient to meet the needs of mental health service consumers and their families. It was becoming apparent that doctors and health services did not have all the answers to consumers' experience of mental illness (Szasz, 1961). Most medications had severe side-effects and the misuse of electroconvulsive therapy (ECT) made many consumers look at psychiatry in a different way. A new agenda was defined that was potentially in conflict with biomedical psychiatry (Foucault, 1971). Our society was asking for a very different kind of psychiatry and a new deal from health professionals.

Growth of family and carer support groups: 1970s onwards

In the past, many theories of mental illness contributed to families feeling that they were somehow to blame if one of their members experienced psychiatric illness. They were blamed for being overprotective, unfit and domineering. Mothers in particular came in for criticism, with the term "schizophrenogenic mother" (Throll, 1997). In many cases they faced the dual burdens of care and guilt.

In 1977, Anne Noonan, Christine Staniforth and Alan Burlton, who were caring for loved ones with schizophrenia, met to discuss their experiences, and in June the *NZ Listener* published, with input from these three, "Not Easy to Live With" (Steincamp, 1977). Overwhelmed by the hundreds of responses to the article, and after receiving material from the British Schizophrenia Fellowship, they organised a first public meeting in July from which evolved a distinctly New Zealand national body (the NZ Schizophrenia Fellowship), directed towards influencing the key structures of mental health services in this country. By 1979 funding was secured to enable a salary for a national coordinator/branch fieldworker, working out of the Christchurch Arts Centre.

In 1982 a rehabilitation project focusing on work-related occupations was introduced, run by a community group of carers. This group later became Step Ahead, a separate, stand-alone consumer organisation. Schizophrenia Awareness Week was first started in October 1985 with the aim of educating the wider

community and lobbying for better services. Their main thrust continues to be family and community education.

Today the Schizophrenia Fellowship national office is responsible for advocating at a national level for better services for families affected by mental illness, offering advice to Government Ministers, and supporting research into schizophrenia. The national organisation is an association of over 18 Fellowship branches and more than 2100 members.

The Fellowship has had an enormous impact over its almost 30-year history, as an advocate for the mentally ill, as an authority on good community care, and as an educational resource and support service for families and the wider community. However, many of the concerns of families still remain. After the 1996 Mason Report, the Fellowship set up a telephone hotline and discovered similar concerns to those of two decades earlier, including clinicians not listening to the family, lack of information on schizophrenia or related disorders, the stigma still apparent because of lack of education, the consumer having to fit the services offered, and the loneliness and isolation of individuals and families. Today a key area for the Fellowship is the promotion of early intervention. It continues to struggle to stay funded but "we never go out of business" (Throll, 1997, p. 113).

Role of nongovernment organisations as consumer advocates

In the 1980s and early 1990s support for the promotion of consumer interests came largely from nongovernment organisations (NGOs) and community agencies rather than government, which, through the Ministry of Health, tended to be protective of professional interests and reactive to social pressures in the mental health area, rather than proactive. Much of the earlier activity of NGOs such as the Schizophrenia Fellowship and the Mental Health Foundation (MHF) was directed toward goading the Ministry and Hospital Boards toward a more responsive attitude to consumers and their families.

The MHF, founded in 1974, played a significant role in promoting mental health issues including patients' rights and the need for consumer involvement in decision-making. The MHF, through its national media coverage, reports, workshops, seminars and regional networks worked with groups such as the Schizophrenia Fellowship to put mental health on the social agenda for New Zealanders, to challenge stigmatisation and to provide a base for later consumer-driven initiatives. In 1977, a national Telethon for Mental Health funded a range of community and advocacy initiatives, including the MHF. The extensive national media campaigns were

in some respects a forerunner to the later “Like Minds Like Mine” campaign.

Consumer rights, the Mason Reports and government policy: 1988 onwards

The Cartwright Report, released in August 1988, inquired into the activities at National Women’s Hospital regarding their cervical cancer treatment (Cartwright Report, 1988). As a result the New Zealand medical profession experienced a major blow to its “God-given right” to tell patients what should be done, with little acknowledgement of patients’ rights. This was happening at the same time as social protest into the misuse of psychiatric services and the need to reform the large institutions that provided poor quality and custodial-type services.

It is important to note that until the 1970s there was virtually no research on the delivery of psychiatric care in New Zealand. This changed in the 1980s with significant epidemiological (e.g., Christchurch Psychiatric Epidemiology Study) and service evaluation research, which subsequently became an increasingly important ingredient in policy discussions and decisions in the Ministry of Health. However, there were no major government reviews or calls for improvements to services or funding until 1988, with the first Mason Inquiry into forensic psychiatric services, and it was not until the mid to late 1990s that there were major political and social changes in mental health services.

The Health and Disability Code introduced in 1991 legally required certain rights to be upheld for all users of health services. In 1992 the *Mental Health (Compulsory Assessment and Treatment) Act* was updated to provide for the compulsory assessment and treatment of people who were considered to be “mentally disordered” within the specific meaning of the Act. In 1993 the *Human Rights Act* was passed, making discrimination on the grounds of mental illness in various areas of daily life such as employment, housing and education, illegal.

A 1994 report (*Looking Forward: Strategic Directions for the Mental Health Services*) signaled the beginning of a concerted mental health policy in New Zealand, and established mental health as a priority for the Government (Ministry of Health, 1994). Two key objectives were to decrease the prevalence of mental illness and mental health problems, and to increase the health status and reduce the impact of mental disorders on consumers, their families, caregivers and the general community. This report also set a benchmark of service provision for the 3% of the population most severely affected by mental illness, and this benchmark remains today.

The third, and most critical, Mason Inquiry Report (1996) highlighted significant funding issues,

stigma and discrimination, and workforce issues as areas of difficulty for New Zealand’s mental health services in meeting the needs of people most severely affected by mental illness. This report highlighted the need for a large cash injection, and was followed by a number of reviews and inquiries of various mental health services that all similarly focused on the low level of resources and service delivery issues.

Following this landmark report the Mental Health Commission, a new organisation, was established in 1997 as a catalyst to improve performance, lift the priority given to mental health in New Zealand, provide the necessary leadership for creating a culture of good mental health services, make a difference and infuse the whole sector with a sense of vision and purpose. Mason’s original vision had been for the Commission to “become the single planner and purchaser of mental health services for New Zealand” (Goslyn 1998, p. 69). The Commission went on to develop the *Blueprint for mental health services in New Zealand: How things need to be* (Mental Health Commission, 1998). This cornerstone document set a new direction, establishing the recovery concept as the focus of service development and delivery, as well as setting service and funding levels across the population. Its current vision is “for New Zealand to be a place where people with mental illness have personal power, full participation in their communities and access to a fully developed range of recovery-oriented services” (Mental Health Commission, 1998). The Mental Health Commission also serves as the body responsible for monitoring progress in implementing the national mental health strategy, and funds the anti-discrimination organisation, Like Minds Like Mine (LMLM), which was set up in 1998 as a 5-year project in response to the barriers identified in the 1996 Mason Report.

Since 1996, the Government has made a considerable investment in specialist mental health services. In 1997, the *Moving Forward* document provided strategic direction for more and better health services, ensuring personal rights and public protection, better services for Māori, and strengthening promotion and prevention in mental health (Ministry of Health, 1997). In addition, in 1997 the mental health sector took a step forward in addressing quality improvement in mental health service delivery with the introduction of the first National Mental Health Sector Standard (later redrafted in 2001), the aim of which was to “achieve better mental health services and ensure consistency in the delivery of mental health treatment and support for every New Zealander who needs to use mental health services” (Standards NZ 2001, p. 5).

Since 2001 public health funding, recognising that awareness programs are required, because stigma continues to exist and discrimination still

occurs, has supported a very successful media campaign featuring rugby players, musicians, politicians and other high-profile people as well as ordinary folk. This has increased public awareness about aspects of mental illness; and “significant and quantifiable changes in attitudes among most sectors of the population” (Ministry of Health 2003, p. 3) have occurred.

In 2002 the government developed *Te Puāwaitanga: Māori Mental Health National Strategic Framework* (Ministry of Health, 2002a), which built on key mental health strategies but incorporated for the first time a working document for Māori. Second in 2002, *Service user participation in mental health services: A discussion document* (Ministry of Health, 2002b) was launched by the Mental Health Commission. This was a narrative on consumer participation, citizen participation and developments in the health arena, and provided a participation framework for New Zealand.

LMLM’s National Plan (2003–2005) identifies the cause of most disability as the “social problem of barriers to participation” (p. 4) in the form of disabling attitudes and behaviour. The Plan draws a contrast between this social model of disability and the medical model, which equates mental illness with disability, and locates the problem within the individual who has experience of mental illness. The Plan acknowledges that disabled people face discrimination “in the way society and its institutions are organised . . . by the attitudes, values and beliefs that develop as a result of the systematic exclusion of disabled people from mainstream society” (p. 5). For the LMLM project, it is vital that the people with the experience of mental illness have a central role to play in the leadership, management and operation of project activities.

There has been a major public investment in mental health services over the last decade, with a 125% increase in funding between 1994/95 and 2002/03. Mental health services have continued to increase in line with the Government’s objective to fully implement the *Blueprint*. While the funding increases have been wholeheartedly welcomed by the sector as well as the wider community, there is currently some concern that the financial investment is not fully translating into the “better health services” indicated in national strategies.

Growth of consumer support groups and networks

Mental illness impacts on the lives of thousands of New Zealanders and their families. Those who experience mental illness use a variety of terms to identify themselves as a social, political and advocacy movement. *Tangata whai ora* (person seeking well-being), psychiatric survivors, service users, people with

experience of mental illness and mental health consumers are all terms that are currently used and, as with any social movement, each term has its supporters and opponents. We use the term “consumer”, and define consumer networks as established groups of consumers with national, regional or local members who share common aims and objectives and meet and communicate on a regular basis.

In New Zealand in the 1980s some New Zealand psychiatric survivors were in contact with the United States, United Kingdom and European organisations that were starting to question the values and philosophy behind psychiatry. The first consumer networks for people living with mental illness appeared in the early 1990s in New Zealand. Two of the first Kiwi consumer voices were those of Mary O’Hagan in Auckland and Pauline Hinds in Dunedin (see *Stopovers On My Way Home From Mars*, O’Hagan, 1990). O’Hagan was the first chairperson of the World Federation of Psychiatric Users between 1991 and 1995 and is currently a Mental Health Commissioner in Wellington.

Pauline Hinds founded The Aotearoa Network of Psychiatric Survivors (ANOPS), one of the first consumer groups in New Zealand working to influence national policy and strategic direction from 1988 to 1998. She was also one of the first consumers in the country to get government funding for consumer work. She was contracted in the mid-1990s by the then Southern Regional Health Authority (SRHA) and funded via the Patients and Prisoners Aid organisation to provide consumer advice and support to consumer groups and initiatives including the first employed consumer advisors. She is currently working in consumer advisory work in the Wairarapa, but has contributed much to the national and regional consumer voice throughout the country. Funding has continued and has increased in the southern region and now supports the Southern Consumer Network (SCN) and six local Consumer Action on Mental Health (CAMHs) groups throughout the South Island.

Alongside ANOPS and consumer advocacy groups are networks of other consumers. They are Southern Consumer Network (SCN), the Central Potential regional group (greater Wellington), Midland Regional (middle of the North Island), and the Northern Network (Auckland). Collectively these groups have elected representatives to work together in the Manuka Steering Group, perhaps the first national consumer group arising directly from local and regional consumer networks. The kaupapa or working mandate of Manuka is based on systemic advocacy, media work and provision of feedback to the Ministry of Health. Unfortunately, it may be running before it can walk, because its

structures and lines of accountability are not yet clearly developed, it is not directly funded or nationally recognised and its further development may be at risk.

Consumers have been in paid employment as Consumer Advisors since 1997, when one of the first in the country was employed by Healthlink South (now the Canterbury District Health Board, CDHB). These positions have increased in number, and collectively consumer advisors now have a national body. The National Association of Mental Health Service Consumer Advisors (NAMHSCA) links all consumer advisors employed by or contracted to Mental Health Services in the 21 District Health Boards (DHBs) around New Zealand. They provide opportunities for networking and support, role development and lobbying Government. Two areas (Canterbury and Otago) have also established Consumer Councils to support and back up the Consumer Advisors in their demanding roles. NGOs are now hiring consumer advisors in order to meet the mental health sector standard requirements.

Consumer advocacy at an individual level is relatively strong but currently without any national body or structure, although local groups exist (e.g., Christchurch's Psychiatric Consumer Trust).

Exciting recent developments include the growth of the consumer peer support programs run by consumer providers across the country. This is an area where consumers have much to offer one another within the continuum of services available. The Mental Health Workforce Development Program (MHWDP) is sponsoring one mental health service to implement a 12-month peer support service for older adults with experience of mental illness in the Counties Manukau area (Headlines, 2005).

Consumers are employed as consultants, as educators, as researchers, as policy makers, and as funders (in DHBs), but most of the drive and impetus for consumer-funded work is located in the Mental Health Commission itself. The Commission employs many consumers for policy, research and education roles and are instrumental in putting consumer voices and experiences on the agenda for all mental health services in this country.

“Nothing about us without us”: Consumer participation as public policy

1995 saw the first formal recognition of consumer participation with the Ministry of Health when the Ministry produced a set of Guidelines for mental health service providers. A later and more robust document was *Service user participation in mental health services: A discussion document* (Mental Health

Commission, 2002). The National Mental Health Sector Standard were first introduced in 1997 and later revised to become law in 2001. They include Standard 9 which reads:

Consumers are involved in the planning, implementation and evaluation at every level of the mental health service to ensure services are responsive to the needs of individuals.
(p. 24)

The Mental Health Commission (2002) identifies four types of consumer participation: no participation in decision-making (neglect and abuse); limited participation in decision-making (paternalism and tokenism); joint decision-making (partnership); and autonomous consumer decision-making. Levels of consumer participation include participation at (a) the care and treatment level, (b) the service or unit level, and (c) the organisational level. In New Zealand there are varying degrees of participation in services from consumer-run groups, from autonomous decision-making to where consumers are still not recognised as having a valuable voice or input. Some consumers (e.g., Read, 1996) argue that there is an inverse law of participation operating; that is, the further away from individual care and treatment, the more participation is permitted or encouraged.

Service user participation is not fully incorporated into the mental health system. Some organisations perceive it as too difficult to achieve because they do not recognise it as a fundamental right, do not understand the role and importance of participation in a person's recovery, may lack skills and knowledge to implement effective processes, may not find suitable consumer representatives, or the time or resources. Consumer participation requires “positive attitudes and behaviour towards service users that acknowledges their right to participate” (Mental Health Commission, 2002, p. 40).

Recovery approach: The vision and new policy

In the 1990s, community mental health in New Zealand shifted to the theme of recovery, with the goals of helping people pursue independence, self-management, personally meaningful activities, and a better quality of life. The overall aim of mental health rehabilitation or recovery is now to help individuals on their journeys to function “despite” their disability. The growth of this approach has been internationally welcomed as one of the most progressive and client-centred developments within mental health in the post-institutional era. Essentially, the recovery approach focuses on the processes by which people with mental illnesses actively create

meaningful community lives, in spite of the presence of intermittent or even pervasive and continuous, mental illness. Recovery is said to be happening when people can:

live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them. (Mental Health Commission, 1998, p. 1)

In the United States the emergence of strong consumer organisations has been accompanied by a growing discussion of this new vision for mental health, that of re-orienting both services and research toward recovery from severe or long-term mental illness (Anthony, 1993). During the 1990s the recovery vision became more and more influential in the United States, Britain and in New Zealand. Some argue that we are riding a new recovery paradigm wave, noting the 1999 landmark recommendation of the U.S. Surgeon General that all mental health systems move to adopt a recovery orientation (US Department of Health and Human Sciences, 1999).

In the New Zealand context the recovery approach has become official policy. The NZ Mental Health Standards (2001) incorporates recovery principles. The *Mental Health Recovery Competencies* (Mental Health Commission, 2001) states in its introduction:

This paper is an elaboration of the recovery principles... The Blueprint is to be fully implemented by the current Government – this is a clear signal that the mental health workforce must be educated and competent in the recovery approach. (p. 1)

Kia Mauri Tau (Lapsley, Nikora and Black, 2002) reports local research into the use of the recovery approach and concludes that “today, the recovery vision now guides the development of mental health services in New Zealand” (p. 2). Among their research participants, they found fundamental processes of change in individuals leading to recovery.

Each person who experiences a severe mental illness is faced with the task of learning to manage and live with that illness, and all its day-to-day and lifelong implications. What adds authenticity to the recovery approach is that it is not just a useful theory developed by academics about living with mental illness, but has come out of the consumer movement, growing out of individuals’ lived experiences of mental illness and what they have found useful in managing their disabilities within the context of their everyday life. As Lunt (2000) suggests:

... the key concept to recognise is that mental illness is an affliction that often, if not always, results in a catastrophic

loss of self. . . . Whether or not one realises it, one has been sent on a journey the point of which is to define new meaning and purpose in one’s life. This quest is the single unifying aspect to recovery. (pp. 44–45)

Deegan (1988) argues that recovery is understood as a personal journey that is more or less facilitated by individuals with potential supports, including the formal supports offered by professionals. People in recovery like themselves as they are, accept their disabilities, and enjoy the lives they have. Indeed, acceptance of one’s disability can lead to greater appreciation of one’s own strengths (Henderson, 2004). Recovery is considered to be highly integrative, in that the processes by which individuals come to experience better community and functioning also positively influence the course of their mental disorder (Davidson & Strauss, 1995).

2006 and beyond: The continuing journey for Kiwi consumers...

The Second Mental Health Plan Te Tāhuhu: Improving Mental Health 2005–2015 (Ministry of Health, 2005) builds on the current Mental Health Strategy contained in *Looking Forward* (Ministry of Health, 1994) and *Moving Forward* (Ministry of Health, 1997), and the Mental Health Commission’s *Blueprint for Mental Health Services* (Mental Health Commission, 1998). *Te Tāhuhu* outlines Government policy and priorities for mental health and addiction for the next 10 years, and provides an overall direction for investment in the sector. Based on an ‘outcomes’ framework, the document has been informed by extensive public and health sector consultation over the past 18 months, but a number of challenges remain to be addressed before the rhetoric of consumer participation and recovery-focused policies is likely to be matched in the day-to-day delivery of mental health services in New Zealand.

Māori mental health in the 21st century

While mental illness is an issue for the whole population, it is a major issue for Maori in Aotearoa: New Zealand. Mental health admission rates of Maori are 40% higher than for non-Maori, and they have higher rates of presentation to crisis, acute and forensic services. It is estimated that at least 38% of Maori referrals come from welfare or law enforcement agencies (Ministry of Health, 2002a). In addition, the Maori population has been steadily increasing since the 1920s and its population will increase 29% to 760 000 over the 2001 figure (Statistics New Zealand, 2006).

Te Puawaitanga, Maori Mental Health National Strategic Framework (Ministry of Health, 2002a), is

a framework outlining actions that can be taken by DHBs to assist them to meet Government mental health objectives over the next 5 years. As a result, there has been a significant increase in the number of service providers, including both DHBs and NGOs, which have adopted, to varying degrees, Maori models of practice as a means of accommodating the needs of Maori clients and whanau.

The government invested \$1.8m over a period of 5 years to enhance the Māori health workforce by setting up Te Rau Puawai, a program run by Massey University aimed at accelerating the training of 100 Maori mental health workers. The 2002 Ministerial document, *He Korowai Oranga Māori Health Strategy* (Ministry of Health, 2002c) supported Māori-led development to improve Māori health gains, and acknowledged traditional modes of healing. The Maori philosophy towards health is based on a wellness or holistic health model. Maori see health as a four-sided concept representing four basic beliefs of life: *Te Taha Hinengaro* (psychological health), *Te Taha Wairua* (spiritual health), *Te Taha Tinana* (physical health) and *Te Taha Whanau* (family health). This is known as *Te Whare Tapa Wha* (Durie, 2003). A key element in mental health service and systemic reform in New Zealand is that the tools and programs that have been implemented for Maori were developed by Maori themselves.

Expanding role of NGOs

Currently, the role of NGOs is crucial in the delivery of community-based services, in a context where funding is always constrained and often suboptimal, where contractual negotiations with government funding agencies are often difficult and monitoring requirements sometimes burdensome, and the balance of competition/collaboration between service providers an uneasy one. The proportion of mental health funding that is spent on services provided by NGOs from 2000 to 2003 remains at 28% while DHBs receive 72% (Mental Health Commission, 2004) and it must be noted that some NGOs are now large and significant providers.

However, the climate that the NGOs work in offers challenges. According to Walmisley (1998) “the RHAs [Regional Health Agreements] and their accountants have created a contracting environment that so narrowly defines the task that is to be done that the gaps between the numerous providers are getting bigger and bigger” (p. 71). He argues further that the client “needs to be placed at the heart of the spending decisions instead of at the rear end... at

the moment we are fixated on buying structures. Nobody is interested in the outcome for the patient” (p. 71).

Mental Health Workforce Development

The first Mental Health Workforce Development Program (MHWD) supported and funded by the Ministry of Health and the Health Research Council has a clear remit to develop the Consumer workforce: in particular the need to enhance consumer advisory work and grow consumer peer support services. Comprehensive national, New Zealand-specific resources including competencies, employment guidelines, training needs assessment and training programs for mental health consumer advisors working in mental health services are being developed (www.mhwd.govt.nz). Durie has developed the Maori mental health workforce development plan outlined in *Te Rau Matatini* (Durie, 2003), and this is currently being reviewed by the Ministry of Health.

Consumer advisors and paid consumer work

There are a number of issues for paid consumer advisors and other paid consumers in the mental health field. The demands placed on them can produce misplaced doubts about their abilities to do the work, and can perpetuate myths and negative stereotypes around people with mental illness. Consumer advisors are a heterogeneous group who come into paid consumer work with a range of existing skills, motivations and backgrounds. A “too little, too far” approach can undermine their effectiveness in the eyes of other mental health professionals and management, to the detriment of the important work they do.

Mental health clinicians

Mental health professionals themselves have faced major changes since the 1950s and their models of working and rehabilitation approaches have changed dramatically. The task of facilitating recovery in partnership with consumers presents an ongoing challenge for mental health professionals. This may mean a substantial renegotiation of power and privileges. Dr Nick Argyle (2005), a psychiatrist and Clinical Director for the Auckland District Health Board expresses some of the difficulties currently faced by mental health professionals:

... the positive development of consumers, the NGO sector and of the recovery paradigm has unfortunately been accompanied by a pervasive negative attitude to clinicians.

It is not currently politically correct to be a clinician. This is curious when clinical staff make up the majority of the mental health workforce. . . We have a great opportunity to create a very strong Mental Health Sector in New Zealand, but we shall not achieve this without clinicians or without clinical leadership. (p. 2)

In the future, mental health professionals will face even stronger challenges from a more comprehensive paradigm shift to working in partnerships with consumers. Furthermore, the rise in numbers of trained community support workers may mean that the traditional roles of professionals will be reviewed. Some argue that community support workers are ideal to work within the recovery paradigm because they have less of a medical model emphasis and training.

Thus, although the recovery approach is a fundamental part of mental health thinking and funding in this country, many professionals and services seem challenged or uninterested in working in partnerships with consumers towards recovery, limiting the impact of the approach. Wells (2001) talks of the challenges to the mental health workforce if they are to facilitate recovery, and asks them to: (a) assist us (*consumers*) to reach our own understanding of our illness or distress; (b) be aware of their own life experience and culture and understand discrimination and social exclusion; (c) give us respect, rights and equality; (d) learn about our service user or consumer movement; (e) encourage us to have hope for our future; and (f) facilitate our inclusion in our communities and cultures.

Internationally, some consumer groups are exploring a social model of madness that looks at how society constructs and defines the notions of "madness" and "distress" and discriminates accordingly. This model is increasingly examining the social causes of madness and distress; the medicalisation of the experience and distress; the destructive and discriminatory response to it from both psychiatry and broader society; the need for a social response to the distress that survivors experience and addressing of the social origins and relations of their distress; and the need for survivor-led alternatives to prevent distress and offer appropriate support for survivors (Beresford, Gifford & Harrison, 1996). Such an approach resonates with the experience of New Zealanders with mental illness, many of whom find that their society is "structured in a way that fails to recognise that not everybody has or wants stable moods and perceptions" (Like Minds: Like Mine, p. 5). Recognition of the social links between poverty, unemployment and mental illness also requires consideration of social context, and commitment to the partnerships that consumers and their families have been seeking for many years.

Conclusion

Mental health services worldwide are continuing to undergo significant changes in philosophy and direction due to the increasing influence of the consumer or service user movement. The personal experience of mental illness must always be placed at the centre of mental health knowledge, practice and funding. Doing this requires ways of supporting and valuing consumer views that are often seen to be reactive or counter to current thinking or operating. Policies and funding in New Zealand may change and some consumers may be employed in key roles within mental health services, but fundamentally there has not been enough of a cultural shift towards recognising consumers and their journeys to recovery as the core business of mental health services.

This paper has taken the reader on a Kiwi journey: from custodial care to community care, thence to carer empowerment, leading to our landmark 1996 Mason Report, which led directly to the formation of the new Mental Health Commission, and beyond. It is important to remember that the family/carer movement and NGOs in this country played an instrumental role in developing the climate for consumer participation, prior to the Mason Report. Since 1996, consumers and consumer groups have come of age and empowered themselves sufficiently to work in partnerships for change and to promote the recovery approach nationally, locally and clinically. They are assuming increasingly crucial roles in policy formulation as well as service design and delivery. In 2006, it is generally accepted that service consumers are to be seen as people who have something valid to say about the treatment and care they are given or have to receive, and the services and systems that deliver that care.

However, some great systemic challenges for our mental health services remain: the need to work more holistically incorporating Te Whare Tapa Wha principles and working biculturally, the expanding role of our NGOs, the pressures on our employed consumer workforce, the tensions for some of our clinicians to work within a recovery paradigm and the full adoption of a consumer-empowered partnership.

It is our hope that the full implementation of the recovery approach will orientate professionals and supporters to work more in partnership with consumers on their recovery journeys as we all become more well-informed and empowered (Muir-Gray, 1999).

Acknowledgements

Grateful acknowledgment is given to the late and great Linda Simson, Manager of Step Ahead Trust,

Christchurch, Kelley Allen of Otepoti CAMHS (Consumer Action on Mental Health) and Elizabeth Biddington of the Southern Consumer Network, Christchurch for some of their personal history of the consumer movement used in this article. Also, many thanks to Heather Gridley for her encouragement and support. We also acknowledge the useful information and helpful advice provided by the anonymous reviewers of this article.

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