



Enacting policy in mental health promotion and consumer participation

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ABSTRACT

Objective: *Over the last decade Australia has established and endorsed sound policy and strategy documents under the National Mental Health Strategy. However, the enactment of proposed levels of consumer involvement in effective and respectful ways is yet to be fully witnessed in reality. This issue requires sustained attention where barriers need to be named and understood in order to move forward and build on past successes. This paper addresses this issue and offers some responses to the following question: What does a commitment to enacting consumer involvement mean for mental health promotion practice?* **Conclusions:** *Despite progress, consumer involvement in mental health promotion work, like the mental health field in general, is yet to reflect national visions. Barriers include: structural issues and insufficient education and training to support workers putting policy into practice; lack of clarity about who is a consumer; the many difficulties consumers face in progressing mental health consumer agendas; and disagreement on how consumers understand what constitutes 'mental health.' In order to embody proposed commitments attention must be paid to: the process of engagement, dialogue and liaison with consumers; advocating and facilitating active involvement; an understanding of partnership accountability; and active engagement with rigorous evaluative processes.*

NATIONAL POLICY & STRATEGY COMMITMENTS

At a global level, mental health has been recognised as a critical public health issue (Desjarlais, Eisenberg, Good, & Kleinman, 1995) and acknowledged within international health policy, reflecting the orientation of the "new public health era" (Baum, 1998).¹ In 1997, for example the World Health Organisation (WHO) formed a Mental Health Promotion (MHP) Unit primarily concerned with activities related to mental health promotion and the influence of psychosocial and behavioural factors on overall health. Both European and World conferences with mental health promotion focus have been increasingly held over the last decade.

The Australian National Mental Health (NMH) Policy and Plans (Australian Health Ministers, 1992; 1998) have mirrored these global developments, documenting commitments in areas that previously gained insufficient or no attention. Commitments of interest in this

paper are the shift to an early intervention, prevention and mental health promotion orientation, and the promotion of consumer participation.

Consumer involvement was directly addressed when the "Mental health statement of rights and responsibilities" was endorsed in 1991. This statement addressed consumer rights to information, education, training, treatment and available services, and participation in decision-making regarding the development of mental health policy, provision of mental health care and representation of mental health consumer interests. It also identified the availability of prevention and mental health promotion programs as a right, with the expectation that strategies and programs will be implemented to minimise exposure to risk factors, with outcomes being documented and evaluated. At this point, mental health promotion work was still dominated by a focus on risk factors, maintaining a disease rather than health orientation.

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“Consumer rights” and “promotion and prevention” were listed as two of twelve policy areas in the 1992 NMH Policy. Objectives for consumer rights were to ensure they were affirmed in mental health legislation and that Commonwealth and State governments had mechanisms for protecting these rights. Objectives for promotion and prevention focused on public education to improve knowledge about mental illness and minimise stigma, develop primary, secondary and tertiary programs for people at greater risk of developing mental disorders, support further research regarding causality, and develop effective ways of evaluating preventive work. This document reflected a predominant focus on prevention rather than promotion.

By 1998 when the 2nd NMH Plan was launched, the Commonwealth judged that since the early 1990s:

- progress had occurred in consumer/carer participation at national and state levels in advising on strategy implementation and decision-making,
- more tools and training programs had been developed for consumers/carers to enhance their skills in consultation, advocacy and media work,
- consumers had greater involvement in shaping professional education and training,
- community awareness of and positive attitudes towards mental illness had improved, and
- frameworks for promotion and prevention had been developed (Australian Health Ministers, 1998).

The 2nd Plan outlined three major platforms, with promotion and prevention being one of them, while consumer involvement was embedded within the “partnerships in service reform and delivery.” Consumers, families and carers were identified as key stakeholders from

receiving services through to involvement in their planning, delivery and evaluation. References to consumer involvement were made under promotion and prevention strategies, e.g. regarding further development and evaluation of education, training and professional development. The plan’s language reflected a shift toward more fully embracing the health-oriented focus of mental health promotion. This became increasingly apparent in the National Action Plan and accompanying monograph to address mental health promotion, prevention and early intervention (Commonwealth Department of Health & Aged Care, 2000a; 2000b).

In the “Ways Forward” report (Swan & Raphael, 1995) on Aboriginal and Torres Strait Islander mental health, two of the fifteen policy initiatives identified were self-determination, which strongly argued for community and consumer involvement, and the need for promotion and prevention work. While focusing mainly on needs, required actions, and service system design, the discussion paper on promoting children and young people’s mental health (Raphael, 2000) acknowledges that young people as consumers and their carers/parents have an important place in shaping policy and service design despite the “challenge” of creating suitable mechanisms.²

BARRIERS TO THE ENACTMENT OF INTENTIONS

Rhetorically speaking, the tides have turned so that mental health promotion and consumer participation have become expectable language within Australia’s mental health sector. Although no comprehensive research verifies the degree to which intentions have become everyday practice (or at what level of commitment), anecdotal evidence, personal experience personal communication and government commissioned reports suggest that practice is yet to match national visions. Several factors present barriers to this occurring.

Education, training and curriculum

Progress has been made in the shift toward health-oriented practice in the mental health field, yet it has been slow, playing catch-up to the broader health sector which initiated the turn during the 1970s (Baum, Fry & Lennie, 1992). The mental health workforce are more familiar with the rhetoric than the skills for its practice, in part because routinely including health-oriented theory and practice in education and training curricula is a recent phenomena and an intended action (Commonwealth Department of Health & Aged Care, 2000a).

The *Learning Together* report recommended adoption of the following principle:

The relationships between consumers and service providers and carers and services providers, should be the primary focus of practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health work force. (Deakin Human Services Australia, 1999, pg 1)

Although focussed on education and training regarding work with people experiencing severe mental illness, the report identified wider applications, eg early intervention, prevention and mental health promotion. It outlined recommendations for consumers and carers to become major players in education and training, and supported development of a common framework to guide curricula for professional disciplines in the mental health workforce. The framework was informed by three attitudes: “treat consumers and carers with respect and dignity...recognise the rights of consumers and carers...[and] take responsibility for their own [mental health professionals’] attitudes and behaviours” (pg 64-5). The

draft “National Practice Standards for the Mental Health Workforce” (NMH Education and Training Advisory Group, 2001) has begun enacting the Learning Together recommendations regarding a common curriculum framework. Considerable effort will be required to integrate this work nationally.

Service design and practice

Structurally, the mental health system remains predominantly illness driven in design and practice, particularly in the adult area. The child and youth area is under sustained pressure to focus more on serious mental health problems with limited or no additional funding. Early intervention, preventive and mental health promotion efforts may be minimised with other primary health and human service providers relied upon to step into this work. Fuller involvement of other sectors is hampered as they report being without sufficient knowledge and also under-resourced (Stacey, 2002; Herron, 1999).

Therefore, in the face of limited “real” structural support and inadequate resources, sustainable funding and/or incentives, the very work nationally advocated as a critical component of the mental health spectrum of interventions will be minimally enacted by a necessary key player - specialised mental health services. Mental health may be ‘everybody’s business,’ but this should **include** rather than exclude mental health services.

Health-oriented practice plays more attention to working in partnership with consumers (Wass, 2000), whereas this has not been a standard feature of mainstream disease-oriented interventions, despite recent efforts to reorient mainstream practice. Where health-oriented practice has occurred, the capacity to effectively engage in partnership work has often been dependent on service providers’ individual initiatives to develop their skills, or success

in gaining agency support to up-skill. This includes access to independent training resources, attending professional workshops or gaining accredited qualifications. The unfortunate aspect of this ad hoc approach is the loss of expertise when individuals leave agencies and contrasts with implementing capacity building models (e.g. New South Wales Health Department, 1997).

Who are the consumers to be involved?

Consumers³ are typically defined as “a person utilising, or who has utilised, a mental health service” (Australian Health Ministers, 1998, pg 25). Simultaneously, a population-based approach to mental health promotion has been advocated where target audiences range from the whole community to special population groups (Commonwealth Department of Health & Aged Care, 2000a; 2000b). At first glance these parallel ideas appear incommensurate. If our definition becomes a person using **any** aspect of a mental health service, then we can widen the net to include those people who have not yet needed to experience the traditional mental health system as also “consumers.”

The *CHAMPS* and *Amigos* youth mental health promotion projects in South Australia illustrate the potential range. *CHAMPS* aimed to “improve the mental health and well being” of rural young people “by enabling them to have a voice in shaping the way in which mental health services are provided to them and to participate in mental health promotion activities” (Stacey & Turner, 1998, pg 3). It includes young people who have had no contact with a mental health service, as well as those who have had some or extensive contact. In contrast, *Amigos* aimed to “improve the health outcomes of young people with mental illness...[by increasing] knowledge of relevant health professionals in identifying and addressing...[young people’s needs, improving] community understanding...of

issues affecting young people with mental illness...[increasing] the range of services to support young people...[and increasing] the knowledge and confidence of young people...in managing their illness” (Higgs, 2001, pg 3). *Amigos* included the most information rich young people - those who have personally experienced mental illness.

Carers have become defined as “a person whose life is affected by virtue of a close relationship and a caring role with a consumer” (Australian Health Ministers, 1998, pg 25). Consumer and carer needs are both similar and different - there is not intention here to dismiss this. However, from a mental health promotion perspective carers are also consumers.

All of these people are consumers of mental health services and have a right to participate in mental health promotion design, implementation and evaluation.

Progressing agendas in mental health consumer movements

Globally, there has been a long and arduous history of consumer involvement in mental health services (e.g. Baldini et al, 2001; Bowl, 1996; Epstein & Olsen, 1999; Epstein & Shaw, 1997; Meagher, 1995; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Perkins and Repper, 1998; Salzer, 1997; Stacey, 2000; US Surgeon General, 1999). Despite progress, consumers still struggle for adequate and respectful recognition of their right to active involvement. Opinions of how to proceed are diverse, with some consumer advocates wishing to pursue historical issues exclusively or operate based on individual diagnostic categories (ie via NGO self-help groups), while others seek cross-collaboration and engagement with contemporary mental health practice. Knowledge of health-oriented approaches, especially mental health promotion, is not uniform amongst consumers (like mental health workers). There is continued need for consumers and carers to have access to

education, training and contemporary debates that enable them to increasingly engage in a range of areas in the mental health field (Epstein & Rechter, 1999; Mental Health Council of Australia, 2000).

“Consumer participation is about power and the redistribution of power” (Church, 1996 pg 29). In order to progress a range of agendas in the mental health consumer movement this cannot be ignored. It requires surmounting the following five barriers to the inclusion of consumer voice:

- The dismissal of consumer views and ideas because consumers are diverse, ie they don't agree with each other.
- Limited resources where facilitation and resourcing of consumer participation is seen as "icing on the cake" rather than "the cake itself."
- Tokenism through having consumers fit into existing committees and agendas without opportunity for them to shape structure and content.
- Humouring and patrony in which people may listen but not hear and respond.
- The assumption by professionals that views and opinions of consumers reflect their psychopathology, ie are delusions, faulty cognition, hallucinations, or disturbed thinking. This leads them to interpret what consumers "really" mean. (Perkins & Repper, 1998, pg 3-5)

Surmounting these barriers requires ongoing structural and cultural change in order to progress from consumer participation as ad hoc and token to committed, systemic practice (Bowl, 1996; Epstein & Shaw, 1997; Perkins & Repper, 1998). The “Consumer and Carer Participation Policy Template” (Mental Health Council of Australia, 2001) offers some clear direction in this regard.

Who understands what mental health is?

Until recently consumer understandings of ‘mental health’ have seldom been explored. This reflects common belief that consumer perspectives of mental health are ‘self-evident,’ merely reflecting mental health professional and service views. Others argue that work on consumer perspectives of mental health fail to ‘theorise the status of the perspectives’ (Mauthner, Kiloran-Ross & Brown, 1999, pg 41), with little reference to research methodology literature that critically addresses the status of accounts as versions of reality (Olesen, 1994).

Pavis, Masters and Cunningham-Burley (1996) and Rogers, Pilgrim & Latham (1999) both concluded that lay people⁴ (mainly service users) find it difficult to think of and discuss mental health beyond the ‘taken for granted’ and reflected understandings typified by the ‘mental illness’ system. Mental health was either a euphemism for mental illness or a bipolar opposite where mental health is merely the ‘end product’ of the absence or reduction (through treatment) of mental illness. Pavis et al (1996) argued that when exploring non-service users’ perspectives, ‘positive mental health’ has limited, if any, salience to lay people and adds very little to aid our understanding of the concept ‘mental health.’

In contrast, Herron (1998) argues that lay people do think and discuss mental health **beyond** the taken for granted and there is clear salience for the concept ‘positive mental health.’ Perspectives are wide ranging and are gender, race, religion and age specific. Most explanations were socially contextualised and embedded within deep discussion around the influence and legitimacy of language. They were not passive watered-down versions of professional discourse and in many instances contradicted evidence collated simultaneously about mental health

workers' perspectives of both the concept 'mental health' and required service development.

This evidence suggests that lay/consumer perspectives of mental health are actively constructed and negotiated in light of new experiences and knowledge, via daily social interaction. Therefore, it is strongly argued that consumer understandings of mental health must **underpin** and **lead** service development. Ignoring consumer perspectives will lead to ill informed, irrelevant and ineffective use of resources and service provision – an outcome any country can ill afford (both financially and morally).

THINKING BROADLY ABOUT RESOURCES

What does it take to further facilitate this shift toward more practice of mental health promotion with effective and respectful consumer participation? In short, conceptual, financial and infrastructure resources are needed. The presence of these resources does and must impact on the other levels. In Australia, some of these resources already exist – what is at issue is advocacy for and greater distribution of them.

Conceptual resources

As noted above, despite language and concepts relevant to mental health promotion and consumer participation existing at national levels, their translation into standard education, training and ongoing staff development for the workforce, and everyday practice in mental health services has lagged. Advocating for their enactment requires persistence, courage and political will. The "Enhancing Relationships between Health Professionals and Consumer and Carers" project report (Mental Health Council of Australia, 2000) acknowledged that despite consumers and carers identifying some achievements and examples of good practice, "there was frustration that the

same questions were being asked and the same issues discussed, with little evidence of follow up from previous studies, projects and programs" (pg 2).

Financial resources

Although services and health departments are now more likely to allocate funds to support consumer participation, forums for involvement still reflect professionally planned rather than consumer/carer designed or advocated forums. Consumers are likely to receive honorariums to cover expenses, whilst direct payment for time involved is a less frequent phenomenon. Salaried consumer positions are not yet commonplace, although many advances have occurred, usually on the basis of projects that have bravely pioneered different ways of working - often after considerable work to justify their objectives and strategies.

Substantial advocacy for project learning and outcomes to influence practice at a systemic level has and will be required to achieve further change. New projects are still frequently designed and funded without sufficient attention paid to funding appropriate consumer involvement, or consideration of the contribution that consumers make through salaried positions. Apart from the Australian and New Zealand Mental Health Conference, appropriate levels of funding for consumer participation at professional run conferences in mental health and related areas is largely a matter of hindsight, if considered at all, despite reports of how valuable these experiences are (Mental Health Council of Australia, 2000).

Availability, funding of and support for education and training opportunities for consumers to contribute to mental health services, and become part of the mental health workforce is also limited (Deakin Human Services Australia, 1999; Mental Health Council of Australia, 2000).

Infrastructure resources

Not only are funds required, but service structures that enable effective and genuine participation must exist. Moving from an ‘either/or’ to a “both/and” position will also facilitate health-focused approaches where mental health promotion is considered viable work alongside intervention. Some, but not all, structural change can occur despite the availability of further funds, as it is dependent on internalising conceptual resources, shifts in attitudes and changes in funding allocation priorities. Like advances in other resource areas, this involves contesting current power relations - very visible changes may occur to the face of mental health services.

The mental health infrastructure determines when, how and by whom decisions are made in relation to service delivery, design, monitoring and evaluation. It determines who provides the range of mental health services and at what level of authority – it can act to include or exclude consumer-dedicated service positions. Along with the other resources, it determines whether initiatives remain pilots and “good practice” projects or become sustainable service policy, structure and practice. It is a site for the practice of advocacy, risk-taking and political will. Examples of this being demonstrated exist, but are not commonplace.

All of these resource matters are partially addressed in the “Consumer and Carer Participation Policy Template” (Mental Health Council of Australia, 2001), offered for consideration by mental health services although not yet endorsed within the National Mental Health Strategy.

EMBODYING COMMITMENTS

Surmounting barriers and harnessing resources is the task facing us if we genuinely desire to embody the consumer participation commitments within the national vision, and mental health

promotion work in particular. Navigating this task requires processes and skills that address pragmatic issues. Giving sufficient attention to the real-life practicalities of our laudable concepts depends on making accountability a focus.

Consumer participation and partnership without accountability is like being in a car with no steering wheel and out-of-reach control pedals. It may have a motor to run it, a fuel tank that can be filled, windows from which to survey the territory - it can even map its desired direction, but it has no capacity to manoeuvre its way through that territory and spend as long or short a time as it requires in any one place. When limited in this way, consumers wonder what they are doing there. They have been provided with a car as a means of participation, but someone else is driving, manipulating the controls and negotiating the environment. Empowerment starts to fade, as the car does not go where they hoped. It becomes a cardboard cutout version of the vision they had heard described or read about.

Paying attention to the following four areas could be the “service” the car needs for the rhetoric of policy to have a reality that is witnessed in the everyday work and lives of consumers and mental health workers.

The process of engagement, dialogue and liaison

Mental health promotion work involves engaging in a range of primary health care practices, including community development (Mauricette, 1998; Wass, 2000). A key principle within such practices is according respect to local expertise and experience, i.e. consumers, through dialogue with workers and others who may contribute alternative perspectives. Consumer perspectives remind professionals of the need for specific attention to the wider social and political contexts of people’s lives and how this shapes their mental health, both

positively and negatively (Herron, 1998). As each party informs and influences the other through genuine dialogue⁵ outcomes have a synergistic quality.

Professionals are also members of the wider community and participate in community construction of meanings about mental health. Professionals contribute to perpetuating meanings of mental health that highlight a pathogenic rather than health focus (Deakin Human Services Australia, 1999). In the context of advocating for and engaging in consumer participation strategies, professionals may utilise pathogenic mental health concepts to resist efforts for more respectful and accountable involvement of consumers (Perkins & Repper, 1998; Stacey, 2000). When doing this and speaking from their position of authority on mental health and illness, professionals undermine and diminish the strength of consumer perspectives that reflect health emphases (Herron, 1998). Professional cultural change regarding the range of available meanings or perspectives on mental health needs addressing in order to maximise the positive outcomes of dialogues.

Another key player is the media. It is both a critical communication source and resource that shapes concepts of mental health. The way issues are represented has the capacity to influence community members in both negative and positive ways. It can serve to foster and reinforce stereotypes, or challenge them, leading to more accurate and helpful knowledge and understanding. Not only can the media address issues of stigma, it can promote mental health as a positive concept and resource, as well as provide mental health resource and service information to its audiences (Commonwealth Department of Health and Aged Care, 1999). More active engagement of the media in conversations about representation and mental health could be a strategic means of fostering dialogue and liaising with the community

for both workers and consumers involved in advocacy.

Advocating and facilitating active involvement

Engagement, dialogue and liaison imply active involvement. There is an array of approaches to participation that range from very token efforts where consumers' presence is more about "icing on the cake" than a meaningful role (Perkins & Repper, 1998), to situations where lay people have full control over a project, service or issue (Arnstein, 1971; Westhorp, 1987).

At the token end, this means "ad hoc" connections with consumers that that mental health workers note in the course of their work and bring to staff meetings or management, or a "suggestion box" in the service reception area. At the fully engaged end, this means a consumer-managed project or service, where staff (who may include consumers) are directly accountable to a consumer management committee who oversee all key activities. This does not suggest a continuum from poor through to excellent participation as such. Rather, participation strategies should be **matched** to tasks and commitments, and, wherever possible, more engaged strategies used. Often, more than one participation strategy is needed.

Another common word when discussing active involvement is "partnership," which implies action by all stakeholders involved in the activity, mutually agreed responsibilities and shared decision-making. Partnership is not a benign term where an assumption of everyone starting from the same position can be made. The nature of partnership, or whether it exists or not, is determined by power relations. When they remain unspoken and unaddressed, genuine partnership is not possible and accountability not present.

Empowerment is critical to determining meaningful participation or partnership,

but needs to be more than the common (mis)conceptualisation of giving over power. Empowerment involves an act of agency by consumers to step into and speak from a position of power (Stacey & Hills, 2001). Rather than being seen as giving something up, professionals need to view this as dismantling barriers and getting out the way (Byas et al, 2002)!

Active involvement of consumers in developing, implementing and evaluating mental health promotion initiatives can be mental health promoting by itself, provided it **honours** their contributions. This does not mean simple acceptance of anything consumers put forward – usually recognised as patrony, particularly when no further action is taken or feedback provided as to why ideas were discarded. There is little point for consumers in moving from being silenced, to being heard then disregarded, which is merely ‘pseudo-consultation.’ Dialogue is more than the sum of previous individual ideas. It weaves together and enhances existing ideas, as well as generating new ideas. To be a **valued** member of an engaged process of meaning generation is mental health promoting:

If I am to have a sense of belonging in a social reality, then it is not enough for me merely to have a ‘place’ within it; I must also myself be able to play an unrestrained part in constituting and sustaining it as my own kind of ‘social reality,’ as not ‘their’ reality, but as of me and my kind, as ‘our’ reality. (Shotter, 1993, p.15)

Some consumers groups are more effectively silenced or sidelined than others. These groups usually bear the brunt of other forms of discrimination, e.g. based on gender, cultural identity, age, sexual orientation, and (dis)ability. When thinking about active involvement attention must be

paid to groups who are even more likely to be left out and consider proactive ways to include them so they experience being welcome and respected. This may take both mental health workers and consumers out of their comfort **and** knowledge zone, **requiring** them to develop an understanding of partnership accountability in order to avoid ‘hand-balling’ this responsibility or deciding it remains in the ‘too hard basket.’

Partnership accountability

A basic premise for advocating participation and partnership is that the contributions non-professionals make and expertise they bring is valuable, and critical to developing a range of services that respond effectively to individual and community needs. A crucial assumption is that consumers have expertise regarding the circumstances of their own lives and communities that is not as readily available to professionals (Deakin Human Services Australia, 1999). These matters are vital to consumer participation in mental health matters across the board, but especially pertinent in the design, implementation and evaluation of mental health promotion strategies.

A frequent absence from the language of participation and partnership is "accountability," which requires a more detailed examination of power. Engaging in participation does not always guarantee constructive and positive outcomes for consumers, particularly when no account is taken of power and accountability. Professionals’ willingness to engage in participation strategies may outstrip their ability to do so in an accountable manner. When such gaps between intentions and effects occur, it is a painful experience for all, particularly those in the least powerful position - consumers. Hence, the concept of ‘partnership accountability’ needs to be more fully understood and enacted to minimise disrespectful and ineffective outcomes.

Partnership accountability is a specific approach to participation, where participation is the larger "umbrella" term. Partnership accountability principles describe relationships between traditionally powerful and disempowered groups in a society, such as professionals and consumers, that are based on:

- mutual respect,
- accountability of powerful groups for their actions and beliefs to disempowered groups,
- strengthening disempowered groups' voice(s) and influence,
- enabling disempowered groups to work alongside powerful groups as partners, and
- restorative action by powerful groups.

Partnership accountability focuses upon the accountability of professionals to consumers for their actions, beliefs and decisions on matters that impact on consumers, both in their presence and absence. It entails significant learning, challenges and benefits for all parties, also requiring an exploration of 'relationship' in human services work, ie trust, respect, reciprocity. Hence, it specifically addresses ethics. (See Stacey [1999; 2000; 2001] for more detailed discussion of partnership accountability.)

A compact definition is: "Partnership accountability is about giving...[consumers] the opportunity to fully develop a project, program, service, group or idea with as much control as they feel comfortable without setting them up to fail" (Stone, 1998, pg 87).

Evaluative processes

Evaluative processes may involve:

1. Critical reflection in which people engage regarding the everydayness of their work. This may occur as a solo activity or in dialogue with peers and

others via ad hoc or organised means, eg supervision sessions, strategic review, performance appraisal.

2. More formal processes that are named as 'official' evaluation or research.

Critical reflection may lead to more formal evaluative processes, for example, through using action research (Stringer, 1999) or cooperative inquiry (Heron, 1996). It should be an integral part of planning, designing, implementing and analysing formal evaluation and research programs. Both approaches are needed in addressing consumer involvement in mental health promotion work. Consumer perspectives are critical to evaluation and research efforts, despite the fact that such involvement is a rare phenomenon (Byas, et al, 2002; Macran, et al, 1999).

This is more than an issue of rights. Reasons for ensuring consumer participation extend beyond the rights to embrace benefits. The National Community Advisory Group on Mental Health (1995) addressed benefits in putting forward good practice guidelines for consumer and carer participation. Participation enables the gathering of locally-developed expertise, assists in setting community-relevant priorities, provides feedback on quality and effectiveness of services, and fosters better understanding of government decisions. Further, it facilitates accountability to those people most affected by services. These benefits impact at agency, state and national levels - their full possibilities are yet to be felt across the mental health sector.

Evaluation is now more vigorously pursued as a non-negotiable element of funding mental health services and projects. A basic question to address is: against what indicators do we evaluate mental health promotion? One response attempt is provided in the current National Action Plan for Promotion, Prevention and

Early Intervention (Commonwealth Department of Health & Aged Care, 2000b). Indicators may be of limited use if they do not concur with or reflect consumers' definitions of mental health. Further, outcomes may be misleading if consumers are not involved in the design, implementation and analysis of evaluation processes. If we are not asking questions about and measuring those factors that consumers believe impact upon or promote their mental health, then the pictures we offer based on evaluation outcomes will not represent the realities of people's lives. If we are committed to promoting mental health, then consumers are non-negotiable, vital partners in evaluation processes.

CONCLUSIONS

Notwithstanding advances in the mental health field to embrace a health orientation and support consumer involvement, professionals have yet to sufficiently acknowledge the critical place of consumers in the dialogue over how we conduct mental health promotion. Respectfully acknowledging consumers means enacting existing policy through proactively addressing barriers, and both harnessing and strengthening resources. Mental health workers need to be educated in the knowledge and skills that embody the attitudes required for genuine and

effective consumer involvement in order that it is more widely practised. This must become a routine process rather than relying upon ad hoc and/or individually initiated efforts. The litmus test will be whether more full-bodied consumer involvement is experienced and witnessed by consumers across all mental health areas, not just mental health promotion.

This paper has discussed some of the issues to be addressed, and knowledge and skills to be strengthened so that practice comes into line with the contemporary thinking outlined in our national visions for the mental health field. Further, it has advocated greater engagement with the notion of accountability.

Returning to that car - a steering wheel has been installed and it is firmly in the grasp of consumers. They may invite professionals to drive with them, even steer at times! In fact, the car may be considered a joint resource and the destination of its travels based on mutual goals. For anyone who has been on a long road-trip, as consumer participation clearly is, you know that despite the strength of a relationship, negotiation will always be required and hiccoughs encountered. Getting to the destination will be a test of commitment.

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Notes

1. The new public health era is represented by major WHO documents, such as the Alma Alta Declaration in 1978, Ottawa Charter in 1986 and Jakarta Declaration in 1997. Please see the Appendices in Wass (2000) for a reprint of all of these documents.
2. No acknowledgement was made of the existence of possible and appropriate mechanisms, eg Higgs (2001), Stacey (1999) and Stacey and Turner (1998).
3. “Consumer” has become the predominant term in Australia, although survivor and ex-patient have also had circulation, whereas “user” is more commonly used in the UK.
4. “Lay people” is used in the UK to refer to non-professionals, both consumers and people who do not use mental health services.
5. The concept of dialogue used here is congruent with Paulo Freire's (1994) notions. It also aligns with the notion of “deep dialogue” advocated by Epstein and Rechter (1999).