Developing Human Capability: Employment institutions, organisations and individuals

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Discussion Paper

Mental health services in Northland

Tihē mauriora
Ki Te Whaiao
Ki Te Ao Mārama!

The breath and vital energy of life
To the Dawnlight
To the World of Light of Illumination!

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Abstract

This case study of mental health services in Northland has proved particularly formative in broadening our understanding of developing human capability in New Zealand organisations. It widens the meaning of developing human capability beyond the dominant interpretation of workplace skills to do the job, to include social arrangements which through work also expand people's opportunities and positive freedom of choice to lead lives they value.

The case highlights the strong influence of institutional or system wide arrangements in the mental health sector on the development of human capability. For example, a national mental health strategy has shifted focus to communities and has shaped mental health occupations; the health sector contracting environment and specifically contracts for mental health services which require investment in formal up-skilling of staff; a stair-cased industry training system which is able to capture those who have missed out on other educational experiences; through to the capability development power of the management culture of organisations expressed in balanced work teams sharing expertise and knowledge. However, while factors such as these provide the environment for capability development, they also contain constraints – many of which are discussed in this paper.

In particular this case also illustrates the issues for Maori mental health workers in pursuit of defining and developing their capability.

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The Research Programme

The overall context and aims of the research programme

Capability development has been identified as a vital component of the Government's vision for New Zealand's future workforce. Capability is about being able to do things, to achieve. It includes all the skills, abilities or competencies that contribute to the economic performance of firms. Moreover, it includes the ability to change and adapt in order to sustain performance over time. Developing capability (i.e., a talented, highly skilled and innovative workforce) is seen as a path to global competitiveness, wealth creation, economic prosperity and well-being.

The aim of the *Developing Human Capability* research programme is to identify the conditions for the optimal development of human capability in New Zealand organisations. To this end, we are investigating how organisations develop the skills and capability of employees, and the influences on this (e.g. organisational performance, government policy, vocational training systems, skill shortages, etc). We are also investigating what individual employees think about their skills and capabilities, how they have developed them, and what has influenced that development (e.g., job opportunities or lack of them, affordability or access to training, etc). Exploratory case studies of human capability development are being conducted in a number of New Zealand industries with the perspectives of employers and employees within organisations, as well as key personnel in industry and training organisations, contributing to our understanding.

The programme also aims to take account of the degree to which the ability to develop human capability is structured by gender, age, ethnicity and disability; by access to information communication technology; with reference to organisational size and sector and the range of employment and contractual arrangements. Through a Maori research stream, exploration of Maori experiences also thread through the programme.

Mental Health Services in Northland

Examining the development of human capability in the mental health services in Northland has interest for a number of reasons. Firstly, the policy environment in which health services, and in particular, mental health services, are provided has devolved substantially in New Zealand over the past 15-20 years away from centralised funding and provision towards more community-based provision. Thus, how this evolution in the wider policy environment impacts on human capability development is of interest. Secondly, compared with most regions in New Zealand, Northland has a number of structural disadvantages which are likely to impact upon human capability development. Its long, narrow geography makes access relatively difficult and costly. More than half of its population live in the major centre, Whangarei, the remainder are scattered in small, rural communities across the region. Thus the local funding bases for infrastructure such as roads and broadband in areas outside of Whangarei is low. Secondly, whilst there has been steady growth in economic activity in the last five to six years, this growth has come from a low base as this region, because of the predominance of agriculture in its economy, was hit particularly hard by the structural reforms of the late 1980s and early 1990s. The region is still recovering from these structural reforms with median annual incomes lower than the national average, general unemployment higher than the national average, and higher again among the Maori population, relatively low educational

attainment levels in the population, and poor physical and social infrastructure such as roads, telecommunications and access to social services and to higher-level education (TEC, 2007). Thirdly, around 30 percent of Northland's population is Maori, most of whom are tangata whenua (original peoples) (Statistics NZ, 2007). This density of Maori (around twice the national average and exceeded only by the Gisborne region) for whom Northland is home, together with a growing political strength and resource base to push for tino rangitiratanga (self-determination), has implications both for developing human capability in Northland, and in informing the process of the Maori research strand within this research programme.

Methodology

General Approach

Sixteen organisations involved in mental health services provision in Northland were selected and invited to participate in the research. Selection criteria included the organisation's type, role, size, funding model, community served, range of services offered, and area of operation within Northland. The participating organisations ranged in size from one community trust with seven staff (including the manager); to a district health board (DHB) with a total staff of 3,000, including 380 mental health services staff.

The selection was not intended to provide a representative sample for the purposes of generalization, but to obtain a cross section of 'snapshot' perspectives from staff in different roles from a variety of organisation types and funding models that contribute to the provision of mental health services in Northland.

Twelve of the organisations decided to participate in the research project. Forty-three interviews, over an eight week period in mid 2007, were conducted. Interviews followed a semi-structured format and were taped for later transcription and analysis. Interviewees were assured of confidentiality and that data that could be used to identify individual staff would be removed from the final transcripts.

The semi-structured format allowed interviewees to focus on the areas that they felt were most relevant to their own situations and for many interviews, the sets of questions were used more as a prompt sheet. All interviews of staff from the nine main organisations however, attempted to cover three key areas:

- the individuals personal 'career path' to their current position, including probing the career decisions made;
- the individual's current job and the skills required; and
- the individual's assessment of skill and capability issues generally for their team, mental health services in Northland, and mental health services nationally.

Additional contextual information was gathered from sector stakeholders such as Ministry of Health and District Health Board New Zealand (DHBNZ) decision-makers with responsibility for mental health services, from representatives of Tertiary Education Providers of health qualifications, from the Industry Training Organisation (ITO), and from representatives of the major unions covering the mental health sector: the New Zealand Nurses Association (NZNO) and the Public Service Association (PSA).

Maori Research Process

Contemporary research practice involving Maori acknowledges the validity of Maori worldviews as well as the importance of a Maori critique of societal structures in order for research to be relevant and useful to Maori communities. The theoretical framework supporting this acknowledgement is known as Kaupapa Maori[1]. As a taxonomy of different types of research involving Maori shown in Table 1 below indicates, Kaupapa Maori research is one controlled by Maori, produced for Maori and done by Maori.

Table 1: Characteristics of Four Identified Types of Research

Characteristics	Research not Involving Maori	Research Involving Maori	Maori-Centred Research	Kaupapa Maori Research
Description	Research where Maori participation or data is neither sought nor considered relevant; Research whose results are thought to have no impact on Maori	Research where Maori are involved as participants or subjects, or possibly as junior members of a research team; Research where Maori data is sought and analysed; Research where Maori may be trained in contemporary research methods and mainstream analysis	Research where Maori are significant participants, and are typically senior members of research teams; Research where a Maori analysis is undertaken and which produces Maori knowledge, albeit measured against mainstream standards for research	Research where Maori are significant participants, and where the research team is typically all Maori; Research where a Maori analysis is undertaken and which produces Maori knowledge; Research which primarily meets expectations and quality standards set by Maori
Examples	Quantum chemistry; clinical trial; volcanology	Analysis of ethnic differentials in disease rates; genetic study of familial cancer	Longitudinal social science study of Maori households	Traditional study of cosmology; study of cultural determinants of health
Control	Mainstream	Mainstream	Mainstream	Maori
Maori participation	Nil	Minor	Major	Major, possibly exclusive
Methods/tools	Contemporary – mainstream	Contemporary – mainstream	Contemporary – mainstream & Maori	Contemporary – Maori & mainstream
Analysis	Mainstream	Mainstream	Maori	Maori

Source: MoRST

Whilst sympathetic towards Kaupapa Maori research methodology, two significant constraints hinder the adoption of Kaupapa Maori in this study. First, not all of the researchers in the team were Maori and therefore not fully aware of Maori worldviews. Secondly, the context of mental health servicing in Northland is one dominated by western world views – although this is being challenged – thus it is not possible to undertake Kaupapa Maori research. Following the taxonomy in Table 1 below, the Maori research methodology in this study can be described as on the borderline of research involving Maori and Maori-centred research.

[1] For a useful discussion of Kaupapa Maori research see Te Puni Kokiri (2002), pp. 13-20.

Overview of Mental Health Funding and Provision

Health Funding and Provision at the National Level

New Zealand's health and disability system is predominantly publicly funded. Health and disability support services in New Zealand are provided by a mix of publicly owned, privately owned and not-for-profit providers. Publicly owned hospitals provide most secondary medical and surgical care, while most primary care is provided by publicly subsidised but privately owned general practices. The private hospital sector specialises mainly in elective surgery and long term geriatric hospital services. A wide range of not-for-profit providers and other providers are involved in disability support services.

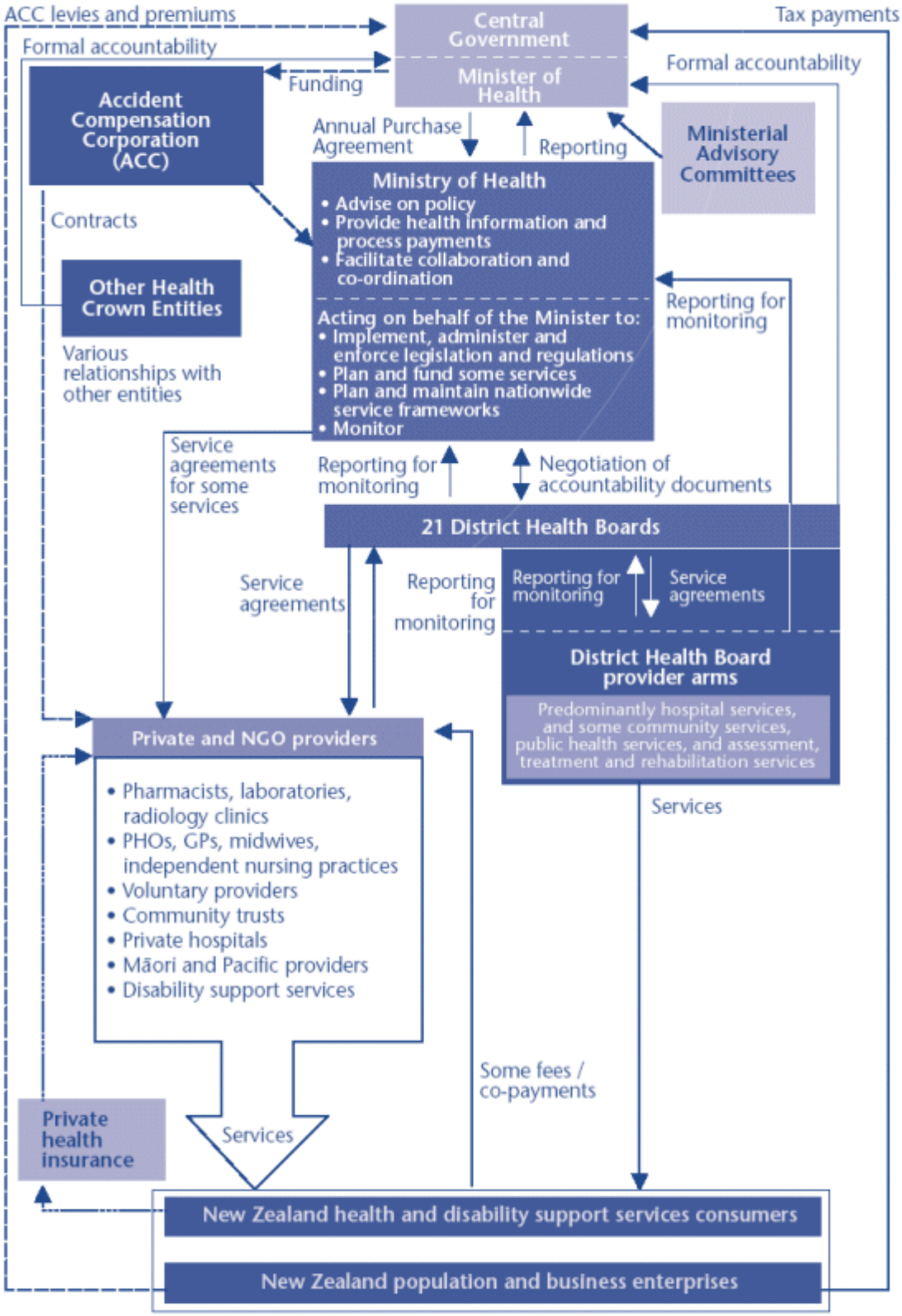
The organisation of health and disability support services in New Zealand has undergone a number of changes over the last two decades. In 1993 the Health and Disability Services Act introduced a system which replaced the Area Health Board model by separating the purchasing of health care and disability support services from the organisations that provided these services. Responsibility for purchasing services then lay with four Regional Health Authorities (RHAs). These RHAs contracted with providers of services in both the primary and secondary care sectors. The RHAs were not responsible for public health services. These were the responsibility of a fifth organisation, known as the Public Health Commission. The structure of the health and disability sector at this time reflected an international trend towards market-based systems.

Under the 1996 Coalition Agreement on Health the purchaser/provider split in health was retained, but the emphasis on competition between providers was removed. The four RHAs (the Public Health Commission having been dissolved in 1996) were replaced by a single Transitional Health Authority that subsequently became the Health Funding Authority (HFA). The Minister of Health appointed all the board members of HFA. The HFA was, however, expected to reflect the needs of users of services and to have a commitment to community consultation.

In 2000 the Labour-led government initiated changes in the sector that amalgamated the purchase and provision of services in the same organisations, re-absorbed the HFA into the Ministry of Health, and decentralised decision-making to community-focused District Health Boards (DHBs). The 1993 Health and Disabilities Act was repealed and replaced by the New Zealand Public Health and Disability Services Act 2000 (NZPHD Act). Figure 1 shows the current structure of the New Zealand health and disability sector in 2003 under the NZPHD Act.

The Minister of Health has overall responsibility for the health and disability support system. The Minister works through the Ministry of Health to enter into accountability arrangements with DHBs, determines the health strategy, and agrees with government colleagues how much public money will be spent on the public delivery of services. The Minister with responsibility for disability issues determines the disability strategy.

Figure 1: Key Funding-providing Structures in the New Zealand Public Health System



Source: Ministry of Health, 2004

The Ministry of Health plays a central role in the sector to:

- provide policy advice on improving health outcomes, reducing inequalities and increasing participation;
- act as the Minister's agent;
- monitor the performance of District Health Boards, and other health sector Crown entities;
- implement, administer and enforce relevant legislation and regulations;
- provide health information, and process payments;
- facilitate collaboration and co-ordination within and across sectors;
- provide nationwide planning and maintenance of service frameworks; and
- plan and fund DHB's, disability support services and other services that are retained centrally (Ministry of Health, 2004).

DHBs are Crown entities responsible to the Minister of Health (administration is through the Ministry of Health). Each board has up to 11 members, seven of which are elected by the community. A minority of members (up to four) are appointed by the Minister of Health. In recognition of the Crown's partnership with Maori, each board must have at least two Maori members, and preferably a greater number if Maori make up a higher proportion of a DHB's population.

DHBs are responsible for planning, funding and ensuring the provision of health and disability services to a geographically defined population. This reflects a move away from the purchaser/provider split, as DHBs provide hospital (and some community-based) services. DHBs are responsible for improving, promoting and protecting the health and independence of their populations. Boards must assess the health and disability support needs of the people in their regions, and manage their resources appropriately in addressing those needs. DHBs in turn co-ordinate their activities at a national level on selected issues through a sector group, District Health Boards New Zealand (DHBNZ).

Central government, informed by national priorities set in the New Zealand Health Strategy and the New Zealand Disability Strategy, provides broad guidelines on what services the DHBs must provide. Services can be delivered by a range of providers including public hospitals, non-profit health agencies, iwi groups or private organisations. Funding is allocated to DHBs using a weighted population-based funding-formula.

Much health and disability service provision now comes under the wing of DHBs. However, general practitioners, primary health organisations (PHOs), rest homes and midwives are independent and are contracted to supply services by DHBs or the Ministry of Health. DHBs are responsible for establishing, funding and monitoring PHOs, which are responsible for providing a set of essential primary health care services to a defined population. At a minimum, these services include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell. The first PHOs were established in July 2002.

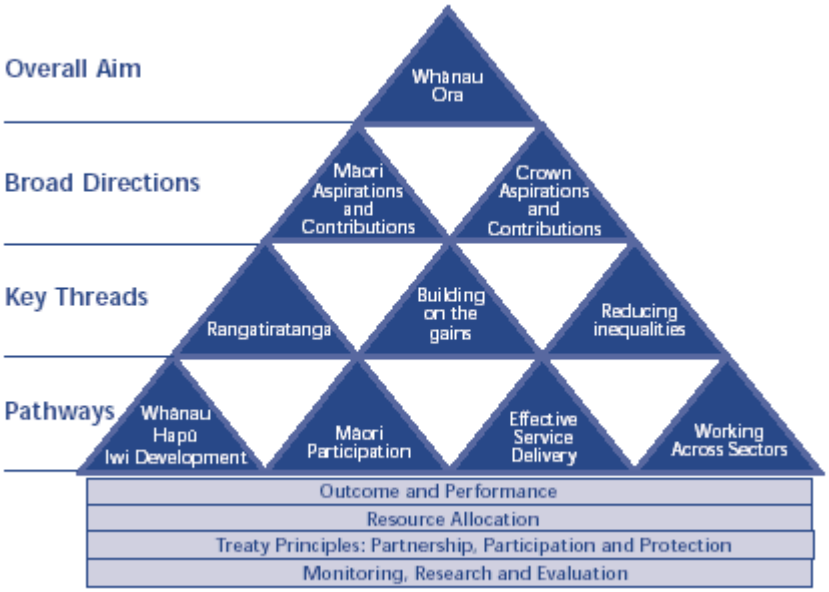
The non-government organisation (NGO) and voluntary sector is also important in the health and disability sector. Not-for-profit services are provided by more than 50

national organisations and even more local providers. This group of providers includes some large organisations such as the IHC, the Plunket Society, the Family Planning Association and the Salvation Army. In recent years community trusts and iwi-based bodies have also become important. Several communities, especially in rural areas such as Northland, have established community trusts to develop health services for people in their area, and iwi-based organisations are providing an increasing range of health and social services. An example of a community trust is Hauora Hokianga which provides integrated community and specialist services in Northland. NGOs are particularly important in the mental health sector and currently account for about 30 percent of mental health funding (Mental Health Commission, 2007).

The Crown's partnership with Maori under the Treaty of Waitangi is central in the health sector and has been interpreted according to the principles of partnership, protection and participation. Specific reference to the Treaty and the need to recognise and respect its principles is contained in the NZPHD Act. The Act requires that Maori be part of the decision-making processes within DHBs and that DHBs have processes in place to foster the development of Maori capacity for participating in the health and disability support sector. In addition to such legislative requirements, the Treaty and the consideration of Maori health issues are central to the work of the Ministry of Health.

Maori health status is consistently poorer across many indicators than that of non-Maori New Zealanders. The Maori Health Strategy, He Korowai Oranga was released in November 2002, the overall aim of which is whanau ora or healthy Maori families. As Figure 2 outlines, four pathways are proposed to achieve this: development of whanau, hapu, iwi and Maori communities, Maori participation in the health and disability sectors, effective health and disability services and working across sectors.

Figure 2: Strategic framework for He Korowai Oranga: The Maori Health Strategy



Source: Ministry of Health, 2003, Figure 6

Mental Health Servicing at the National Level

Mental health services include crisis and acute services, forensic services, sub-acute and rehabilitation services, continuing care services, specialised services, and drug and alcohol treatment services. Almost all clinical mental health services are now provided by DHBs. Community-based residential, day care drop-in, recreational and vocational services are provided by independent service provider agencies. Publicly funded mental health services are expected to give priority to treatment and care for the most seriously ill and for those most disabled by a mental illness. People with less serious mental illness or problems are usually treated by the generic primary health sector.

Like many other developed nations, during the 1970's and 1980's a number of reviews and inquiries were undertaken in New Zealand into mental health service delivery. These were prompted by adverse incidents affecting service users, and general perceptions that services were run down and inadequate. In order to address some of these issues the (then) Ministry of Health commenced the current cycle of mental health planning in the early 1990's leading to the publication of *Looking Forward*, the first national mental health plan, in 1994.

In 1996, an Inquiry that became known as the second Mason Inquiry was commissioned by the government to look at the availability and delivery of mental health services in New Zealand. The Inquiry was a defining moment, and its findings set the scene for the structure of mental health and addictions services available today. Findings that the Mason Inquiry identified included that the sector was under funded; there was a lack of co-ordination between and across services; there was poor service delivery to Maori; there was a lack of services for children and youth; there were major workforce issues particularly with recruitment, retention and training; and the importance of a public awareness campaign. As a consequence of the Mason Inquiry, the Mental Health Commission was established, first as a Ministerial Committee and then formally as a Crown entity under the Mental Health Commission Act 1998, to monitor and report to the Minister of Health on the performance of the whole mental health sector. In 2000, the Mental Health Commission Act was amended by the NZPHD Act with the effect of extending the life of the Commission by three years until 31 August 2004. The term of the Commission was extended because implementation of national mental health strategy was incomplete and it appeared that access to services was falling below targets. Subsequently, in September 2006, Government extended the term of the Commission until 2015.

The Blueprint, published in 1998 by the Mental Health Commission, provided a plan for a well functioning mental health system. The *Blueprint* had two innovations that proved fundamental to the development of mental health services over the following decade. Firstly, it specified guidelines for the types and levels of services required to meet the needs of people most affected by mental illness and these gave a strong focus to sector funding and development and to Commission monitoring. Secondly, it espoused a recovery approach which became the major model upon which service development has occurred in subsequent years. This recovery approach implied a shift towards a community-focus for mental health service and away from the historical institutional-based focus of mental health care. This document was supported by Government as a guide to implementing the national mental health strategy.

Over the following decade other policy documents, such as the *New Zealand Disability Strategy* (2001) and a number of policy documents specific to health or

mental health have been added to the national mental health strategy. In 2005 the second national mental health plan, *Te Tāhuhu*, was published. It lays out the Government's priorities for mental health and addiction services in the future. Its corresponding action plan, *Te Kōkiri*, sets out the next steps to meet the challenges identified in *Te Tāhuhu*. *Te Kōkiri* has a large number of actions some of which are to be led by DHBs or the Ministry of Health individually, and others that have been identified as being jointly led by the Ministry of Health and DHBs. These strategic documents are supplemented by the Mental Health Commission's own recent *Te Hononga,* a destination picture of the mental health and addiction sector and the wider environment for the coming decade until 2015 and it gives a picture of what mental health in New Zealand will look like when the challenges of *Te Tāhuhu* are achieved.

Mental Health Servicing at the Regional Level: the Northland Case

The Northland District Health Board Te Poari Hauora a Rohe o Te Tai Tokerau

The Northland District Health Board (NDHB) is the funder, planner and key provider of health and disability services for the 150,000 people who live in that part of Te Tai Tokerau which stretches from Topuni in the south to Te Rerenga Wairua in the north.

The NDHB delivers these services through public hospitals sited in Dargaville, Kawakawa (the Bay of Islands Hospital), Kaitaia, and Whangarei (Northland Base Hospital). Together these provide a comprehensive range of specialist services and 328 beds, through a significant network of community-based outpatient and mental health services.

The NDHB is a major focus of employment in the region. It directly employs over 2,200 staff, and indirectly supports the employment of hundreds more people across the region through contracts for services. It is the largest employer of people working in the mental health field in Northland, employing some 350 staff (representing 225 full time equivalents). Almost all of these staff are employed by NDHB's provider arm, Mental Health and Addiction Services. About a third of Mental Health and Addiction Services' staff are Maori, and the majority of the management team are Maori women.

NDHB employs a Manager in charge of contracting (community) mental health services to Northland private providers. Other private providers from outside Northland who operate in the region are generally under national contracts to the Ministry of Health.

The following services are supplied by NDHB's Mental Health and Addiction Services:

- General Adult Mental: community based assessment and treatment services to people through community follow-up and outpatient clinics. This service also provides the crisis response for Mental Health, dual diagnosis, maternal mental health and Clinical Rehabilitation;
- Alcohol and Drug Services: community based assessment and treatment to people presenting with alcohol and drug issues. The service has been integrated into the locality teams in the outlying districts. A methadone programme is also provided;

- Kaupapa Maori: Te Roopu Whitiora: community based assessment and treatment for Maori clients with mental illness, based on the principles of whanaungatanga. The service has been integrated into the locality teams in outlying districts while in Whangarei it remains a stand alone service;
- Acute inpatient: an inpatient unit at Whangarei Hospital with a 31-bed ward, plus six sub-acute beds and two intensive care beds;
- Respite care: predominantly designed for General Adult, although there is funding for Child and Youth and Maternal Mental Health. Provided by approved non-government services throughout Northland;
- Child and Youth Mental Health – Kimiora: a community based assessment and treatment service for children and youth up to eighteen years;
- Psycho-geriatric: a small community based assessment and treatment service which also has funding to purchase inpatient services from approved non-government services. The psycho-geriatric team is managed regionally from Whangarei Hospital;
- Service Co-ordination: provides services such as individualised packages of care and/ or access to support residential accommodation for people requiring more support than can be provided by clinical staff and community support workers;
- Hospital Liaison: provides psychiatric assessments to Whangarei Hospital inpatients; and
- Intensive Community Treatment Team: provides assertive community outreach to clients identified as at high risk, primarily due to their reluctance to engage in mental health treatment. This service operates in the Whangarei, Mid North and Far North districts.

Mental Health and Addiction Services is headed by a General Manager (who is also General Manager, District Hospitals), and a Clinical Director.

Under these positions are nine Service Managers in the areas of:

- Older peoples services (POPs);
- Child and Youth Mental Health: Te Roopu Kimiora;
- Adult Community Mental Health;
- Adult Maori Mental Health: Te Roopu Whitiora;
- District Manager, Community Mental Health, Kaipara;
- District Manager, Community Mental Health, mid North;
- District Manager, Community Mental Health, Far North;
- Nurse Manager, Inpatient Unit (IPU); and
- Service Development Professional Leader/Clinical Director.

Seven of these managers are responsible for teams of up to 30 'on the ground' staff including psychiatrists, occupational therapists, community mental health nurses, social workers and so on.

The majority of Mental Health and Addiction Services are provided in each of the region's four sub regions of Far North, Mid North, Whangarei and Kaipara. Alcohol and Drug, Clinical Rehabilitation, Psychology, Crisis outreach and General Adult services are co-located and managed as one team in each locality.

The Nurse Manager, Inpatient Unit (IPU) is directly responsible for two charge nurses, who are themselves responsible for the ward staff, which is comprised of nurses and mental health auxiliary officers (MHAO).

The Service Development/Professional Leader, Nursing has line management responsibility for two staff: a clinical nurse educator, and a suicide prevention co-coordinator.

Other mental health services providers

Maori Co-purchasing Organisations

The NDHB engages with Maori at the levels of governance, operational funding, and planning through the mechanism of Treaty-based relationships with Maori Co-Purchasing Organisations (MAPO), developed since the mid 1990s. The MAPO model empowers iwi-governed organisations to co-purchase and co-monitor health services in conjunction with the NDHB. Any NDHB purchasing that will impact on the Maori health status must be done in conjunction with the appropriate MAPO body.

Tihi Ora MAPO, governed by Te Runanga o Ngati Whatua, has responsibilities for Maori in the Kaipara which coincide with the NDHB's responsibilities for the Kaipara District.

The governance structure of Te Tai Tokerau MAPO (TTTM)[2] consists of iwi representatives from Ngapuhi, Ngati Wai, Te Rarawa, Ngati Kahu, Te Aupouri, Ngai Takoto and Ngati Kuri. TTTM's responsibilities for Maori in Te Tai Tokerau correspond with NDHB's responsibilities for the Whangarei and Far North Districts.

The NDHB and the individual MAPO authorities utilise an active partnership approach to the management of all health and disability service contracts and to relationships with health providers.

Primary Health Organisations

The first Primary Health Organisations (PHOs) were established in 2002 as local structures for delivery and co-ordination of primary health care services. Depending on the community that they represent, PHOs consist of teams of health professionals; doctors, nurses and other health professionals (e.g. Maori Health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives), that work in the community to serve the needs of their enrolled populations.

There are six PHOs in Northland who between them cover all of Northland's population[3]:

[2] The NDHB and TTTM written Partnership Agreement dates from May 2001, and the funding and planning was established during the DHB transition period.
[3] An area in eastern Kaipara is covered by a PHO based in Rodney District.

- Manaia Health (Whangarei District): 77,800 people;
- Te Tai Tokerau[4] (Bay of Islands and Far North Districts): 42,700 people;
- Kaipara Care Inc (Kaipara District): 11,500 people;
- Tihewa Mauriora (Kaikohe District): 8,500 people;
- Hauora Hokianga Inc (Hokianga District): 6,400 people; and
- Whangaroa (Whangaroa District): 3,100 people.

Hauora Hokianga Health PHO (under the Hokianga Health Enterprise Trust) is an integrated and extended PHO originally established in 1947 as a Special Area to serve an isolated rural area with a population of low socio-economic status and with a large Maori population. Hauora Hokianga PHO operates Rawene Hospital and Whangaroa PHO operates Kaeo Hospital. These are both small rural hospitals and provide the bases for a range of health services for the respective communities.

Summary

This section has identified the institutional structures which shape how workers involved in the funding and provision of mental health services in Northland go about their work. Whilst complex, such complexity in institutional structure, in turn reflects the ongoing complexity of the political, social and economic struggles as to how New Zealand society funds and provides health care, including mental health care, for its people. The current institutional structures resonate with the compromises that have been met out of these struggles: an established role for the state to fund a public health system but mediated by concerns about the cost and hence over how health services are delivered or provided; a shifting world-view towards structures that facilitate health for people rather than mere treatment of disease and illness; and the ongoing struggle for governance between communities (particularly but not solely Maori communities) and the state to establish the bounds of control over what constitutes health outcomes and their means of provision within communities.

[4] Te Tai Tokerau PHO is a partnership between Primary Health Holdings (a General Primary Provider Network made up of doctors, nurses and other staff from 10 general practice providers) and Te Tai Tokerau Māori Strategic Alliance (an entity of 5 iwi-based Māori provider organisations - Whakawhiti Ora Pai, Te Hauora O Te Hiku O Te Ika, Te Runanga O Te Rarawa, Ngati Hine Health Trust, and Ki A Ora Ngati Wai) which represents major iwi in Northland.

Working in Mental Health Services in Northland

Why do People Work in Mental Health?

From the interviews, there appeared to be close alignment between people's personal 'drivers' and the type of work that they were doing, which at its core was about developing and managing relationships with people who are having difficulty doing exactly that. Mental health work is one employment area where people with a particular interest in their own and others' psychologies are paid to 'be themselves' and are given the opportunity to purposefully develop that personal interest towards self-knowledge or self-mastery through formal and workplace learning that is also directly applicable to their work.

Despite this alignment, what constituted people's personal drivers differed across interviews. Interviewees gave many different reasons for getting involved in the mental health field. Personal experience of mental health issues was important for many.

> …a lot of nurses that came here, came here because they had whanau who had a mental illness and they wanted to come and work here to have a better understanding of why they do all these things and stuff so they can understand and explain to their family this is why and this is the terminology…
> *DHB Worker 3*

However, personal experience turned out to be one of several themes that interviewees pinpointed as influencing their career choice. For some people, mental health services were something that family members had provided as a matter of course as an ethical and pragmatic response to expressed need to the wider whānau or community, as part of whanaungatanga or as a supportive neighbour. Others were motivated partly by social justice issues and the chance to 'make a difference'.

> I think that one of the underlying things when I look at mental health ... was … I like fighting for the underdog.
> *DHB Manager1*

For many people, their entry into mental health work areas was more about a desire to help people foster personal development and wellbeing. Sometimes this was expressed as wanting to work with people who were more vulnerable than the average person, or as wanting to understand the underlying reasons to people's decision-making processes and actions, sometimes as a way to learning more about themselves as well.

> But I guess more importantly, I'm learning more about myself in this job, because if you don't know who you are, it's very hard to work with other people, to help them find whatever direction they're looking at. So I guess that's why I'm still here. So it taught me lots of skills, because they are so challenging at times, the behaviour, and just trying to understand where they're coming from, when they're behaving like that. I've learnt heaps about that, just behaviour of people, and managing people.
> *DHB Worker 17*

Another theme influencing career choice was that someone they knew and admired worked in mental health, or that they encountered role models in the workplace who challenged, encouraged or formally mentored them towards specialising in mental

health. Sometimes the role models appeared to have an uncanny knack of being able to judge straight away where the person would fit best in the sector.

Many people who self-selected to mental health services also possessed the capability to accurately assess their own capability for adaptation to the field, and to project themselves mentally as being able to obtain what they wanted from a job within a field.

> I really thought – what is it I like and I thought people, working with people – that's what I really like. So I wanted to get into some sort of counseling, psychology so I sort of started going down the track of psychiatric nursing…I suppose I looked at my values and what I wanted in life as well, that's when I thought working with people…I do like being a part of people growing – you know where they sort of learn things and they mature in themselves, like emotional maturity and sort of physical maturity where they just learn how to cope better in life, you know, that type of thing … .
> *DHB Worker 5*

The factors that led some people into working in the mental health field were therefore more associated with a particular interest in how people think, in working with people to improve their lot, as part of a journey of learning about self, or following the lead of family or role models, rather than personal involvement with mental illness. A few again had joined mental health from a purely pragmatic motivation – locally available work that was interesting and long-term.

What do Mental Health Workers Describe as Worker Capability in the Mental Health Field?

When asked 'what was human capability in their field?', mental health workers articulated two key factors. Firstly, all the people interviewed, from community-based mental health support workers to formally trained medical staff and managers, shared the view that real world ('life') experience outside of the workplace had as significant a bearing on capability development as does formal training in medical and technical skills and qualification acquisition. Secondly, that in the mental health field, 'real' life is not separate from work life, rather, paid work is an aspect of the wider life experiences.

The concept of human capability as encompassing the development of the whole person reflected a widely held perspective in the mental health sector that the process of developing human capability is more complex than mere training in task-related skills. A capable worker in the mental health sector was generally perceived to be professionally trained and skilled, and at the same time, able and willing to invest sufficient of their personal self and wider life experience to relate as a 'real person' with the people with whom they worked – both the users of services and team colleagues.

As examples of formal skills required for working with the mentally ill, mental health workers identified an understanding of the Mental Health Act, patient assessment and diagnosis, and the management of pharmaceutical and therapeutic treatment options. Significantly, interviews also showed that mental health workers regarded appropriate resourcing, in terms of professional skills and knowledge, physical infrastructure and access to suitable pharmaceutical treatment options, as strongly connected to the provision of quality service.

In the in-patient context, appropriate resourcing related primarily to planned shift rosters so that there was a judicious mix of senior qualified staff with newer staff members in the wards at any one time. This mix of experience was necessary to ensure firstly, that sufficient depth of professional expertise was at hand, and secondly to facilitate effective workplace learning and mentoring. A recurrent theme around capability was that hands on experience 'at the coalface' was what transformed training into genuine skills and developed effective, theory-based practice.

In the community based sector, appropriate resourcing related more to support the realities of workers being expected to work more or less autonomously in the field and often dealing with complex or demanding situations in isolated locations.

> The other goal is for us to do that (work autonomously in the field) well, it's about training people, to give them the best knowledge that they can to do that. I think the other part of it is about to do the job well, then there are resources that the team need. We're talking modern technology, having laptops that you can operate in the car instead of coming back to work (and) satellite phones so we can operate anywhere … when you get a call you can tap in right there at home, get all the information and do what you need to do, having resources so that we can do the role or do the job as best we can. We've upgraded (vehicles) which is great. Because the travelling that people, … has to do is quite a distance. All those things are part of ensuring that we do provide a good service or a service that is of a high standard.
> *DHB Manager 9*

Interviews also identified capability in the mental health sector as being strongly related to well-developed personal skills that both assist workers to engage with the users of the services and recognise their own personal limitations and weaknesses.

> A capable worker? One, (someone) who's got skills and engagement. Two, is someone who's got a passion for the job. And three, is someone who's got the recognition to be able to, when they see things that could be slightly out of their depth …they will be able to relate to the team. And obviously the team with a lot of good clinical skills to be able to support that. But if you haven't got all four of (these capabilities), to be able to be at least be part of the team, they can actually be able to share that, so that other people can impart their knowledge.
> *DHB Manager 7*

A person with the required level of capability was expected to be able to deliver quality, client-centred services that were appropriate and effective, and to manage their own ongoing professional currency and performance to standards.

> It means having the capacity to be able to perform your role to meet expectations set by the organisation, but also on a personal level it means being the best I can be in the role that I'm currently in. Making sure that (I) keep myself up to date, access supervision, conduct myself in a professional manner. It means all of those sorts of things. Capability, having the capacity to fulfill my role to a standard that I think is a good standard, that satisfies me personally as well as within the organisation professionally.
> *DHB Worker 2*

Examining the description of capability at a deeper level, it is clear that people working in the mental health arena have a highly developed awareness of the particular type of interpersonal skills required for someone to be able to work effectively with people with mental health issues. People who do well in mental health were described as warm, approachable, a 'people-person' who could build good relationships with the users of the services and their team colleagues. Good communication skills were defined as including effective listening, effective speech, an ability to interpret body language and what was not being said.

> Sometimes you get clients that are quite sort of mono-syllabic in their approach (it's) like trying to bleed a stone, so you've got to use lots of open-ended questions. You can't be badgering them; lots of closed questions (and) they get irritated … another skill is having the sensitivity to them and their needs and sort of their body language. I think you've got to be good with people, good at managing people, flexible.
> *DHB Worker 5*

In many cases, people were quite detailed in their description of the specific nature of the inter-personal skills demonstrated by capable mental health workers. The skills described included an awareness of self and self in relation to others, the impact of personal values on one's approach to work, a highly developed understanding of others' self-perceptions; and the ability to help people (sometimes through persuasion) to move towards resolution of issues. These skills are largely learned through experience.

> The therapeutic self should be the main thing in all nursing, that all nurses have.
> *DHB Worker 14*

> …and you only get this through experience to assess people, to de-escalate situations. [To] try and empower people rather than direct them or do things for them. To give them ownership. It's not so much the skills of nursing around medication or what have you, although that is a part. That's always there but I think that's a minor part.
> *DHB Worker 15*

The same skills of communication, rapport building and reflection were seen as important to the functioning and effectiveness of mental health worker teams. Several managers and team members talked about the importance of these skills in building and creating safe, supportive and professional teams comprising colleagues with different backgrounds, personal approaches, qualifications, specialisations and levels of experience.

> When you look at the backgrounds of the current members, it's quite a diverse makeup. And considering that, we all get on very well as a rule. We have our moments but we get on very well. Quite tolerant of other peoples' points of view. That's not to say we agree with them, but we're quite tolerant…
> *DHB Worker 15*

In ward-based mental health work (IPU – inpatient unit or 'psych nursing'), a balanced team is important in a very practical health and safety sense.

> Working in MH is quite strenuous. It's one of those jobs where you can burn out really really easily. So things like shifts and overtime and the balance of shifts and creating the right skill mix so that you've got new staff,

> inexperienced staff, with older more experienced staff or staff who have more experience in certain areas. There's a bit of an art to it.
> *DHB Manager 6*

The effective treatment of individual users of services requires that that person is seen as a member of the wider community who is being treated either within that community, or to equip them to return to it. The ability to develop and maintain effective community networks with local government department representatives (e.g. Police, Work and Income) and community-based contacts (e.g. schools, service groups, Maori Wardens, youth workers, local organisations) was therefore seen as a characteristic of capability for many mental health positions, particularly of community support workers.

> The individual that we work with lives out in the community, is supported by different groups in the community. So the networking is crucial.
> *DHB Manager 9*

While their primary task was to identify individual users' links within the community, community mental health workers were also expected to 'present a friendly face' on behalf of the mental health service sector as a whole, and to work to 'normalize' the concept of mental illness, its treatment and the importance of community support as part of the treatment process. This personalisation of the service by the worker is magnified in smaller centres where peoples' work roles are more common knowledge and accompany them socially: at the supermarket, the school, and the marae, often proving to be both a boon and a bane to the individuals concerned. In one respect, the diagnosis and treatment of mental illness is normalized, in another, some in the community never recognise that the mental health worker is entitled to be 'off duty'.

The skill of assessment of mental health appeared to most clearly exemplify the interdependence of the technical/medical with social/interpersonal skills and knowledge that mental health workers captured in describing human capability in their field. Accurate mental health assessment was described as requiring the ability to synthesize these two strands of capability – of proficiency in 'technical' skills obtained through structured and formal training, and in sophisticated inter-personal skills, gleaned from people's life paths and social experiences.

This interdependence is underlined in the way that mental health worker's comments about capability moved seamlessly between 'technical' competencies, or 'hard skills' and interpersonal competencies generally referred to as 'soft skills,' and skills and tasks.

> Often the way in which people work is a skill and often what they know is a skill.
> *DHB Worker 4*

What do Maori Mental Health Workers Describe as Maori Worker Capability in the Mental Health Field?

Maori mental health workers described a set of Maori worker capabilities additional to those in the section above. Usually expressed through their frustrations, these capabilities reflect the common desire amongst Maori mental health workers for tino-rangitiratanga (self-determination) in the governance and delivery of social services, including mental health, to Maori.

Even though it is acknowledged that progress towards self-determination had been made,

> Mental health is streets ahead of mainstream services in terms of involvement of whanau, in terms of cultural responsiveness. I'm aware of what the other services are, so if you take that from where mental health was, compared with 30 years ago, I think mental health's done an amazing job…
> *DHB manager 1*

the frustrations of working within Pakeha-dominated institutional structures was clear,

> when we're talking a rationed environment, what do you prioritise? … the Maori development aspect of it? And the mainstream enhancement stuff needs to be continued to be built in but you've got to prioritise the Maori development side of it. Unless you do, you're not going to get any enhancement happening on the mainstream side of it because you haven't got any better over here in the Maori side of it…
> *NGO manager 1*

The importance of bringing Maori/iwi cultural values to their work practice and work relationships with professional colleagues and service users, and of its contribution to the quality of services offered in Northland's mental health services was emphasised by a number of interviewees.

> But what [Maori mental health workers] also have is something that you can't learn, you can't go and do a course on, and that is that inheritedness about the Maori world view and how you deal with Maori clientele and how you actually support Maori through the system, because they're going to be in the system, it's a dominant culture system. How you actually support them through and actually break down the barriers for them.
> *NGO manager 4*

> I suppose for me, being Maori as well, calling on a lot of the cultural sort of stuff, because I was brought up in a really strong Maori cultural – that was a big part of who I am as well.
> *DHB Worker 2*

The legitimacy to be a Maori was also valued, usually expressed by its absence.

> I know so many Maori people, young people like myself – or relatively young – who've come away from one of the professional training courses because there was a non-acceptance of things that were very real to Maori … like for me I want to continue with professional development but I don't think I should have to sacrifice who I am and what I believe in, to be able to do that. And it seems to me that that is the expectation from a lot of the educational institutions that you have to do that, standards that are set for, say Pakeha – standards that are acceptable norms, they don't always apply to Maori…it's like you're not allowed to be who you truly are, you have to become somebody different in order to be able to work in this field. And it's not right.
>
> *DHB Worker 2*

This legitimacy was commonly expressed through interviewees talking about experiencing a lack or withdrawal of support from management for using or learning te reo Maori me ona tikanga in their workplaces. One worker pointed out that despite Maori service users "coming in [here] in droves", even Maori staff did not use Te Reo

Maori in the workplace, commenting, "We don't have that here, we don't talk in our language".

Levels of knowledge about Te Ao Maori among non-Maori mental health workers ranged from a demonstrated ease and competency in Maori contexts, through to a real diffidence about the need to actively pursue learning about more than basic marae protocol. This potentially impacts on how non-Maori work with and support Maori colleagues, as well as Maori service users.

One mental health worker newly arrived from overseas was by turns intrigued and frustrated at the 'secret' knowledge that others seem to possess about Maori concepts, and about particular words and phrases that are part of the Northland region's shared lexicon. This worker had attended Treaty of Waitangi training but wanted to access a different sort of information about contemporary Maori life and how to effectively engage as a non-Maori with Maori.

> I'd like to sort of know a bit more, partly for my own personal fascination and it would be interesting to know another culture but also sort of keep me safe and keep me from offending... . I'm aware that there are things that I need to learn ... like different words like whanau and stuff, and you know exactly what it means…it's not just family but it's a wide sense of family. Took me a while …okay, I know what whanau means, it's not just family, it's the network – like you could be really close but you're not necessarily related but still be part of the whanau.
> *(New arrival to New Zealand)*

Capability for Maori mental health workers, and to those non-Maori working with Maori, were thus expressed around the principles and practices to be able to exert tino-rangitiratanga. These capabilities include: being able to claim Maori health initiatives as their own; being able to legitimately 'be a Maori' and thus for te reo Maori, tikanga Maori, mātauranga Maori and āhuatanga Maori to be taken for granted; for Maori mental health workers to be able to choose their own mental health pedagogies; and where the principle of whanau and the practice of whanaungatanga being an integral part of the practice of mental health.

An Emergent Meaning of 'Developing Human Capability'

As stated in the introduction, the broad aim of this research project is to identify the conditions for the optimal development of human capability in New Zealand organisations within a broad context of a state project to facilitate economic transformation and development in New Zealand. Whilst the specific meaning to attach to 'development of human capability' was open at the beginning of the research phase, because of the economic aims and context of the overall research project, a prior working definition of human capability tended to be one of 'the sustained ability of workers to perform' and developing human capability tended to be equated with skills and training.

Although the research began with a working definition of capability, in the interviews of Northland mental health workers, as in earlier interviews of workers in a range of different industries and workplaces (see Bryson, Pajo, Ward & Mallon, 2006; Bryson & Merritt, 2007; Bryson, 2007; O'Neil & Bryson, 2007) we observed a serious contradiction with respect <u>to whom</u> does developing human capability relate. Does human capability refer to capability of people within organisations to meet or serve the goals of the organisation, and therefore to developing human capability referring

to aspects such as training and development? Alternatively does human capability go beyond the organisation and refer to workers themselves and how they live or would like to live their lives? In such a case the subject/focus becomes the humans themselves, of which work is but part of a broader capability to live.

In our reading of the interviews we have tended toward the latter interpretation of human capability. Capability in the sense of competence to meet organisational ends was important in the interviews we conducted but such capability was part of a wider endpoint which related to the ability to lead a good life of one's own choosing. Capability to "do the job" was merely part of how people defined themselves and what they could do with their lives. Through the skills and training 'to do the job' to assist patients recovery from their illnesses, mental health workers in Northland were also purposefully developing their personal interest towards self-knowledge and self-awareness. For Maori mental health workers, capability 'to do the job' also encompassed the capability to have a valid and legitimate life and existence as Maori.

There is also diversity in the reasons why people entered a job or profession, diversity in what people bring into a job, and diversity in what people take out of a job.

Capability to "do the job" as merely part of how interviewees defined themselves and what they could do with their lives, and the diversity in lived experiences of the mental health workers we interviewed, leads us to thinking of human capability as the freedom to achieve things. This sense of capability as a positive freedom is one which resonates within the 'capability approach' of the Nobel laureate, Amartya Sen. Sen's capability approach helps inform an emergent meaning to attribute to developing human capability which the interviews expose.

Sen's use of the concept of 'capability' originates in debates within welfare economics and is principally applied in the context of economic development. Sen's thought has been widely summarised and presented in the literature[5]. Sen himself has provided many summary accounts of his thoughts[6]. Whilst Sen's 'capability approach' raises complex philosophical issues and is developed out of a detailed critique of mainstream economic approaches to welfare, the essential point of departure of Sen's work is his focus upon human well-being and within that his arguments that the purpose of development is the expansion of people's well-being and freedoms so that people have the opportunity to expand their achievements.

As Sen himself (1993) and other commentators (Robeyns, 2000; Sehnbruch, 2004) emphasise, the capability approach operates at three levels, but is primarily and mainly a framework of thought, or a mode of thinking. Sen stresses 'the plurality of purposes for which the capability approach can have relevance' (Sen, 1993, p. 49), below which is a critique of other welfarist approaches in welfare economics. On a third level is the capability approach as a formula for interpersonal comparisons of welfare.

The capability approach involves 'concentration on freedoms in general and the capabilities to function in particular' (Sen, 1995, p. 266). The major constituents of the capability approach are the concepts of functionings and capabilities. In *Development as Freedom*, Sen offers a set of definitions of functionings and capability:

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[5] see for example, Pressman S. & Summerfield, G. (2000); Osmani, 1995; Gasper, 2002.
[6] See for example Sen, 1984; 1985;1987; 1992; 1995; 1999.

> ‘the concept of ”functionings”… reflects the various things a person may value being or doing. The valued functionings may vary from elementary ones, such as being adequately nourished and being free of avoidable disease, to very complex activities or personal states, such as being able to take part in the life of a community and having self-respect… A capability [is] a kind of freedom: the substantive freedom to achieve alternative functioning combinations’ (Sen, 1999, p. 75).

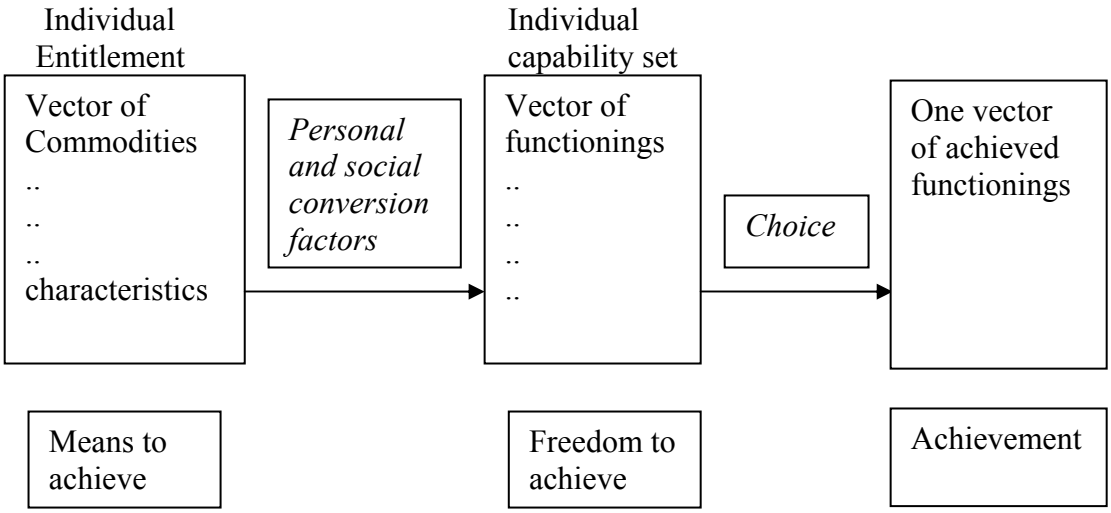
Functionings are thus the ‘beings and doings’ of a person, whereas a person’s capability is the various combinations of functionings that a person can achieve. The two concepts are related but distinct in that:

> ‘a functioning is an achievement, whereas a capability is the ability to achieve. Functionings are, in a sense, more directly related to living conditions, since they are different aspects of living conditions. Capabilities, in contrast, are notions of freedom, in the positive sense: what real opportunities you have regarding the life you may lead’ (Sen, 1987, p. 36).

A key point that Sen is making out of his critique is that the availability of a commodity (such as a money wage or a job) does not necessarily or automatically imply that people can achieve an intended act or state of being. With the concept of ‘functionings’, Sen is trying to capture the notion that what ‘doings and beings’ a person achieves depends upon command over a particular set of commodities, her individual circumstances, the physical and social environment she lives in, and all other factors that may impact on the conversion of commodities into achievements.

Following Robeyns (2000), a schematic representation of the capability approach is presented in Figure 3 below. By introducing the concept of functionings, Sen is concentrating on what an individual can achieve with a particular set of commodities given that person’s circumstances. In this process, they have to make choices and make decisions. Capabilities captures this notion of choice by considering what people *could* achieve given a certain set of commodities. Capabilities thus refer to the ability of a person to do or be something, whereas functionings refer to the actual actions or states of people. The capability of a person thus corresponds to the freedom that a person has to lead one kind of life or another, chosen from a range of options.

Figure 3: A Schematic Representation of the Capability Approach



Source: Robeyns, 2000, p. 5

In recognising agency, crucial to the capability approach of Sen, is what Browne, Deakin, and Wilkinson (2004) refer to as the conversion factors which facilitate freedom or capability. These conversion factors are the characteristics of people and the society and the environment they live in, which together determine a person's capability to achieve a given range of functionings. Personal characteristics in this sense include such things as a person's metabolism, age and gender. Societal characteristics would include such things as societal norms, legal rules and public policies. Environmental characteristics would include such things as climate, physical surroundings, infrastructures and legal-political institutions.

The capability approach of Sen thus provides the framework of thought or lens through which to identify the factors that lead to the optimal development of human capability in New Zealand organisations. It asks, what are the social arrangements or conversion factors that lead to the ability of people to do or be something? Viewed through this lens, the research becomes an end-based approach: in organisations focusing on workers as ends-in-themselves, rather than merely as a means-based approach focusing on the income workers earn, the skills they have or the type of job they hold[7].

Assisted by this lens, in the section that follows is a discussion of the drivers and barriers or conversion factors which affect the capability of mental health workers in Northland to lead the lives they value.

[7] The means-based focus has already slipped into the project description with reference to the linkage between human capital, skills and training. Whilst not denying the relevance of the concept of human capital, its focus upon skill and its individual rational acquisition misses the point that the individual also needs the effective means to apply such skill into an achievement. Skills are only a part of a wider concept of a person's broad capability to achieve his or her goals. The case studies highlight how this capability develops or declines depending on daily circumstances in life and work, at least as much on formalised periods of education and training.

Social Arrangements for Developing Human Capability in Mental Health Services in Northland

Drivers and Barriers

This section discusses the social arrangements for developing human capability in Northland's mental health services. It is argued that there are three dominant social arrangements: the national mental health strategy, management culture and kaupapa Maori, which together shape other social arrangements into developing human capability.

National Mental Health Strategy

As previously discussed, following the Mason Enquiry in the 1990s, the strategy of mental health care changed towards a recovery approach in the delivery of mental health services. This approach implied a shift towards a community-focus for mental health service and away from the historical institutional-based focus of mental health care. This shift in strategy both drives and creates barriers to the development of human capability of those working in the Northland mental health sector by shaping the social arrangements which establish occupations and which segment labour markets.

Occupations

The mental health strategy shapes the occupations of those who deliver mental health care. Basic training for the core professional group, mental health nurses, has now changed from a brief exposure in the third and final year of comprehensive training to an integration of mental health nursing skills across the curriculum. The first mental health placement now takes place in Year two of comprehensive training. This placement is with an NGO, thus student nurses' first experience of mental health services is with community-based services rather than the traditional internship in an in-patient unit. In Year three, student nurses have three weeks mental health theory followed by another compulsory mental health placement in an area of their choice. Students wishing to specialise in mental health nursing can choose a mental health elective as well, in which they complete up to twenty of the thirty weeks of year three training in that sector.

This approach is expected to increase the number of nursing trainees choosing mental health as an area of specialisation and overcome many of the negative introductory experiences through traditional internship which turned many away from mental health nursing as an occupation.

> ...it's the first time we've accessed (NGO placements) because … I had a lot of students coming into MH that were terrified, absolutely terrified. I wanted them to see people well and living in the community that had diagnoses of mental illness before they go in to the acute ward. I want them to see that people are people …so this is the first time we've done that…. What we're hoping is now in Year 2 they'll be looking at MH as a real option because they've seen what it's like out in the community, they've met people that have got a diagnosis of mental illness and you know, some of those fears have gone away… the little green men and the rest of it so you know, they've been more

> able to make a choice as to whether they want to spend the whole (third) year in MH.
> *TEO 2*

These community-based introductions notwithstanding, because of the increased complexity of jobs which the recovery strategy requires of mental health nurses, there remains a strong call for deeper mental health training for nurses who wish to specialise in this area.

> Psychiatric nursing prepared people specifically to look after that top end of treatment, of people with acute and enduring mental illness…. The comprehensive course looks at mental health in well populations as well as mental illness, so it's a broader look … (one thing). I think it will start to come more to the fore again for …some people are talking again about [the] need for separate training for mental health nursing. So it is an issue that hasn't really gone away, dampened down for a while but I'm sensing it's bubbling to the surface again…
> *Sector stakeholder 3*

Post-graduate study remains the predominant route for nurses with comprehensive training to specialise in mental health nursing. Northland is reasonably well-serviced to provide such post-graduate study with three tertiary education providers in the region who understand the importance of this route.

> I think if they're going into mental health (comprehensive nursing training) actually doesn't prepare them very well and I think they do desperately need that post-grad thing in there …. I don't think they're, if you like, they're only just getting used to the controls of the car and they're not ready to drive on their own when they get out there.
> *TEO 2*

The most significant impact of the mental health strategy on occupations in the mental health sector has been in community support work – much of which is done under contract to DHBs by NGOs. Community support workers are employed under a range of different titles depending on the staffing structure of their employing organisation. Historically, the criteria for recruitment into community support work was a demonstrated aptitude for working in mental health rather than an academic qualification. Thus, recruitment to community support work was, and still is, strongly associated with people who have not experienced tertiary level training and with mature people returning to paid employment who are sometimes not interested in formal training. However, with the focus on community-based recovery have come policy directives from the Ministry of Health requiring the need to build capability in the mental health workforce to meet higher service delivery expectations. NGO service contracts for example, require that they employ staff with the appropriate qualifications to achieve contracted outcomes.

The National Certificate in Mental Health Support Work (Level 4) is increasingly seen as the minimum entry level for the sector, and also provides a useful tool for organisations wanting to lift their general standards of professionalism. This qualification is developed and managed by Careerforce, the Industry Training Organisation (ITO) for the health and disability sector and three TEOs are active in delivering the qualification to Northland learners, including a distance learning option.

Demographic data for Northland Mental Health Support Work students shows that over 90 percent are female, about 80 percent are Maori, and the average age is 45 years. The Certificate study is the first tertiary study experience for the majority of students.

> Most of our students haven't done NCEA. Most of them have left school end of 4th form, whenever they're 15, 16. No quals… Eighty percent of our students had a really poor deal with the NZ education system and they don't have any secondary qualification. So staircasing is really important for getting people onboard to education and professional development and professionalising their approach to their work.
> *TEO 1*

> (The Certificate programme has been) designed with extensive consultation with employers and they suit employees and employers. Most of our students work. They hold full time jobs, they've got dependents, be it older parents, children, extended whanau. So we've designed our programme totally in response to the student population in Northland.
> *TEO 1*

Local delivery of the Certificate is seen as a strength in that it helps students to develop their first collegial and support networks in the region where most of them will first be employed:

> If you're in the social service industry, you are working with people and you need to have that interaction as part of your learning. So I don't really favour undergraduate stuff that is isolated. That's why I was quite keen to have stuff in Northland, that students have regular contact, have regular support groups, they don't have to travel places, they don't have to travel to Auckland or Palmerston North to do their training, they've got people in Northland they're connecting with while they're doing their learning, which helps the industry anyway…
> *TEO 1*

> This foray into having qualified staff is a new venture for us, a new adventure. And it was something we originally were a little concerned about because of whether we could get the right people to do the job…. (Now) all of our staff we like to have with the National Mental Health Certificate, so we just encourage staff to do that – we've made it possible, paid all their fees, gave them day release to go and do it. If they were on shift or going to be on the job on the day we'd pay them and replace them with somebody else so we could do that. If they're not on shift, not employed that day then they do that in their own time but we've always paid all their fees. So it's cost neutral to them … there's no real training plan as such but almost all the staff now … have a National Mental Health Certificate.
> *NGO Manager 1*

Despite the poor academic background of many community support workers, there is positive feedback related to particular skills gained:

> That MH Certificate for me taught me about structure and it's something that I've always got other people to do for me but now I can do structure…. I would never write anything down – hold it all up here but I had too much to hold up here so I got a pad and I think I ended up with 88 pages for that whole

> course of me keeping myself in check – What's the next move? Whose turn is the next move? Who's going to do this bit, and what are we going to do there, and that stuff…
> *DHB Worker 3*

> I think that having assessments and standing beside your judgements and decisions that you're making about the information you're presenting is a really important part of the Certificate in Mental Health.
> *TEO 1*

The NDHB assisted the rate of uptake for two years by paying the qualification study fees for some students and arranging that the ITO training subsidy was in turn paid to their employers towards the cost of relief staff required to cover for students attending weekly off-site training.

This support towards the achievement of the Certificate was significant in another way in that it conferred a particular organisational and sector value to community support worker skills sets and contributions to the wider mental health service sector that had not been previously accorded. As part of the National Qualifications Framework, it links to the qualifications environments of both secondary schools and other industry sectors and as such, has a currency that is understood by people across related social service and other sectors. The Certificate structure for example, opens up a potential pathway from secondary school for young people interested in the mental health field, and comments from several people identified that achievement of the qualification had a liberating effect in terms of choices in career pathways both within and outside the mental health sector.

> You've got NCEA and students coming through High School now are used to this boxy type of learning, so that NCEA will staircase quite nicely into these unit standards because the students just have to tick that off, have to do a little assignment for that and get that one ticked off…
> *TEO 1*

> One of the things I have to say about our graduates that I've heard is that when they graduate from something, it gives them more choices. And that's a really interesting thing because even though they're working in an area that they've had passion about, they might not be confident to apply for other jobs because they haven't got the qualification to make that application. So once they've got the qualification, they can then make the choice about staying in that job. They can make some … that's quite a clear thing my graduates have said – it gives them choice that they're happy with.
> *TEO 1*

Less positive feedback on Certificate training was a level of concern that the formal qualifications-based training (off-site, classroom based learning) was not effectively integrated with workplace requirements or realities; that in a lot of cases the classroom-based learning resulted in very limited change in work practice. This suggests that students needed more direct assistance to transform academic concepts into applied learning.

It is likely that a more active involvement of employers with their employees' study progress would assist this process. Equally, active outreach into the workplace on the part of the TEO seems appropriate. One suggestion was that TEO tutors spend some

regular, structured time in each student's workplace working on the application of learning to specific situations:

> The Polytech training ... it's like a lot of academic courses. They prepare you, but they don't prepare you for … the necessary on the ground floor level stuff. And whether our staff in reality are actually marrying up what they're learning in theory with what they're doing on the floor, I don't know if they are…. So I don't know whether we've actually got to the stage with the level 4 that it's actually making some shift in their thinking (that can be evidenced through changes in their practice)….
> *NGO Manager 2*

The sector is now preparing for a new round of training activity associated with a Level 6 mental health diploma qualification. This is being developed by Careerforce and the TEOs for delivery from 2008. The indications are that future NDHB funding support will target the Diploma qualification rather than the Certificate.

> We know that the contract conditions might change and there's a push for the level 6 in Mental Health, so we're going to respond to that market…. We've done our own research.... By going out to employer groups and just doing exactly what you're doing in terms of capability study. So we've just finished a big project ourselves and we're going to gear some training and development in response to those needs that were highlighted.
> *TEO 1*

The increased emphasis on qualifications for mental health community support workers has wide acceptance amongst employers, but there was a level of concern expressed about the longer term implications around increased credentialisation of the workforce.

> …even at Level 4, becoming a pre-requisite brings with it some concerns…. One of the problems with the whole training thing is there's a potential to ratchet up the qualification levels, the entry levels and all that stuff to the point where you can't actually recruit the people who are going to be good at the job because they've got to have gone to the Polytech before they get the qualification and then where are they going to get the experience?
> *NGO Manager 1*

Regardless of the occupation concerned, there was a strong belief amongst mental health workers that formal, structured learning was fundamental to working in the sector. 'People and life skills' were regarded as important, but a formal theoretical framework and training in the implementation of research-based practice were considered essential for effective and safe work with mentally ill people, and to provide the intellectual and ethical infrastructure for mental health professional practice.

A particular value of formal, structured learning for many was that it contextualised personal and life learnings as valuable in itself but also as it contributed to developing a wider theoretical framework.

> Structured training … taught me a lot about myself – I guess what sort of person I was. That – I don't know how to explain it – it was a good journey for me myself but the structured part taught me that whatever I knew, I had to learn more about.
> *DHB Worker 6*

> Exposure to tertiary educational systems teaches you or gives you the ability to access a whole bigger bag of tricks so that when you're working with a person you can – if this doesn't work then you can try this, and if that doesn't work you can try this, and if that doesn't work you can try that…. Always having options available for them… I think that's what structured learning provides. It just gives a different perspective and a whole different range of ways of working.
> *DHB Worker 2*

Despite the value accorded to formal learning, not all mental health workers had fully grasped the fact that their roles have been undergoing a huge shift in focus and responsibilities. Mental health services are now expected to train and support their workers to empower service users, assure their rights, increase their own control over their mental well being, and assist them towards full participation in society. This represents a considerable shift in skills and knowledge base for most mental health workers. There is some resistance to this new 'skill set', particularly from within the traditional nursing profession.

> We've got very much now people are recovery oriented at management level. Nurses are changing greatly towards recovery thinking but there's still an overhang of 'this is enough.' 'Just visiting somebody is enough.' So we're still operating on the level that we want to see actually a lot more engagement in nurses.
> *DHB Manager 4*

> I think personally that the big bin mentality has just changed its shape. There's containment. We still hear nurses talking about containment. 'We can't manage that person. We can't contain them.' It's not a matter of containment. It's a matter of education and naturally developing that person or allowing that person to develop their social skills, the betterment and quality of their life, not to make our job easier…. Teaching the person to use the service as a tool for the betterment of their life, not us using the client to the betterment of ours, as an ongoing part of our industry…
> *DHB Worker 10*

Labour Market Segmentation

As discussed in an earlier section, as part of more widespread economic and social reforms with the aim of distancing the state from provision of public services, the public health system has been substantially decentralised and organised into a funder-provider model. In Northland mental health, this model creates a segmented labour market structure of workers working for the Northland District Health Board (NDHB) enjoying good resourcing for their activities, training, professional recognition, and wages harmonised through multi-employer collective agreements (MECAs), and a periphery of workers in agencies within the non-government sector that are dependent upon contracts with NDHB for mental health and do not enjoy the same conditions of work. This structure both drives and impedes the development of human capability of workers in the peripheral sector.

NDHB is the funder of mental health service provision in Northland. As funder it purchases services through the mechanism of contracts with its own mental health services provider arm and with a number of non-government organisations – some

which are community not-for-profit, and others of which are iwi-governed organisations.

There is a considerable wage and skill differential between NDHB and non-government agencies which is maintained and reproduced by contracting for services. As discussed above, there has been a growth in the NGO sector providing the community link to mental health recovery which has been accompanied by a growth in community support workers who are less skilled in terms of qualifications than their nursing counterparts. The non-government labour workforce is predominantly not unionised and their pay rates and conditions are not aligned to rates set in MECAs. NDHB by contrast is unionised with pay rates and conditions set as part of MECAs negotiated through the sector's two main unions and contract rates for individuals benchmarked against DHBs in other regions.

> …in the public sector you have a very dense population of registered nurses, and very few unregulated carers … the NGO sector is very low in registered nurse numbers and works mainly with mental health support workers which are unregulated workers. So there's a high density of unregulated workers and that brings its own challenges as far as delegation and supervision, responsibility and accountability by registered nurses … largely untrained workers … so it's quite a different skill mix, quite, quite different…
> *Sector stakeholder 3*

In addition, the dominant groups in the NDHB, doctors and nurses, are professionalised. With professionalisation, control over entry, maintenance and development of standards, and the social recognition and status of holding an occupation is controlled by governing bodies of the professions themselves, for example the Medical Council and the Nursing Council, rather than by the employer. With the autonomy professionalisation confers, governing bodies of professions have the power to demand of employers, training bodies and the community at large, for training to a sufficient standard 'to do the job'.

Because of the absence of autonomy in determining their own standard of care which the professions enjoy, community health workers do not have the power to force funders or employers to support training. There is thus often an impasse between non-government organisations and funding agencies which prevent non-government agencies from innovating or expanding their service levels because of a lack of recognisably trained employees. Employees in turn do not have the opportunity for job advancement or progression.

Other legislation favours the autonomy of professional occupational groups to determine standards. In particular, the Health Practitioners' Competency Assurance Act, 2003 seeks to ensure that health practitioner's practice is within the scope of what they are trained to do – such scope being determined by the professional associations.

A number of drivers promote job progression in the government mental health sector, particularly among the professional occupations. Professional development is usually encouraged by professional governing bodies as a condition of continuing registration. Usually evidence of professional development is used to support promotions in performance assessment – a process which large organisations, such as District Health Boards, have the human resources to conduct. For instance, registered nurses are encouraged by both the Nursing Council and their government employer to engage in

the Professional Development Recognition Plan (PDRP) – a professional portfolio to evidence competency development over time. A mental health specific PDRP is in the process of development in Northland. A complementary driver for job progression is the power the Public Service Association (PSA), a major state sector union, can bring to bear upon employers. PSA membership density is very high amongst mental health workers in the government sector. Also, the PSA has a philosophy of going beyond being bargaining agents for their members to constructively engaging in industrial democracy with employers. Thus, backed by their organisational strength, the PSA does engage in effective decision-making within the mental health sector, and in so doing enhances job security and job progression within the sector. A further fairly recent complementary driver for job progression is conscious workforce planning by the Ministry of Health as a response to an existing and projected international shortage of health workers[8].

These drivers are less effective in the non government segment of the mental health sector because of the presence of non-professional groups of workers, low union density, and the shortage of resources to engage with job progression issues because of financial pressure and lack of agency size. As such, there is little evidence of job progression within the non government mental health sector.

This difference in wage and skill level between the two branches is reinforced by the NDHB in its contracting to the non-government sector. First, the NDHB uses the difference in skill levels to justify the contracting out of low-skill level work.

> We try to keep everything clinical away from NGOs because (if we don't) they've got to try to attract a nurse…. We use the nurses here to support the services out there. So we try to alleviate the responsibility to the NGOs. They can't afford to pay them and they can't attract them. The hospital has no trouble really attracting nurses because the pay is so hugely different.
> *DHB Manager 1*

Secondly, the NDHB though its focus on input and output measures in its contracts, puts sufficient financial pressure upon non-government agencies so that they cannot afford to pay sufficient wages to attract skilled workers.

> We need to be sure that our financial base is right because whenever you go to a brand new project, you put in your price, the DHB then screw you down to the money they're prepared to pay, so now we've got to make it work for those dollars…
> *NGO Manager 1*

Thirdly, the NDHB uses its near-monopoly position as mental health funder to control the business development options of non-government mental health provider agencies.

> We are very dependent upon the District Health Board for any expansion because they are the only funder that we work with.
> *NGO Manager 1*

> …the perception in NGO land – and we've experienced it ourself – is that the main input for advice in terms of the funds decision making is coming from the (funder's) own provider … the DHB are trying to effect this change and do planning with everybody but in fact we're just doing planning with ... the

[8] See Ministry of Health (2007 a, b, c)

> biggest provider … and it just drowns out the voices and the perspectives and the innovation that could be brought into that mix. It's an issue of will to change that and actually recognise that that's what's going on.
> *NGO*

At the same time as contracting and the associated competition between service providers effectively drives or holds down the price paid for provision of services, increasing pressure is being applied to providers around the qualification levels of their workers, as part of the general policy moves towards accreditation in the non-professional part of the mental health sector. Providers' contracts however, are slow to be adjusted accordingly.

> …It's my view that that's exactly what government did and it is driven by cost because I would dearly love … to employ everybody probably who had a psychiatric qualification … because they know what you're talking about. But now the government's asked us to do this after eroding (our financial viability). Because there's only a certain amount of pie you can buy with the money they give us and if you want to have the, say, 1 to 5 ratio on the floor and you've only got that amount of money to do it, you're not going to be able to afford to pay a registered nurse to do it for instance. So that's where all these new little titles came in of residential support worker, healthcare assistant, those sorts of roles.
> *NGO Manager 2*

> You could always request from on high that all contracts must have a workforce development component in them, given the huge crisis that is workforce in the health system… you'd actually say, "OK, if this is the cost of delivering this service, then we accept that there's a 20 percent overhead that also needs to be applied to it which is actually specifically for workforce development." Because you know as well as I do that when organisations are really, really tight, what falls off the edge? Training is one thing that can fall off the edge because the priority is patients.
> *NGO*

In the pressured financial context outlined above it can be difficult for some non-government organisations to focus on investing in training and on innovative activities. Others have difficulty persuading some of their entry-level workers, or some of their workers of longstanding (who are used to more of a caregiving than rehabilitative role) that although the push for training is to a large extent compliance driven, it is also about lifting the capability of the organisation to be able to deliver services with more of a recovery focus now, and positioning qualifications based training as part of the non-government organisation's culture for the future.

As discussed earlier, NDHB's assistance towards non-government organisation's Level 4 training costs has been a major driver behind the uptake of this training. Once this financial assistance shifts to subsidizing the cost of the new Level 6 qualification however, most agencies will still be faced with the costs of Level 4 training for new entrants to the workplace, as well as meeting the shortfall of the costs for the new Level 6 to meet the signalled NDHB expectations.

Notwithstanding this segmented labour market structure, these are some counteracting pressures from within the sector.

Quality of life considerations lead some professionals to prefer working in the NGO sector, even if this means less pay. For instance, the benefits of less shift work and subsequent more time for family and social life, and working with service users who were not in the acute needs category, for some nurses working for an NGO more than compensated for a loss in income.

> When it came to employing nurses of course we really struggled because we weren't funded to pay at the level that the hospital people are funded to pay and so we've had real trouble attracting people. But what has attracted them is changed circumstances; they want to reduce their hours, they want to reduce the intensity, they want a more friendly working environment, those sorts of issues. …[one of the] … challenges facing the sector. Being able to pay staff good fair wages, I think that's important for us to keep that on board. We don't want to be using and abusing our staff.
> *NGO Manager 1*

At the institutional level, the drive towards more community care means that the projected role for NGOs is to increase as providers of much of the community-based acute and continuing care of mental health users.

> A third of mental health services are provided by the NGO sector and they're now taking on what I would call the more challenging spectrum of long term seriously ill people who need quite a lot of support in the community. Some are doing it better than others. The thing about the NGO sector is that there's a greater, I think there's a greater level of innovation about what they can do (compared to DHBs).
> *Sector stakeholder1*

This brings particular challenges for all types of NGOs (the private and community not-for-profit sector as well as iwi-based organizations) to step up their workforce capacity commitments in order to achieve a workforce with both higher-level and broader capability in time to respond to these provider expectations.

As part of this, DHBNZ is trying to develop a networking relationship with the NGO sector, which it sees as being more effective at community engagement than DHBs but less well organised in terms of business management and workforce capability development. DHBNZ's particular interest is around harnessing the NGO sector's ability to engage with the community as a partner or 'integrator' to help DHBs meet their own requirements to effectively engage with the community.

> We like to be a bit more flexible than the hospital board can be. One of the reasons for packages of care coming into NGOs is that we can make a quick decision that a client's about to lose their house, we'll employ a contractor to go and mow the lawn – $100 done – just write a cheque or ring up the phone and do it – whereas the hospital board it's going to take 5 weeks to get across the CEO's desk… we can make those sort of quick decisions, one of the benefits of NGO style.
> *NGO Manager 1*

This is part of a slow move towards looking at the mental health sector from more of a partnership perspective that recognises different yet complementary roles and the need to better understand each other's areas of business as means of building a services contracting environment characterised by both high trust and high accountability.

> Although we all talk about having an integrated and seamless care system and that's the whole ethos of the New Zealand Health Strategy, the reality is that we're just emerging from a competitive tendering era and so whereas the relationships between individuals may be okay between organisations, there's still constraints and patch protection…
> *NZNO2*

> The goal, to keep maintaining and improving relationships between the two (sub sectors) so that it's seamless…
> *DHB Manager 7*

NDHB has recently made some moves towards actively assisting development of the NGO sector. One example is the inclusion of NGO workers in any NDHB training sessions at no cost, which although it fails to address NGOs' staffing release issues around training, does increase NGO access to relevant training, and also helps to strengthen professional relationships between the two sub sectors.

> The NGOs have difficulty in attending training like that because of capacity issues. They don't have the staff to backfill. They still have to run their services. So that is a big, big issue…
> *DHB Manager 1*

Another example is some funding for provision on a capacity rather than an occupancy basis. Such an approach is reliant on higher levels of communication between NDHB and the NGOs concerned around available capacity at any one time.

> All the other funds are given to us on an FTE basis or a bums in beds basis (but) … for our new house we're getting funded on a capacity basis, which is great because it means you don't have to be full to make any money. (At our other site) we budget on a 92 percent occupancy … and if occupancy is less than that, and remembering that the referrals are not something we have any control over, referrals come through the hospital system. …But the capacity based funding means that we're funded for six beds, whether they're full or not. And that's a much more secure place for an NGO to be in. We don't carry the risk then.
> *NGO Manager 1*

As the NGO sector has matured, its expectations around the contracting relationship have changed. NGOs are acutely aware of a shortfall between the outcomes required by some contracts and the funds offered for their delivery, particularly around services for "difficult" and mobile service users.

> The other driver of this organization has been around being money makers not money shakers when it comes to contracts. We dictate. Not (NDHB) saying "here's a couple of hundred thousand". (Us saying) "This is what we want." And it's ridiculous what they're asking, when you look at the contract and think you've got to deliver on this and you're not even properly resourced or the resources are minimal.
> *NGO Manager 3*

The line between the two types of service provision is also becoming blurred as the impact of policy changes and a new emphasis on community-based service provision starts to filter down to the level of providers. The Ministry of Health and DHBNZ are two stakeholders who anticipate some innovative approaches developing out of what

may appear as a growing overlap in servicing responsibilities between DHBs and NGOs.

> I think that DHB services have tended to provide more of the same hospital based traditional service and they seem themselves as being the safety net and taking …which isn't strictly true but … I think they perceive … they take everyone else that no-one else wants. I would challenge that. I think that there are issues with the DHBs about being gatekeepers in the end (as) the safety fallback…. I think NGOs can equally do that … I don't think that's limited to the DHB domain. I think DHBs tend to do traditional, NGO can do more new community based work rehabilitative type things, but there's no reason why … they couldn't cross over, join forces, do something different.
> *Sector stakeholder 1*

> We have done all of those stages and so we are at the next one which is "Partner with the third sector", which is the NGO sector, so we want to have strong networks across DHBs, strong networks across PHOs and strong networks across NGOs, and once you have that you have all three legs on the stool.
> *Sector stakeholder 2*

Management Culture

Placed in various levels of authority to direct, and be responsible for, labour effort, the practices of people in management can be seen to be both drivers and barriers to developing human capability. Most labour activity in mental health care, as with much 'knowledge' work, is reliant upon workers' own motivation to be effective with the labour they perform rather than be reliant upon managers' ability to 'command and control' labour effort. Hence effective management is largely about creating and maintaining a culture wherein workers' volunteer effective work effort.

> There's the aspect of our quality of service and to make sure the philosophies are properly embedded in the new service … because in a lot of ways I'm the culture carrier… One of the challenges … is to make sure that that philosophy continues in the agency.
> *NGO Manager 1*

Evident from the interviews and organisations viewed, there appears to be a cultural value shared across groups that was oriented towards the public good outcome of sustained mental health in the population through the intervention of various mental health activities. Managers, of course, most clearly espoused these values because it is their job to do so. Mental health workers, as evident in the earlier discussion on why they entered and remain in the sector, also however espouse these broad values.

Management practices, in general, seem to correspond with these values and so mental health workers generally volunteer effective work effort. Most managers talked of management practices of open direct communication, getting 'buy-in', and encouraging autonomy in work practices which is consistent with 'carrying the culture'.

> The more people that are there for the initial planning the more people you've got who are directly communicating as opposed to getting it second hand... you get more buy-in, you get a greater collective energy and collective ownership of what's going on and it's a good way of developing people. … if

> you talk to people, unanimously they normally go 'lots of autonomy, a lot of freedom to do what we want,' but at the same time I'm there at the end of a phone call…
> *DHB Manager 1*

> Here the management style is open and it's encouraged to be flexible. People will look at the areas they work, their own needs, and the skills where they want to head to … so staff often pick their own kind of journey in terms of where they want to practice.
> *DHB Manager 7*

These practices broadly correspond with what mental health workers view as the practices which allow them to have capability. Some of these practices were described in the earlier section on 'what is a capable worker', but in a broader organisational sense, such practices as working in teams and the role of reflective practice with colleagues to lead to praxis both develop human capability and assist management to manage.

It is management practices which do not correspond with these shared values where tensions and barriers to capability development arise. The most evident practice from the interviews creating tensions concerned performance appraisal or review. In this process, management is reflecting an organisational value of efficiency in production which is not necessarily shared or understood by workers. The practices of performance review seem to focus upon outputs, or things that can be measured from the previous period, and such measurements are seen as somewhat removed from the longer term (shared) outcomes which concentrate work effort and which are by nature difficult to measure. The worker's commitment to these shared values is therefore questioned by this process.

> I think the organization could probably show a little bit more interest in our approach to our patients in that kind of way. And I mean things beyond just that we behave in a culturally sensitive manner. …What about just person to person? …And I think it would be really useful feedback for me, because I'd probably get feedback that says I'm doing a really shitty job in places where I thought I was doing OK. I might get feedback vice versa … I don't think the organization values that. I guess it's not really something that's fully acknowledged particularly. I rarely get asked about that in my performance appraisals…
>
> But, you know, I have to be real, it's kind of like a tick box, you know, you do it, if you want a pay rise, you've got to demonstrate that you're doing all these skills, and I guess that's where it's at… Something you do, something that you need to tick to get the next stage, right?
> *DHB Worker 11*

Another related management practice concerned with performance which creates tensions, concerns the use by management of the Professional Development Recognition Plan (PDRP) as an evidence-based assessment tool for performance assessment or review of nurses when the intent of the tool was for its control by the Nursing Council to codify professional development and to protect nursing as a profession. As with the discussion of performance reviews above, the use of this tool contradicts the assumption of shared values of the outcomes of work, but more particularly places value on (measured) nursing practices which are contrary to what

nurses value but cannot quantify. This then creates a tension of not being valued and undermines both their capability development and their commitment to organisational values.

> (Nursing should) have a standard that people reach and then leave them alone. Nursing's become too political and too – for want of a better word – too PC. So one of the bugbears I hear a lot from my staff, who are very experienced, is that … they've been doing a job for 30 years and they seen that they've got a core group of skills and they should be recognised for what their core group of skills is, not have to constantly do PDRPs and all that…. And it's turning it into a kind of backward step as most of these senior nurses (are) getting near the end of their kind of careers and (yet) the younger nurses are doing (PDRPs) and becoming expert type practitioners and all that, and it's not making the balance quite right.
>
> I just hope that the places like the Nursing Council and people that turn themselves into political monsters, that they're in the profession, will wake up one day and say 'Hell, we've got a dwindling resource, how can we support the people that have been in the field for a long, long time without marginalizing them?
> *DHB Manager 7*

A management practice which creates a tension between shared values and other values concerned the induction process of workers entering the sector and placements of students in their practicum. Interviewees were almost unanimous that the initial induction into their work roles was inadequate.

> I did a three minute orientation when I came – because I'd worked in the hospital for 20 years they just assumed that I knew what I was doing but this was a new ball game for me, but I looked, watched, read and fumbled my way through and then decided that I'd like to be part of that because of how I struggled and I had 20 years up my belt working in this environment. Just imagine what someone who has no experience, except maybe in their own life looking after people – so that's why I'm pretty passionate about (induction) and it's all geared around safety.
> *DHB Worker 3*
>
> My boss went 'Come with me, we'll go to the Mental Health unit,' and that was it. He didn't even show me the toilets, man. Nothing. That was my induction… I did it myself… Oh, where's the torch? What do you guys do what you do? Where's the organization here? Someone sort of put their hand up… (I said to myself) Get yourself out of the context of 'worst job I've ever had' stuff. I'm sitting here, OK, no orientation, no squat. 'Anyone happy to take me out with them?' OK, one person put their hand up and that was it.
> *DHB Worker 9*

As with performance reviews, the practices of induction are inconsistent with the practices expected in creating and reinforcing and reproducing the common culture which both the organisation espouses and individual workers seek. This created tensions and undermines developing human capability.

Lastly, inter-organisational management practices concerning audits undermine the shared values over health outcomes. Audit requirements from NDHB appeared to be poorly aligned with the more community-based context of non-government agency

service provision. The potential for the current audit response to develop into a genuine quality assurance approach based on self-assessment and evaluation in the future was subsumed by the difficulties agencies had in trying to align the audit process and results with their own organisation priorities, and even in some instances, common sense practice.

> …We were operating a home for people who were going to move into their own homes in the community, so we were trying to make it as home-like as possible. The last thing you want is signs and tick boxes everywhere. We had always worked on the philosophy and not on the tick box, so I thought 'I'm not sure how this is going to impact us'…Because we had something like 64 corrective action requests. And that was all about paperwork. It wasn't service quality. It was about proving that you were doing things. If it's not on paper it never happened. If it's not signed somewhere it never happened.
> *NGO Manager 1*

> So the auditors go and look at that stuff and it looks fine, but what is happening is there's a huge gap now between talking the talking and walking the walking as far as delivery of care…. There's no one saying 'ok, you've had this patient for x number of days or x number of weeks. Show me where they're at on your continuum of care and your continuum of rehabilitation'.
> *DHB Worker 10*

As with other management practices, the practices of audit, by concentrating on what is measurable (inputs and outputs), creates tensions in what were assumed to be shared values. These tensions undermine developing human capability.

Kaupapa Maori

The clearest example within Northland mental health that leads to the interpretation of human capability as the positive freedom to live a life of one's own choosing comes from within iwi organisations in the sector. For within such organisations the cultural values of Te Ao Maori (literally, the Maori way) are dominant. With this dominance, the aims and practices of those working in iwi organisations, as well as for their large Maori clientele, correspond with that collective, positive desire to live lives according to Te Ao Maori. That is, to have human capability in the broad sense of being able to lead a life of one's own choosing.

There are a number of historical drivers which have enabled iwi organisations to exert a large degree of autonomy from the western cultural values that are dominant at the broader societal level. A key driver has been the ability of Northland iwi to organise politically to exploit shifts in the position of the state towards limited forms of tino-rangitiratanga or self-determination with the state's desire for more devolved, community-driven provision of public goods, including mental health of the population, by creating iwi-based health bodies. This ability to act politically is underpinned by the large Maori population in Northland.

As discussed in earlier sections, Northland's Maori NGO mental health providers are part of a wider grouping of Maori health providers who meet as an Alliance, under a collaborative approach to contracting opportunities in the region across health sectors. The regional Alliance of Maori providers is unique in New Zealand and serves as a forum for the discussion of new national policies and initiatives and for strategic planning around implementation at the local level. There is a pragmatic acceptance that development benefits are both prioritised to have the most effect and that

knowledge obtained is shared across the group for the benefit of the alliance as a political unit as well as for individual member organisations.

> I think it's exciting times for Maori and in particular mental health now… We were talking about Maori models of practice and from this, all these people from all over the rohe all of a sudden are writing all these emails and having their say … we need to have a Maori MH [and we would] hui so that we can … share the models we're currently working with. Share the issues that are going on for us as Maori providers, how can we make it better for us. How can we make it better for our people around accessing these services, accessing sufficient funding to produce the goodies, to give good service?... I'm very much focused around Maori for Maori. By Maori, for Maori, with Maori. Where we can.
> *NGO Manager 3*

Within these iwi organisations therefore it is possible to initiate Maori health initiatives, to legitimately 'be a Maori', for Maori mental health workers to be able to choose their own mental health pedagogies, and where the principle of whanau and the practice of whanaungatanga is an integral part of the practice of mental health.

These freedoms notwithstanding, there are a number of barriers to this development of human capability. The first is an uneven spread of Maori mental health workers across Northland. Whilst Northland's demographics suggest there is a sufficient number of Maori mental health staff in proportion to the Maori population, the geography of Northland often leads to an uneven distribution of skilled staff in relation to need. Organisations may have vacancies for skilled Maori staff, but cannot attract them to their locality.

> A lot of OTs (occupational therapists) are female. Very rarely you get Maori and Pacific Island OTs … A lot of them seem to be European – like (from) America, Canada and England. I know over here there's only 11 registered Maori. And being male in OT is quite a minority in itself. So, Maori and male? I think there's only about 4 (in New Zealand).
> *DHB Worker 12*

A related recruitment barrier is the inability of the sector to recognise and acknowledge the particular skills that some Maori mental health workers bring to their work practice and work relationships with professional colleagues and service users, and of its contribution to the quality of services offered in Northland's mental health services. These skills are cultural and cannot be codified and taught and cannot be measured.

> One of the things that often happens is that Maori get used, Maori staff, regardless of where you are. That skill base of yours gets tapped into all of the time but it's never acknowledged as being a valid skill base as such. You're the informed cultural advisor for your colleagues who have particularly curly ones. You're the cultural ambassador for Maori whanau or whoever. There's this whole set of activity that go on that I just wouldn't participate in, up till now!
> *DHB worker 2*

Similarly, there is criticism that the dominant western medical models used in education and professional development hinder the development of Te Ao Maori.

> So clearly why you're responding like this is because there's no relevance in your training for cultural things Maori, so it's irrelevant. But really there's a huge amount of our people in MH and they need a significant amount of cultural training around Maori world view.
> *DHB Worker 1*

More generally, in the more rurally isolated parts of Northland, where Maori populations are dominant, the geography acts to limit recruitment of Maori mental health workers seeking to develop a career. The effect of a rural placement on career advancement, the low value accorded to rural 'generalist specialist' experience, difficulties in accessing professional development and building professional networks; and family related considerations, such as limited schooling and tertiary education options, and lower property-investment returns all conspire to make Northland in general, and Northland Maori mental health in particular to be an unattractive career proposition for workers in demand. This isolation is exacerbated by the lack of capacity due to the contracting environment, of NGOs, including iwi-based organisations, to pay attractive salary packages to potential job applicants.

Developing Human Capability in Northland Mental Health: Conclusion

The sector called Northland mental health is a complex assemblage of many people with different skills and backgrounds working within a diversity of organisations collectively working towards the public good outcome of a mentally healthy population in Northland. As this research has progressed it became clear that, in order to conclude with something to say about developing human capability, explicit account had to be made of this complexity and diversity of people and organisations.

As discussed in the mid-section of this paper, the conceptual framework developed to incorporate this diversity draws upon the capability framework of Sen. Sen's account of capabilities describes individual well-being in terms of a person's ability to achieve a given set of functionings, or things and activities a person values doing and being. The analyses presented in the early sections of this paper extend Sen's account into mental health workers in Northland. For such workers work constituted part, albeit an important part, of what they valued doing and being in their lives. Each person working in mental health care chose to do so, but for their own reasons. Such choice and subsequent ability to make use of their situation to achieve valuable functionings was also constrained and facilitated by non-choice factors which lay elsewhere at the societal and organisational level.

Drawing upon Sen thus is the idea that developing human capability is concerned with those social arrangements, conversion factors, or characteristics of individuals, their society and their immediate environment, which together determine a person's ability to achieve a given range of functionings. The identification of these conversion factors, be they barriers or drivers, identifies those factors which develop or hinder human capability development.

This section summarises the drivers and barriers to human capability development among workers in Northland mental health that have emerged in this research. The drivers and barriers are presented in Table 2 and draw upon the discussions in the previous sections.

Table 2: The Social Arrangements (Drivers, Barriers) to Developing Human Capability in Northland Mental Health

	Drivers	Barriers
Institutional	Mental health strategy Iwi political and economic organisation (e.g., regional alliance of Maori providers enhances capability) Shortage of mental health workers Education system, e.g. the stair-casing of industry training builds capability (particularly for those with poor secondary school experiences); formal, structured learning drives broader understandings and capability development, and establishes professional networks Contracting of mental health provision has driven up-skilling (and consequent increase in individual confidence, choice and capability) Mental health jobs are local, available, long term work in a tight local job market	State constraints on mental health funding Contracting of mental health provision Lack of acknowledgement by the sector of Maori mental health worker skills Rural geography can constrain some capability development opportunities
Organisational	Occupations – recognition of mental health nursing and community mental health work as worthy occupations with certain skill needs and broader capabilities Management belief in goals of mental health, facilitating team work and reflective practice Unions adopting a partnership approach with a desire to engage with employers not just on pay and conditions but also on capability related issues (e.g., productivity, service to mental health users, etc) Professional standards and competency assurance mechanisms Importance of a balanced team – mix of experienced with inexperienced workers for effective workplace learning, mentoring and sharing of capability Appropriate resourcing and infrastructure drives quality service and capability Organisation paying study fees, and providing paid time off work for study The nature of the work (the blend of technical and interpersonal skills) acts as a driver of capability	Occupations – the need to resource exponential increase in occupational qualifications constrains organisational ability to fund basic qualifications Management – performance management based on efficiency of production and outputs Lack of support (in workplaces and in professional training) for use of Te Reo or maori values impacts on Maori capability and non-Maori capability in a Maori environment Perceived inadequacy of organisational induction processes Perceived inequalities in professional development and promotion processes

Individual	Personal beliefs and values and interests influence career choice and desire to foster personal development and well-being Proactivity: -desire to continue learning and developing through experience -self motivation to develop Qualifications and up-skilling opportunities give confidence to be capable Skills, passion for the job, self awareness and a supportive team Networking and links to the community enhance capability as a mental health worker	The absence of confidence, motivation, or no way to access it Poor schooling experiences

It is evident, in this summary and the paper as a whole, that institutional and organisational arrangements have a significant impact on the development of human capability for mental health workers in Northland. These arrangements constitute key drivers of capability development. For example, a national mental health strategy has shifted focus to communities and has shaped mental health occupations; the health sector contracting environment and specifically contracts for mental health services which require investment in formal up-skilling of staff; a stair-cased industry training system which is able to capture those who have missed out on other educational experiences; through to the capability development power of the management culture of organisations expressed in balanced work teams sharing expertise and knowledge. However, while factors such as these provide the environment for capability development, they also contain constraints – many of which are discussed in this paper. This case also clearly shows the importance of Maori institutional and organisational arrangements to developing capability in a kaupapa Maori environment, and also the challenges for Maori to develop their capability within and outside such an environment.

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Glossary

DHB	District Health Board
DHBNZ	District Health Boards New Zealand
MAPO	Maori co-purchasing organisations
MECA	Multi employer collective (employment) agreement
MOH	Ministry of Health
NDHB	Northland District Health Board
NGO	Non government organisation
NZNO	New Zealand Nurses Organisation
PHO	Primary health organisation
PSA	Public Service Association
TEO	Tertiary education organisation