

11. HUMAN RESOURCES

11.1 Introduction

Human resource issues under Mental Health Reform pose complex problems and require innovations in thinking about the deployment and training of mental health personnel. The following review highlights the critical human resource issues identified by various jurisdictions and the approaches used to resolve them. Empirical research findings are not available in the literature to inform this discussion but descriptions of process and identification of problems with recommendations are available in reports and papers. These serve as the basis for this brief overview of human resource issues (see references).

Several important questions help to focus the discussion on human resources under Mental Health Reform. What new services will be provided and what are the skills involved? How should the work force be reorganized and what will it look like? Where will the jobs be and who will do the work? (*Premier's Council, 1994*). Hyde, in writing about human resource development, stresses the direct link between human resource planning and development and the quality and efficiency of program implementation (*Hyde, 1989*). The success of Mental Health Reform is then largely dependent upon good analyses of the human resource problems and the creation of viable strategies to manage them.

The shift in services from institutionally-based to community-based and the concomitant changes in treatment philosophy under Mental Health Reform represent the two major adjustments for the work force as a whole. A whole range of issues is associated with the transfer of resources into the community or redeployment. In the second area the changes in treatment philosophy require that workers prepare for new roles through training and reskilling programs. In each area of redeployment and training, there are specific system and program level concerns.

11.2 Redeployment of Staff

In most jurisdictions the shift to community- based service provision under Mental Health Reform occurs along a given time line, e.g., ten years. It usually takes as a benchmark for reallocation of resources, the transfer of approximately 50 percent of institutional resources to the community. In any system, this represents significant numbers of people whose working lives are affected. The literature shows that issues pertinent to redeployment are uniformly similar across jurisdictions. At the **macro/governmental level** the concerns most commonly identified are:

- differences in levels of compensation between institutional and community workers
- lack of transferability of pension and other benefits
- loss of seniority in cases where workers are coming from a unionized environment
- concerns of **regulated** health professionals that discipline specific work will be replaced by generic/multiskilled workers resulting in loss of provider accountability.

Proposed solutions to these obstacles to change are:

- adjust compensation levels using the principle of ‘equal pay for equal work’. This requires investment in job evaluation
- maintain comparable benefits
- provide job security commitments for those being transferred and alternative placements for staff unable to make the transfer (*Goodrick, 1990*)
- ensure practice standards are developed for new classes of workers and provider accountability is assured
- ensure the role of mental health professionals under mental health reform is defined

The time-frame, pace and magnitude of redeployment should be clearly articulated and negotiated, if necessary, at the governmental level. Determining the size of the workforce involved, the role attrition will play and the impact of governing legislation on plans for redeployment is important. Recently a survey was conducted in Ontario for the Health Sector Training and Adjustment Program that assessed the human resources patterns in the health care field and the activities and resources dedicated to training in preparation for health care restructuring (*Health Sector Human Resources, 1996*). All agree that adequate funds must be allocated to cover the costs of redeployment.

Redeployment at the **program level** involves problems and actions of a different sort. Programs can facilitate change by attending to process variables in employer/employee transactions. Building partnerships, using open communication styles, recognizing the threat experienced by workers, and providing supportive and innovative work environments contribute substantially to the success of the redeployment task. Human resource plans and implementation agreements that detail the specific conditions under which redeployment will take place are common as is the **voluntary** reassignment

of staff. Some organizations negotiate partnership agreements with community service providers that allow for the exchange of staff between inpatient and community services.

11.3 Training and Education

The reorganization of the workforce to do different types of work, e.g., case management, using new models of care, e.g., psychosocial rehabilitation, in community settings, requires careful attention to the preparation and retention of workers for these new roles. Training, education and reskilling initiatives are fundamental to the implementation of Mental Health Reform. Strongly emphasized in the training are the values under Mental Health Reform.

Responsibilities at the **macro level** in this area are:

- clear articulation of values of Mental Health Reform
- establishment of provincial training standards and core curriculum
- identification of attitudes, skill sets and knowledge bases for key Mental Health Reform roles, e.g., case management and crisis intervention
- provision of training funds
- assistance in the development of a structure for delivering training by identifying trainers and developing linkages within professional schools and community colleges to provide **generic skills** that enhance workforce flexibility and adaptability

An example of case management training in Ontario is the Humber College Post Diploma Certificate Case Management Course developed by the International Association for Psychosocial Rehabilitation, Ontario Chapter. The course, in operation since 1990, runs for 15 weeks and is open to students of diverse academic backgrounds, consumers and family members. Students work in a range of mental health and social service settings. The course focuses on the application of psychosocial rehabilitation principles to case management. It has been adopted by other communities in the province.

At the **program level** managers are providing opportunities for the assessment of the learning needs of employees, cost-effective training programs and mechanisms for helping employees with the change process. Organizations and jurisdictions involved in training recommend that training programs use the principles of adult learning and offer the program through a mix of experiential, didactic and in vivo methods, e.g., placements in community settings. Matching the backgrounds of the trainees with the characteristics of the community setting eases acceptance of new roles for institutional workers.

An excellent example of an organization-based course is the St. Thomas Psychiatric Hospital case management education and training program. Using the *Case Management Training Resource Guide (1993)* framework developed by the Mental Health Case Management Association of Ontario and

enhancing it with the addition of training modules, the course was initially designed for psychiatric hospital workers and then expanded to community mental health workers and consumers. The program is currently being evaluated by a local university.

Perhaps the greatest single training barrier for professionally trained institutional workers is the perception that the carefully cultivated discipline specific training valued by the professions will be lost in the change to a more generic role focus. Under Mental Health Reform workers on the whole are expected to provide services using a psychosocial perspective and from a community-based location. That is not to say that the specialized training of psychologists, nursing, social work and occupational therapy is not needed and does not have a place. What it means is that the field will expand to include non-professionally trained workers and those from the professions will be expected to incorporate new methods into their practices.

Integral to the success of training is the importance of respecting the skills and abilities of those undergoing training and recognizing the vast opportunities for skill transfer to the community. Organizations have started to recognize the benefit in making it easier for workers to move between the nonprofessional and professional sectors as the mental health field opens to non-credentialed workers and consumers. At the same time the field needs to ensure practice standards are in place and can be monitored in order to ensure provider accountability.

11.4 Consumers as Providers

The employment of consumers as providers of mental health care is a relatively recent phenomenon which has received some attention from prominent researchers in the field. A recent study by *Solomon et al., (1995)* investigated the use of consumers as case managers in a PACT model program to deliver care to seriously mentally ill patients. Using an experimental design, clients were randomly assigned to two teams, one composed exclusively of consumer case managers and the other made up of professionals. The results show that consumer case managers were equally successful at forming strong working alliances with clients and promoting positive outcomes.

Mowbray and Colleagues (1996) examine the issues created by employing consumers as peer support specialists for a research demonstration project designed to expand vocational services offered by case management teams. They found that peer support specialists (PSS) were highly positive about the benefits of their service. They described several positive outcomes in clients' job successes. They found that the identification factor in which one peer can offer another sympathetic understanding of mental illness - something which is often defined out of professional-consumer relationships - may add a special form of support and perhaps intimacy that can lower the social distance between provider and recipient with positive results.

Woodside and Cikalo (1995) describe a collaborative research project carried out by consumers and mental health professionals to learn what activities are meaningful for clients. The research team found the experience empowering, with consumer researchers discovering new skills and confidence,

and professionals appreciating the knowledge, skills and perspective brought by the consumers. Traditional power relationships between professionals and consumers were shifted during this project

Manning and Suire (1996) discuss factors which affect consumers' success as employees of mental health programs. The authors interviewed consumer case manager aides for information about the "bridges and roadblocks" encountered in their work. These factors include issues around orientation to the job; support from peers and supervisors; clear role expectations including the level of autonomy or involvement in decision-making and opportunities to work independently; empowerment through being treated like other employees and increased awareness of capabilities; the stigma of mental illness which interfered with their relationships with other staff and excluded them from some legitimate work activities; and agency policies which reduced stress and promoted job security including job sharing, flexible hours and a team approach with back up. Manning and Suire conclude by stating that by attempting to overcome the obstacles encountered by consumers in work situations "professionals and co-workers can facilitate new consumer employees' entry into the job market and provide the support they need at a very stressful time of transition. In turn, consumer employees can bring innovative and unique skills and perspectives to the mental health service system" (p 943).

11.5 Human Resource Development in the Health System

The focus of our discussion is human resource issues under Mental Health Reform yet the Health System too is undergoing rapid and significant change, much of which is mirrored in the smaller mental health system. The background paper prepared by the Health System Renewal Working Group on Human Resources refers to human resources being caught up in the 'tangle of reform' (*Background Information, 1996*). Shifts in emphasis in health care policy to primary care, increased community care, prevention and health promotion require new skill sets and in some cases new classes of workers. The larger system is struggling with regulation, remuneration and deployment of these new or 'renewed' workers. The changes too have implications for educational institutions, employers and the consumers of health care. The increased accountability required by the government and the public demands that workers and their employers prove that they are working efficiently and effectively. This emphasis requires the incorporation of best practice methods, the development of excellent information systems and the application of evaluation methodologies for services provided. This represents an enormous challenge to the whole system.

In another document, *Integrated Health Human Resources Development (1995)*, several issues and barriers to more integrated human resources are identified. Those relevant to mental health include: limited linkages between planners, policy makers and human resources development; consumer and provider resistance to change; competition among provider groups; current discipline focused educational models; and limited knowledge regarding the human resources requirements under reformed health care. They recommend collaborative and integrated action among all stakeholders in the areas of human resources planning, training /education and management.

11.6 Discussion

Jurisdictions across North America learned that attention to human resources in preparation for Mental Health Reform is essential to its successful implementation. Redeployment strategies and training frameworks are the key elements of human resource planning and much can be learned from the experiences of others to date. This brief summary has provided an outline of the complex problems that will be encountered in attempts to reorganize mental health services and shift resources from institutional settings to the community. Underlying the effectiveness of these strategies is the importance of political will to work through the complexities involved and a shared vision across all sectors.

11.7 Best Practices: Human Resources

Key Elements of Best Practice

There is a labour strategy to facilitate redeployment of staff that:

- ★ addresses issues such as the impact of collective agreements, loss of seniority, differences in levels of compensation;
- ★ clearly articulates the time frame, pace and magnitude of redeployment;
- ★ allocates adequate funds to cover the costs of redeployment.

There is a training strategy for developing the skilled labour force needed to implement mental health reform that includes both training and reskilling initiatives.

There are strategies in place to enhance consumer involvement as providers - e.g., through training, by including experience as an employment criterion.

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